SADC GENDER PROTOCOL 2024

BAROMETER

Voice + Choice

Editor in Chief: Colleen Lowe Morna

Southern Africa Gender Protocol Alliance

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

Gender Links coordinates the work of the Alliance.

#VoiceandChoice
SADC Gender Protocol Barometer 2024

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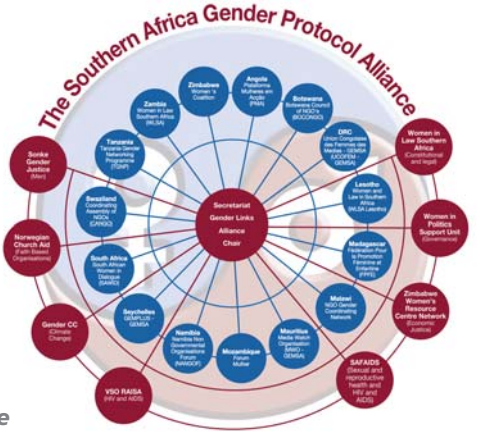

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GENDER LINKS FOR EQUALITY AND JUSTICE

AMPLIFY CHANGE

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Executive Summary

"We are the ones we have been waiting for". The late GL Botswana Director Chigezi Chinyepi giving out awards at the Voice and Choice Southern Africa summit in November 2023.
Photo: Colleen Lowe Morna

This 15th #VoiceandChoice Barometer is being launched at a time when the rights of women and LGBTQI+ people are under serious threat globally as a result of the seismic changes that a second Donald Trump presidency is heralding.

Amongst the many geopolitical changes, the US has signalled its intention to withdraw from the World Health Organisation (WHO) which has serious impact on world health; from the Paris Agreement, with potentially disastrous consequences for the global effort to slow and address the climate crisis. Trump has immediately suspended all foreign assistance through USAID. This includes aid through the President's Emergency Fund for AIDS Relief (PEPFAR) which has been the largest funding programme for HIV and AIDS programmes, with a focus on 25 countries of which 12 are in SADC.[1]

The Trump administration's decision to freeze aid has significantly reduced funding for health research and services. This has affected HIV programmes, contraceptive access, and other reproductive health services. For instance, the withdrawal of USAID funding has denied nearly one million women per week access to contraception.[2] Many organisations, including the South African Medical Research Council have faced catastrophic financing cuts, which has disrupted critical health research and services.[3]

Within the region threats to Sexual and Reproductive Health and Rights include climate crises of drought, floods, cyclones; political uncertainty and on-going violence; with economic decline. There are also opportunities, especially in commitment from the African Union which has recently adopted the African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG), the first continental legal instrument for the prevention and elimination of all forms of violence against women and girls in the world. There is also leadership from SADC which adopted the SADC SRHR strategy and is tracking progress to achieving the targets set in this strategy.

This Barometer provides a comprehensive analysis of 100 indicators that reflect the current state of reproductive health and rights within the 16 SADC countries. Through a detailed examination of Menstrual Health, Family Planning and Maternal Health, Adolescent Sexual Reproductive Health and Rights (ASRHR), Safe Abortion, HIV and AIDS, Gender-Based Violence, Harmful Practices, and Sexual Diversity, the chapters highlight significant areas of progress as well as concern. This edition indicates that, overall, the region's advancement in Sexual and Reproductive Health and Rights (SRHR) and women's rights has been sluggish.

1 Where we work - PEPFAR. https://www.state.gov/where-we-work-pepfar accessed 18 February, 2025.
2 Trump's aid cuts deny one million women a week access to contraception (2025) The Independent. Available at: https://www.independent.co.uk/news/world/usaid-global-health-hiv-women-africa-b2694023.html (Accessed: 21 February 2025).
3 Mandavilli, A. (2025) 'Trump Administration Halts H.I.V. Drug Distribution in Poor Countries', The New York Times, 27 January. Available at: https://www.nytimes.com/2025/01/27/health/pepfar-trump-freeze.html (Accessed: 28 January 2025).

The analysis reveals achievements and challenges, underscoring the need for targeted interventions to improve healthcare access and outcomes, particularly for vulnerable groups such as young women and adolescents. This overview sets the stage for an informed discussion on strengthening SRHR policies and practices to enhance public health and ensure equitable access to services for all individuals, as envisaged in the SADC SRHR strategy 2019-2030.

The Barometer showcases 22 case studies from Voice and Choice partners in eight Southern African countries. These 38 organisations received funding from Amplify Change through the Voice and Choice Southern Africa Fund (VCSAF) managed by Gender Links from 2022 to 2024. The fund aims to empower people to realise their sexual and reproductive health and rights (SRHR) by supporting civil society organisations in regions like Africa, South Asia, and the Middle East to advocate for better policies and actions on critical SRHR issues, particularly in areas where access is most challenging; essentially, they strive to break the silence surrounding SRHR through grassroots activism and policy change.

Partners in progress: Voice and Choice grantees at the November 2023 Summit in Johannesburg.
Photo: Colleen Lowe Morna

SADC Milestone Scorecards

In November 2021, governments 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. The SADC Score Card is a high-level peer-review accountability tool consisting of 20 critical indicators for accelerated action on the ten outcomes of the strategy. The scorecard, which is available online[4], is a graphic display of countries' progress in achieving the targets, indicating upward or downward movement and colour-coding indicating the extent to which targets or milestones have been achieved.

> Member States to report every two years on progress made in the lead-up to the 2030 target date for achieving the SDGs

The SADC 2021 Milestone Scorecard was the first set of results using baseline data from 2019 and the strategy's targets. In November 2023, governments launched their second milestone scorecard in Luanda, Angola. The second milestone enables cross-regional comparisons on progress made, inspires identification and sharing of good practices, thereby ensuring better SRHR outcomes for individuals, families, communities, countries, and the SADC region."[5]

SADC expects Member States to report every two years on progress made against the Scorecard over the next five years in the lead-up to 2030, the target date for achieving the Sustainable Development Goals (SDGs).

The following table provides a summary of the progress and challenges for selected SRHR indicators in the SADC region.

4 https://dev-www.sadc.int/srhrscorecard/
5 ibid

Table 1: Progress against SRHR indicators

Indicator	Progress	Challenges
Family Planning Targets	Eight countries met targets	Six countries have yet to achieve targets
Maternal Mortality	Mauritius and Seychelles met SDG targets	High rates in DRC, Malawi, Zimbabwe
Minimum legal age of consent to marriage, 18 years for all irrespective	South Africa, Zimbabwe, and Zambia's Marriage Act amendments	High rates of child marriage in Mozambique, Madagascar, and Malawi
Percentage of primary schools that provided life skills-based HIV and sexuality education in the previous academic year	Steady increase (4%) between 2021 and 2023 SRHR scorecards	Malawi and Comoros have not yet endorsed the ESA commitment Implementation challenges due to political resistance, cultural beliefs, and institutional challenges
Adolescent birth rate, 10-19 years of age	Programmes to reduce adolescent birth rates through CSE and improved access to contraceptives	High adolescent fertility rate in Mozambique (165 births per 1,000 women aged 15-19) and other countries
Proportion of facilities providing integrated SRH services	Seven countries provide menstrual hygiene products in schools	Only seven countries have removed of VAT on menstrual products
Mother to child transmission of HIV	Botswana and Namibia on track to eliminate vertical transmission	There is a surge in HIV in Madagascar which is cause for concern
Obstetric and gynaecological admissions due to treatment of abortion	Women exercising agency to find safer abortion e.g. traveling to countries where it is legal and accessing medication abortion	Very slow progress in legislation review or change
Density and distribution Health workers per 10,000 population	Programmes to train and retain health workers have been implemented in various countries	Covid-19 exacerbated weaknesses in health systems
Neonatal mortality	Comoros, Mauritius, Seychelles and South Africa have achieved the SDG neonatal mortality rate target	Remains a significant challenge in many SADC countries
Proportion of services within the essential package of SRHR services covered by the PHC facility	South Africa's mobile app for Adolescent and Youth Friendly Services (AYFHS)	Low access to basic sanitation and handwashing facilities in most countries except Mauritius and Seychelles
Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15	HPV vaccination is included in eleven countries' national vaccination programmes National cervical cancer screening programmes in seven countries	Low coverage in some areas
Unmet need for family planning (contraception)	Programmes to improve access to contraceptive methods and family planning services	High unmet need for contraception in South Africa (31% for adolescent girls, 28% for young women)
Percentage of annual budgets allocated to health sector	Malawi raised its health budget allocation from 8% to 12% in the 2024/25 National Budget[6]	Below Abuja Declaration target of 15% in most countries
Percentage reduction in new HIV infections, females 15 - 24	Eswatini, Botswana, Zimbabwe, Zambia, and Malawi achieved the 95 95 95 targets	Higher prevalence among women, particularly young women, than men SADC is still the epicentre of the global HIV epidemic
Percentage of condom use with last high-risk sex among adolescent girls and young women aged 15-24 years of age	Awareness programmes to promote condom use in 16 SADC countries	Reduced availability of highly subsidised condoms
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	South Africa's high court ruling on rape suspects	35.5% of women in South Africa experienced physical and/or sexual violence Increasing risks with access to technology 15 out of 16 SADC countries fail to meet minimum standards for eliminating trafficking
Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation	Nine countries have laws and policies that allow adolescents to access SRH services, including contraception, without third-party authorisation	Lagging access for Adolescents in some areas
Legal status of abortion	SAASA (Safe Abortion Alliance of Southern Africa) in place Public perception programmes in place	Stringent abortion laws in many countries Strong social norms against abortion
Percentage of maternal deaths due to abortion	Efforts to Promote Safe Abortion Care Advocacy for decriminalisation Integration into health services	Between 4% of maternal mortality (in Botswana) and 14,1% (in Zambia) is attributable to unsafe abortion
STI Incidence rate - number of new cases of reported STIs (Syndronic or etiological reporting) over the last 12 months	Targeted prevention and treatment programmes	Six countries with HIV prevalence rates exceeding 10% Increasing strain due to growing number of people on ART
Proportion of women who have experienced sexual violence in last 12 months	South Africa's high court ruling on rape suspects	Women and girls in conflict affected areas like the DRC at risk of violence

[6] Nankhonya, J. (2024) Health budget raise excites Sadc Parliament, Nation Online. Available at: https://mwnation.com/health-budget-raise-excites-sadc-parliament/ (Accessed: 21 February 2025).

Structure of the #Voice and Choice Barometer

This 2024 Barometer follows the format of the previous editions. It contains the following chapters:

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

Key highlights in each theme chapter of the Barometer include:

Menstrual Health, Family Planning and Maternal Health

During his presentation at the launch of the second milestone scorecard, Ketha Francisco, Head of the Primary Health Care Department at the Angolan Ministry of Health, highlighted regional progress on reproductive health. He noted that eight SADC countries have successfully met or surpassed their family planning targets, while six member states have yet to achieve these benchmarks.

The regional average of unmet need for contraception in southern Africa remains high at approximately 19%, which exceeds the global average of 9%. The lowest unmet need is in Zimbabwe at 8%, while Angola has the highest rate, estimated at 38% of married women. This rate reflects significant challenges in family planning and gender equality in Angola, where the modern contraceptive prevalence rate remains one of the lowest in the region at just 12.5%. Seven SADC countries have now removed VAT from menstrual products, and seven countries provide menstrual hygiene products in schools, mainly in rural and disadvantaged communities. Access to basic sanitation and handwashing facilities remains low in all countries except Mauritius and Seychelles.

Maternal mortality remains high. Only Mauritius and Seychelles have met the SDG target of fewer than 70 deaths per 100,000 live births. Efforts to lower maternal mortality across SADC have had mixed results, with high rates in several nations, including DRC, Lesotho, Malawi and Zimbabwe, where economic instability and healthcare limitations are contributing factors.

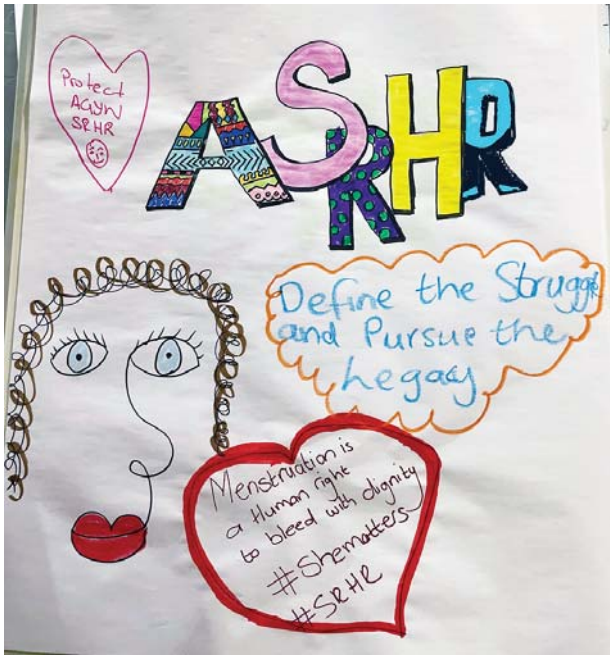
Eleven countries in SADC have included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 67% in Mauritius to 13% in Malawi. The incidence rate of cervical cancer per 100,000 women per year attributable to HPV is higher than the Africa average of 26 incidences in all countries except Mauritius. Seven SADC countries now have national cervical cancer screening programmes. However, large-scale coverage remains a challenge, ranging from 4% in Mozambique to 56% in South Africa for women ever being screened for cervical cancer. SADC's health sector expenditure remains below the recommended Abuja Declaration target of 15% of the national budget. Botswana has the highest proportion of budget for health at 19% while Mauritius' proportion is the lowest at 3%.

Adolescent SRHR

Adolescent Sexual and Reproductive Health and Rights (ASRHR) are critical for the well-being and development of young people in Southern Africa. The region faces significant challenges, including high rates of HIV and AIDS among adolescents, child marriages, adolescent pregnancies, and violence against children. Child maltreatment is widespread, often rooted in the low societal status of children and influenced by cultural, social, and religious beliefs.

South Africa's Department of Health has officially launched a cutting-edge mobile app designed to provide adolescent and youth-friendly health services (AYFHS) and information, aiming to improve access to essential health resources for young people. This represents a significant advancement in improving access to essential health resources for young people.

A study by the Stop Stockouts Project (SSP), found that contraceptives are the most common stockouts in South Africa, highlighting significant gaps in the supply chain. As the region is still recovering from the impacts of the COVID-19 pandemic, new viruses and potential pandemics are emerging, posing additional challenges to weak health systems. In South Africa, there is a notably high unmet need for contraception, with 31% of adolescent girls aged 15-19 and 28% of young women aged 20-24 lacking access to necessary contraceptive methods. The high unmet need for contraception among adolescents and young women in SADC underscores the critical gaps in reproductive health services.



Comprehensive Sexuality Education (CSE) equips young people with the knowledge, attitudes, and skills to make informed decisions about their health, well-being, and relationships. Despite the clear benefits of CSE, its implementation in Southern Africa faces numerous obstacles. Political resistance, cultural beliefs, and institutional challenges hinder the widespread adoption of CSE programmes. Mozambique has the highest adolescent fertility rate (AFR) in the region, with 165 births per 1,000 women aged 15 to 19, which correlates with high rates of child marriages and early pregnancies. These statistics underscore the urgent need for enhanced ASRHR initiatives across Southern Africa to address these pressing issues.

Safe Abortion

Access to safe abortion services in SADC remains a contentious issue due to strong social norms against abortion influenced by gender norms. Despite the existence of the Maputo Protocol, which permits legal abortion under certain circumstances, most African women live in countries with stringent abortion laws, often leading to unsafe abortion practices. It's estimated that about eight million abortions occur in Africa annually, with around 75% deemed unsafe, contributing to Africa's high maternal mortality rate-220 deaths per 100,000 unsafe abortions compared to the global average of 103. High rates of unsafe abortions place significant emotional and financial burdens on women and their families and increase the demand for post-abortion health care. The stigma surrounding abortion drives some women to prioritise social acceptance over their health, resulting in clandestine, unsafe procedures.

Programmes aimed at changing public perception, often with the active support of national obstetric associations, aim to promote safe abortion care integration into reproductive health services. Although there has been slow progress on legal reform, the chapter emphasises that which is possible within existing legislation. This includes women and girls exercising their agency to access safer medication abortion and to travel to countries where the legislation is more liberal. The chapter continues to advocate for decriminalisation of abortion.

HIV and AIDS

The Southern African Development Community (SADC) remains the most heavily HIV-affected region globally. Despite a slow decline in HIV prevalence, six countries still report rates exceeding 10%, the highest worldwide. Women generally have higher prevalence rates than men, with young women in eight countries experiencing nearly double the prevalence of their male counterparts. SADC must continue urgent efforts to eradicate AIDS as a public health threat by 2030. Without a cure or vaccine, the region must sustain extensive treatment programmes beyond this target.

The recent surge in HIV and AIDS in Madagascar highlights the need for vigilance across all countries, as localised epidemics can quickly spread to the general population. Investment in HIV control in Madagascar is critical, where only 22% of people living with HIV (PLHIV) know their status and are on antiretroviral therapy (ART).[7] Prevention efforts remain a priority, particularly for vertical transmission to children, adolescent girls and young women, adolescent boys and young men, and key populations.

Funding for condoms, which are crucial in HIV prevention, has declined, making highly subsidised condoms less available. Botswana and Namibia are the only African countries on track to eliminate vertical transmission to children, achieving fewer than 750 new HIV infections per 100,000 births. However, access to treatment for children continues to lag.[8] All SADC countries have HIV and AIDS policies, strategies, or plans guiding efforts to meet the global 95-95-95 targets: 95% of PLHIV knowing their status, 95% of those diagnosed accessing ART, and 95% of those on ART achieving viral suppression. Most of these policies or strategies are up-to-date:

Eswatini, Botswana, Zimbabwe, Zambia, and Malawi are among the nine countries globally that have achieved the 95-95-95 targets, with Lesotho and Namibia on track to do so by 2025. Women are more likely than men to be tested, access ART, and achieve viral suppression. As the number of people on ART grows, health systems are increasingly strained to provide prevention, testing, treatment access, and support for adherence. Community organisations play a vital role in supporting HIV programming.

[7] UNAIDS 2024. UNAIDS 2023 data, https://aidsinfo.unaids.org/ accessed 25 July, 2024
[8] UNAIDS. (2024) The urgency of now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS.

Gender-based violence

GBV remains one of the most flagrant violations of human rights across the region. The comprehensive study on gender-based violence (GBV) in South Africa, revealing that 35.5% of women have experienced physical and/or sexual violence, underscores the pervasive nature of GBV and its deep-rooted impact on society. The additional findings that 1.3% of men perpetrate sexual violence against other men and 2.3% of men experience sexual violence during adulthood highlight the need for inclusive GBV programmes that address violence against all genders. The US State Department's 2024 Trafficking in Persons report, indicating that 15 out of 16 SADC countries fail to meet the minimum standards for eliminating trafficking, points to significant gaps in legal frameworks, enforcement, and victim support services. The lack of specific domestic violence laws in the DRC and Tanzania further exacerbates the vulnerability of survivors.

The public perception in South Africa, where 78% of people believe domestic violence should be treated as a criminal matter suggests that societal attitudes are shifting towards recognizing domestic violence as a serious crime. The financial exclusion of women in most SADC member states limits their economic opportunities and independence, exacerbating their vulnerability to GBV and other forms of exploitation. In conflict-affected areas like the DRC, survivors face additional risks of violence while seeking essential resources, highlighting the intersection of GBV with broader socio-economic and political instability.

South Africa's high court ruling that rape suspects can no longer rely on the subjective belief that a complainant consented represents a significant legal reform that strengthens protections for survivors. As access to technology increases, there are parallel risks for the perpetuation of technology-facilitated gender-based violence (TFGBV), necessitating comprehensive responses that include legal protections, public awareness campaigns, and support services for survivors. These findings collectively underscore the urgent need for coordinated efforts to address GBV, trafficking, and financial exclusion, ensuring the safety and well-being of all individuals in the SADC region.

Harmful Practices

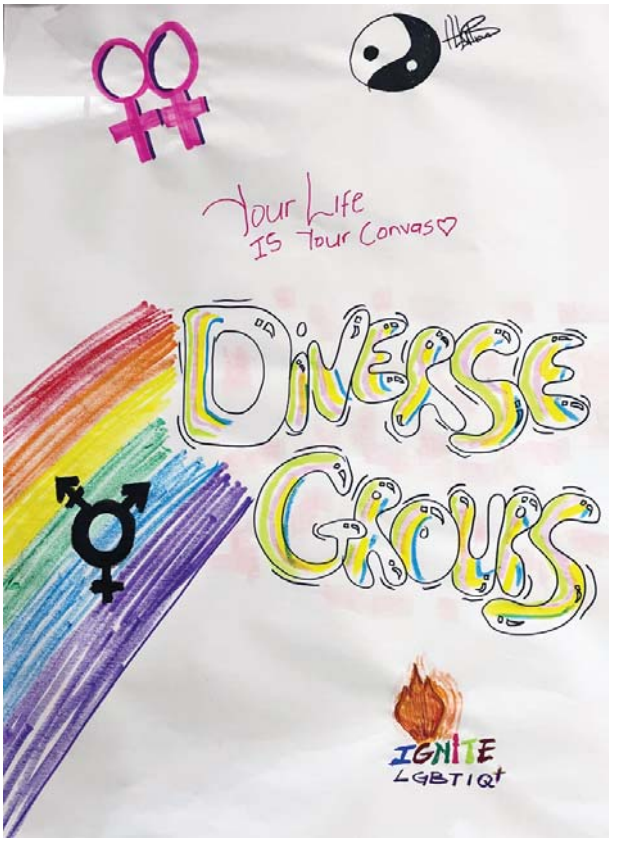
All SADC constitutions generally provide for non-discrimination, including based on sex, marital status, and pregnancy. However, some countries, such as Lesotho and Botswana, still permit discrimination in personal and customary law, and both nations have yet to complete much-needed constitutional reviews.

Progress is being made in addressing child marriage, even though Mozambique, Madagascar, and Malawi have some of the highest rates of child marriage globally, with Malawi ranking 12th worldwide. For instance, South Africa opened a new Marriages Bill for public comment, aiming to consolidate three existing laws into one and addressing the legal age of marriage in all forms of marriage. Zambia recently amended its 1918 Marriage Act to set the minimum age for marriage at 18 for both civil and customary marriages. Tanzania is the only SADC country where female genital mutilation (FGM) is widely practised, primarily in six northern regions.

Disability discrimination in Africa, often rooted in deeply held beliefs with a supernatural dimension, disproportionately affects women, especially mothers of children with disabilities, who may be accused of witchcraft or bringing a curse upon the family. The African Disability Protocol (ADP), which offers a distinctly African perspective on the rights of persons with disabilities, entered into force in August 2024 following ratification by 15 nations, including five in SADC. This protocol complements the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Sexual Diversity

Resistance against LGBTQI+ rights has intensified in many countries, with recent anti-LGBTQI+ backlash observed in Botswana, Malawi, Eswatini, and the DRC. Religious and cultural fundamentalism continues to fuel violence and discrimination against LGBTQI+ individuals across the region. According to Equaldex's equality index, LGBTQI+ acceptance varies significantly, from a high of 71% in South Africa to just 6% in Zambia. Although Botswana decriminalised same-sex relationships in 2019, joining Angola, Mozambique, Seychelles, and South Africa, religious leaders have recently challenged this ruling, allowing lawmakers to delay further debate. Similarly, conservative groups and decision-makers have appealed comparable court orders in Eswatini and Namibia. In a landmark vote in April 2024, the UN Human Rights Council adopted a resolution urging member states to enhance efforts to combat discrimination, violence, and harmful practices against intersex people.



Way forward

Health, especially sexual and reproductive health and rights (SRHR) is a precondition for, as well as an outcome and indicator of all aspects of sustainable development. Further, the goals of sustainable development can only be achieved in the absence of preventable maternal, newborn and child morbidity and mortality.

However, the SADC region's progress in meeting SRHR targets reveals both advancements and critical gaps that have significant implications for public health and gender equality. It is vital that governments in the region redouble their efforts to meet the Abuja Declaration's health expenditure targets to be able to deliver comprehensive SRHR services. The recent crisis resulting from suspension of US financial aid is a warning to the region of dependence on external support for something as crucial as health care.

Countries must develop targeted and efficient approaches to meeting commitments in the SDGs, the SADC Protocol on Gender and Development and the SADC SRHR Strategy. A coordinated approach involving governments, NGOs, and international partners is essential to achieve the health outcomes. Such an approach must actively engage with and mobilise communities, including the private sector.

Introduction

1

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

Key points

- This is the 15th Barometer that is tracking the region's progress in meeting the commitments which governments have made in the SADC Gender and Development Protocol and it is the fifth Voice and Choice Barometer, which focuses on SRHR in SADC. This Barometer is being launched under the shadow of war, conflict and genocide across the globe as well as deep uncertainty emanating from fast moving and quite dramatic changes that are following the inauguration of President Trump in the United States.
- Regionally, many SADC countries have not fully recovered from the devastating impacts of the COVID-19 pandemic but now face the effects of climate change disasters as well as prolonged war and conflicts in some countries, including DRC and Mozambique.
- As a result of these crises, the hard-won rights achieved for women and LGBTQI+ people over the last three decades are being eroded.
- The 2024 Sustainable Development Goals (SDG) Progress Report shows that progress has stopped and even regressed across some areas despite renewed commitments by member states. Just 17% of the SDG targets are on track to be achieved by the 2030 deadline.
- This Barometer shows that the women's movement in SADC must redouble its efforts to protect our hard-won rights and resist regressive forces attempting to restrict women's fundamental human rights.

This is the fifth Southern Africa Gender Protocol Voice&Choice Barometer to focus on Sexual and Reproductive Health and Rights (SRHR) in the SADC region. Since the last Barometer was published in 2022, the world has continued its recovery from the COVID pandemic which eroded many human development gains, adding to the vulnerabilities of millions of marginalised groups and communities. Escalating conflict and war across the world, combined with the devastating impacts of climate change, pose existential threats to people and the planet. Southern Africa is not immune to these threats, and the most vulnerable, including women in all their diversity, children, and LGBTQI+ people, are impacted most. Now, more than ever, we need to protect the fragile gains made for women's and LGBTQI+ rights.

The Barometer measures 100 indicators covering menstrual health, maternal health, family planning, adolescent sexual and reproductive health and rights (ASRHR), safe abortion, 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 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, as well as to address teenage pregnancy and child marriage.

This introductory chapter outlines the current global and SADC context regarding the significant challenges we face - escalating war and conflict, shrinking democratic space, and the climate crisis. The chapter also sets out the methodology underpinning the Barometer. It highlights the work of the SADC Secretariat and member states to advance women's rights in this context and the work of women's movements, specifically the Gender Protocol Alliance.

Global and regional political context

Since the release of the 2022 #VoicandChoice Barometer, numerous global crises have significantly affected women's human rights, especially in terms of their health and SRHR. As the world emerges from the COVID-19 pandemic, ongoing wars and conflicts have created additional humanitarian crises across various regions, further exacerbating the challenges faced by women and girls. The rapid and sometimes drastic changes that have been introduced by the new Trump administration in the United States have had far-reaching implications for global health.

Elections in the USA

The recent election in the United States signals a turning point for women's sexual and reproductive health rights in the United States and also globally. Almost immediately, President Trump issued a series of executive orders which had swift and devastating impacts on the world in general and on delivery of SRHR more specifically. These include:

- Planned withdrawal of the USA from the WHO (World Health Organisation). The USA has been the largest single contributor to the WHO. Threats to withdraw and/or withhold funding from other multilateral organisations.
- Suspension for 90 days of all foreign assistance through USAID, including the President's Emergency Fund for AIDS Relief (PEPFAR) which

has been the largest funding programme for HIV and AIDS programmes, with a focus on 25 countries of which 12 are in SADC[1]. Although there have been some reprieves announced, especially for treatment programmes, there is massive confusion and definite disruption of many critical programmes. At the time of writing this barometer, some organisations had stopped disbursing HIV medications purchased with U.S. aid, even if the drugs had already been obtained and were sitting in local clinics.[2]

- It is unclear what form US foreign assistance will take if and when it resumes.
- Reinstatement of the Mexico City policy, which limits US funding for any programmes through all organisations which support abortion. For now this is a moot point as all foreign assistance has been suspended. If assistance is re-established this order will have serious impacts for access to safe abortion as well as for access to other SRHR services.
- Homophobic pronouncements and orders to defund educational establishments in the US which support transgender athletes. The prevailing homophobic environment is emboldening for very conservative groups that are promoting such ideology across the globe, including resistance to comprehensive sexuality education in various SADC countries.
- Cancelling all Diversity, Equity and Inclusion (DEI) programmes in the USA. Such moves promote racist and anti-disability sentiments globally.
- Planned withdrawal of the United States from the Paris Agreement, severely weakening global efforts to slow, address and respond to climate change.
- Upending global trade with enactment of broad sweeping tariffs. These are likely to have negative impact on the economies of smaller and poorer countries such as those in SADC.

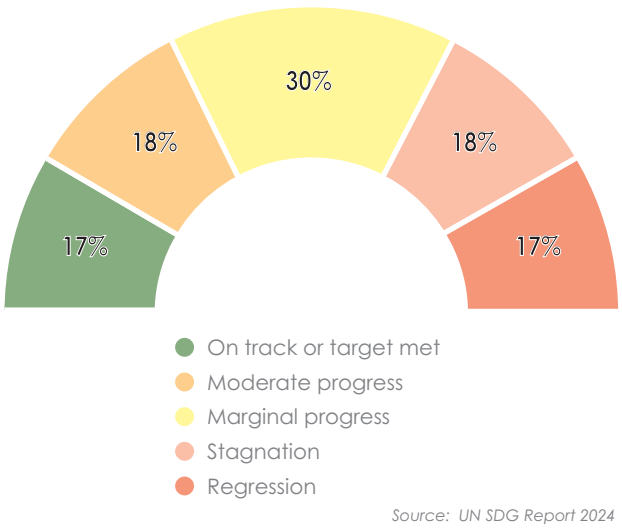
This Barometer shows that the anti-gender and LGBTQI+ rights movements are becoming more robust and better organised. Human rights in general and women's and LGBTQI+ rights in particular are under grave threat. Rights movements must work together more cohesively to resist and push back against these regressive forces.

Progress towards achieving the SDGs

With almost five years to go before the 2030 deadline, this global context and rolling back of rights will have a strong bearing on whether countries achieve the **Sustainable Development Goals (SDGs)**.

Three SDGs include SRHR outcomes. A standalone gender goal, SDG 5, aims to achieve gender equality and empower all women and girls. SDG 3 ensures healthy lives and promotes well-being for all ages. SDG 6 ensures the availability and sustainable management of water and sanitation for all. They include eight targets on maternal and neonatal mortality; universal access to SRHR, services and education; and access to water and sanitation. These targets are highlighted in the relevant chapters of the Barometer.

Figure 1.1: Overall progress across SDG targets based on 2015 - 2024 global aggregate data

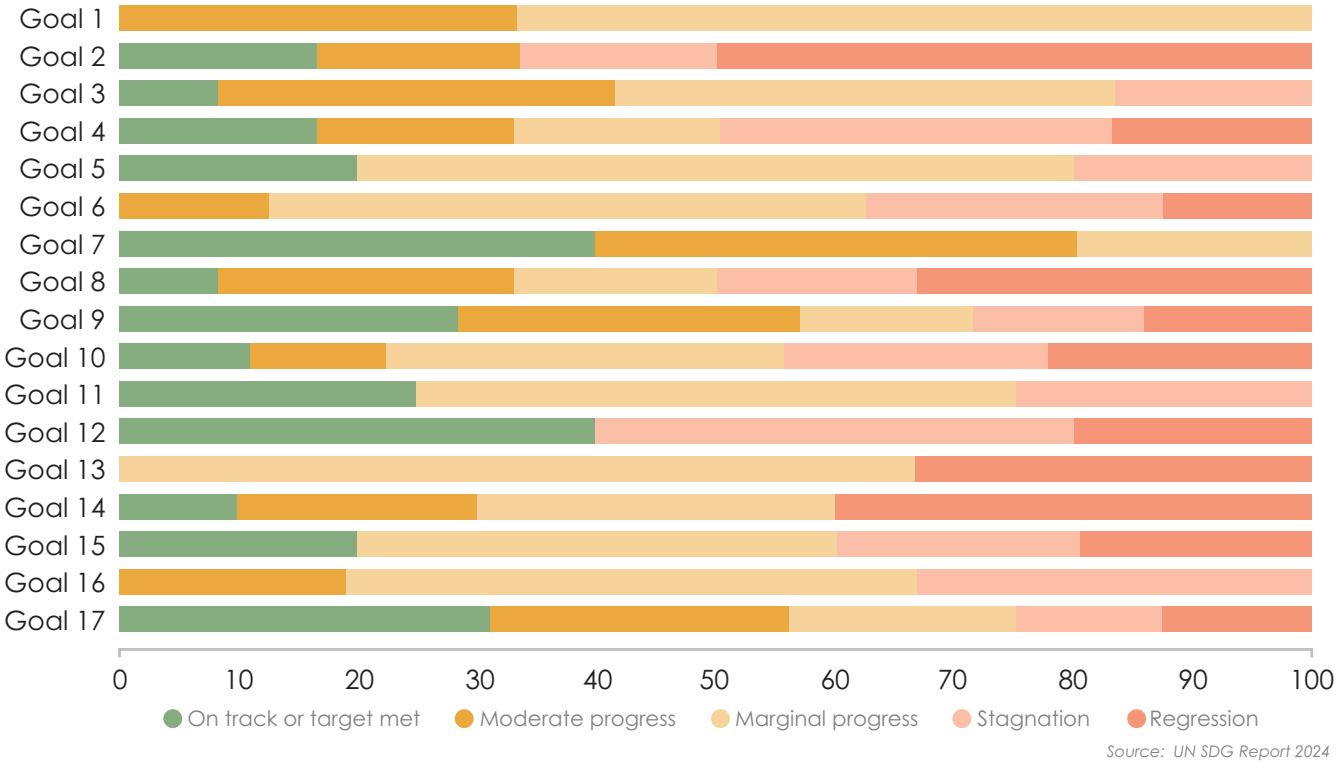


Source: UN SDG Report 2024

The 2024 Sustainable Development Goals Report paints a bleak picture. The latest data shows that global progress has stopped or regressed across some areas despite renewed commitments. Figure 1.1 shows that the world is on track to meet 17% of SDG targets; moderate progress has been made on 18%; marginal progress has been made on 30%; there is stagnation for 18% and regression for 17%. The ongoing effects of COVID-19, conflicts, the climate crisis, and economic instability have worsened existing inequalities. Globally, an additional 23 million people fell into extreme poverty, and over 100 million more experienced hunger in 2022 compared to 2019. While some health indicators have improved, global health progress has significantly slowed since 2015. The COVID-19 pandemic has erased nearly a decade of gains in life expectancy with the rate plummeting from 73.1 to 71.4 which was the level that it was in 2012.

Global progress towards achieving gender equality by 2030 is lagging. While there is decline in harmful practices, the rate of decline does not match the rate of population growth. Shockingly, one in five girls is still forced into marriage before reaching the age of 18. An alarming 230 million girls and women have been victims of female genital mutilation. Additionally, a significant number of women are still unable to exercise their right to make decisions about their sexual and reproductive health. Moreover, violence against women continues to be a pervasive issue, with women with disabilities being disproportionately affected.[3]

Figure 1.2: Progress for the 17 goals based on assessed targets, by goal (%)



Source: UN SDG Report 2024

[3] United Nations, 2024. Sustainable Development Goals report 2024, New York. United Nations Department of Economic and Social Affairs (DESA).

Figure 1.2 illustrates that countries have made mainly moderate progress in achieving Goals 3 and 5; fewer than 25% have progressed sufficiently to achieve these goals by 2030. Countries are not at all on track to meet the Goal 6 targets.

Education, a cornerstone of sustainable development, is seriously threatened as many countries report declines in students' math and reading abilities, putting essential skills crucial for future prosperity at risk.[4] Approximately 300 million African learners were out of school and mainly unable to learn for over a year due to COVID-19 in 2020-21. Some benefitted from programmes such as online learning, but many could not participate in them. The African Population and Health Research Centre (APHRC) and the Association for the Development of Education in Africa (ADEA), supported by the International Development Research Centre (IDRC), conducted a rapid assessment of the perspectives of education stakeholders on the projected long-term impacts of COVID-19 on education in Africa. The assessment was conducted with senior Ministry of Education officials and partner programme staff in seven African countries, including Malawi and Mozambique in SADC.[5]

The findings were:
Children lost much learning and have tried to catch up in accelerated programmes, which is not ideal and may appear as poor outcomes later in their lives. Many learners have dropped out of school and have not returned. Learners were impacted by mental health issues, many of which have probably not been resolved. This is likely to result in more SGBV, crime and increased child marriage.

Teachers, who were "the forgotten frontline workers of COVID-19," were subject to great psychosocial and economic distress. Many found alternative sources of income and did not return to teaching. The same teachers were expected to help learners overcome their psychosocial stresses without help to them for their own well-being.

Schools that could afford it adopted technology and improved their water and sanitation. However, schools that service the most vulnerable could not adopt these.

Without intervention, the researchers concluded that the long-term impact of COVID-19 will be regression in advances towards gender equality and empowerment for women and girls. It is well known that good quality education, especially secondary education, is protective against HIV acquisition, GBV, and child marriage. Thus, ensuring that the quality of education is rapidly restored is critical.

African Union on violence against women and children

The African Union (AU) has demonstrated a strong commitment to addressing violence against women and children through the development of comprehensive policies and legal frameworks. Central to these efforts is the African Union Convention on Ending Violence Against Women and Girls (AU-CEVAWG), the first continental legal instrument for the prevention and elimination of all forms of violence against women and girls in the world which was recently adopted at the Heads of State meeting in February, 2025.[6] The convention aims to eliminate all forms of violence by addressing root causes, strengthening legal and institutional mechanisms, and promoting gender equality and human rights. It is an outcome of the AU presidential initiative on positive masculinity, which was initiated by President Cyril Ramaphosa of South Africa during his tenure as Chair of the AU. The first conference on Positive Masculinity in Leadership for the Elimination of Violence against Women and Girls (VAWG) in Africa in 2020 was postponed due to COVID-19 and it took place in 2021 in the Democratic Republic of Congo (DRC), chaired by President Felix Tshisekedi. This meeting adopted a declaration which pledged action and resources to address the scourge of Gender Based Violence which was adopted as a decision of the full AU Assembly in February, 2022.

[4] United Nations, 2024. Sustainable Development Goals report 2024, New York. United Nations Department of Economic and Social Affairs (DESA).
[5] Namatende-Sakwa, L. and M. Ngware. (2023) The long term impacts of COVID-19 threaten gains in education in Africa. https://www.gpekix.org/blog/long-term-impacts-covid-19-threaten-gains-education-africa Accessed 27 October, 2024.
[6] The African Union Convention on Ending Violence Against Women and Girls | African Union (no date). Available at: https://au.int/en/aucevawg (Accessed: 21 February 2025).

President Tshisekedi was named the first AU Champion on Positive Masculinity. The second high level meeting in Dakar, Senegal, in November 2022 led to a historic decision of the AU Assembly in February 2023 to negotiate an AU Convention on Ending Violence Against Women and Girls (AU CEVAWG).

Additionally, the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) has established guidelines to prevent and respond to violence against children, emphasising the need for robust legal, policy, and institutional frameworks, as well as comprehensive child protection systems.[7] The AU's broader legal initiatives focus on dismantling gender power imbalances, ensuring accountability for perpetrators, and safeguarding the fundamental rights of women and girls to life, dignity, and socio-economic development.[8] Collectively, these efforts underscore the AU's dedication to fostering a safer, more equitable environment for women and children across Africa.

Political context in Southern Africa

Overall, the political context in Southern Africa is characterised by a mix of stable democracies, such as Botswana and Namibia, and countries facing challenges related to corruption, economic instability, and political repression, such as Zimbabwe. Socio-economically, the region grapples with poverty, inequality, and governance issues and faces ongoing political and economic uncertainties. DRC and Mozambique are both experiencing increasing war and conflict. Five SADC countries (DRC, Eswatini, Lesotho, Mozambique and Zimbabwe) held national and/or local elections in 2023.

Lesotho held Local Government Elections in September 2023, a year after the National elections. Voter turnout continues to decline, with just 26% of eligible voters turning up to vote, down from a low of 29% in the 2017 elections. While the local government level allows voters to have a direct say in who will make the most impact in their local town and village, voters chose not to exercise their democratic right to vote.

Mozambique held their sixth local elections in October 2023, and the ruling party, FRELIMO, was declared the winner in 64 out of 65 municipalities. However, the results were contested by the main opposition party, RENAMO, who called the outcome a mega-fraud. Mass demonstrations led by RENAMO's president to repudiate the results resulted in post-electoral violence. There were allegations of electoral bodies changing results to benefit FRELIMO in towns where the opposition had won. Independent election observer groups and partner countries expressed concern and called for the appeals lodged by the opposition to be decided with impartiality and transparency.[9]

The **DRC** held elections in December 2023, and President Felix Tshisekedi won re-election with more than 70% of the vote. However, the opposition and some civil society groups called for the vote to be rerun due to massive logistical problems, questioning the outcome's validity.[10]

National and local government elections took place in **Zimbabwe** in August 2023, in a context of fear and oppression. Zimbabwe's President, of the ruling ZANU PF party, Emmerson Mnangagwa, won 53% of the vote compared to 44% for Nelson Chamisa, his primary challenger. The elections were marred by delays that fuelled opposition accusations of rigging and voter suppression.[11]

[7] https://www.acerwc.africa/sites/default/files/2024-05/Guidelines%20on%20Ending%20Violence%20against%20Children%20in%20Africa_Eng.pdf
[8] The African Union Convention on Ending Violence Against Women and Girls | African Union (no date). Available at: https://au.int/en/aucevawg (Accessed: 21 February 2025).
[9] https://issafrica.org/iss-today/fraudulent-municipal-elections-cripple-democracy-in-mozambique , accessed 1 October 2024
[10] https://www.africanews.com/2023/12/31/president-felix-tshisekedi-declared-winner-of-drc-election// accessed 1 October 2024
[11] https://www.aljazeera.com/news/2023/8/27/zimbabwes-president-mnangagwa-wins-second-term-opposition-rejects-result, accessed 1 October 2024

Across Southern Africa voters in 2024 expressed their dissatisfaction with those that have been leading them since independence. Voters, especially those that are young and in urban centres, are frustrated with poor economic prospects and high unemployment.

South Africa was the first country that went to the polls on 29 May 2024. The election was the most highly contested since the advent of democracy thirty years ago when the ruling African National Congress (ANC) won 63% of the vote. As predicted, the party lost significant ground, attaining just 40% of the vote and losing its outright majority for the first time since it came to power in 1994. This shifts the country from a one-party dominant state to a multi-party democracy. The ANC has now formed a Government of National Unity (GNU) with ten other political parties, including the centrist Democratic Alliance (DA) and the Inkatha Freedom Party, which has its roots in KwaZulu Natal.

Mozambique held national elections in early October. There was widespread discontent and allegations of election fraud when results were announced, with a new FRELIMO representative, Daniel Chapo, as the new President. This led to violent protests which continued for several months, leaving more than 300 dead, looting and disruption of transport routes from Mozambique's ports to neighbouring countries. Protesters support opposition candidate Venancio Mondlane, who rallied particularly urban and young voters through social media campaigning.[12]

The Botswana Democratic Party (BDP) which has been in power in **Botswana** since independence in 1966, conceded that it lost the elections in October and facilitated a peaceful transfer of power to Duma Noko of the Umbrella for Democratic Change (UDC), which won an outright majority in Parliament. Voters were unhappy with high levels of unemployment and poor economic growth.[13] It was disappointing that the share of women representatives in both local and national government, already the lowest in SADC, declined even further. Women constitute only 8.7% of elected members of parliament and only 54 of the elected 609 local government councillors were women.[14]

In national elections in late November, 2024, **Namibia** elected its first female President, Netumbo Nandi-Ndaitwah. Younger voters, especially, showed their disaffection with SWAPO which has been in power in Namibia since independence in 1990. SWAPO lost the two thirds majority that it has enjoyed in parliament as well as control of the key cities of Windhoek, Walvis Bay, and Swakopmund.[15]

Shrinking democratic space

In some regions, rights rollbacks, driven by authoritarianism or conservative socio-political agendas, have led to heightened restrictions on freedom of expression, reproductive health, and personal autonomy. Advocacy for women's rights is gaining momentum, but it faces push-back in many contexts, emphasising the urgent need for solidarity and continuous activism.

In Eswatini, civic space continues to be threatened as dissent is routinely restricted. 2023 started with the brutal killing of Thulani Maseko, a prominent human rights lawyer and opposition activist. More than two years after a series of protests, there has been no accountability for the security forces crackdown on pro-democracy protesters. Political parties were banned from participating in general elections held in September 2023. The elections have not offered any political change to the kingdom, as MPs serve in a purely advisory role to the monarch.

[12] Pinto, Teresa. Political crisis in Mozambique shows no signs of abating, January, 2025. https://www.gisreportsonline.com/r/mozambique-election-crisis/ Accessed 14 February, 2025.
[13] Muia, W and D Zane, Botswana ruling party rejected after 58 years in power, 1 November 2024. https://www.bbc.com/news/articles/c238n5zr51yo Accessed 14 February, 2025
[14] Genderlinks, Women's political participation audit, https://genderlinks.org.za/news/botswana-sober-findings-in-gender-and-elections-report/ accessed February 17, 2025
[15] Duffy, M. Reflections on Namibia's elections. Dec 24, 2024. https://www.e-ir.info/2024/12/24/reflections-on-namibias-2024-elections/ Accessed 14 February, 2025.

Climate change

Climate change is one of the most severe crises of our time, and people's sexual and reproductive health rights are negatively affected by climate-driven disasters. Cyclones have pounded SADC countries on the east coast, bringing torrential rains and flooding to the region and causing death and destruction. These storms are becoming more substantial and more devastating. In 2023, Cyclone Freddy, which hit **Madagascar, Mozambique, Malawi** and **Zimbabwe**, was the longest-lasting and highest-ACE (Accumulated cyclone energy) producing tropical cyclone ever recorded worldwide. Over 1200 people died, and 2000 people were injured as a result, and it is estimated that over 1,7 million people were affected, mainly in Mozambique and Malawi. Parts of South Africa have experienced disastrous flooding.

The **2023-2024 El Niño**, which was one of the strongest on record, caused below-average rainfall between October 2023 and February 2024 across much of SADC. This resulted in widespread water shortages and drought, significant livestock losses and reduced agricultural output in many countries, which has led to food insecurity and malnutrition.

Gender equality, SRHR and climate change are inextricably linked. On one hand, the climate crisis is increasing social, economic and gender inequalities. As global temperatures rise, extreme weather events like floods, droughts, and heatwaves threaten the health and rights of girls and women. On the other, gender, sexuality, age, wealth, indigeneity, and race are determining factors in vulnerability to climate change. Crises make reproductive health harder to access and result in higher unmet need for contraception, a rise in unintended pregnancies and maternal deaths due to unsafe abortions. Collapsed infrastructure and the shortage of safe water, sanitation and hygiene services impact women disproportionately as they are typically responsible for collecting and managing household water supplies. The lack of water, soap, and secure changing and washing facilities also make it challenging to manage menstrual health.

Escalating war and conflict

War and conflict globally have profound and multifaceted impacts on women, exacerbating existing gender inequalities and creating new challenges. There is ongoing conflict in **Mozambique**. The country has been facing a violent insurgency in its Cabo Delgado province since 2017, which has led to widespread displacement, loss of lives, and a humanitarian crisis. The conflict has also spread into neighbouring regions, including Nampula and Niassa. There was a recent spike in violence, with over 100,000 people displaced in the southern parts of Cabo Delgado, many of whom had been previously displaced.[16] The conflict in Mozambique remains complex and volatile, with no immediate signs of resolution. Meanwhile the simmering conflict in the DRC has also recently flared up, with the rebel M23 movement, purportedly supported by Rwanda, taking two major cities in the Eastern part of the mineral rich country.

Rape as a weapon of war

The UN Security Council Report to the Secretary-General on conflict-related sexual violence shines a spotlight on this horrific form of violence. Sexual violence continues to be used as a tactic of war, torture and terrorism amid deepening political and security crises, compounded by militarisation and the illicit proliferation of arms. The report highlights the dire situation in the eastern **Democratic Republic of Congo (DRC)**, where the ongoing armed conflicts are seriously affecting civilians. In North Kivu, more than half a million people have fled their homes. According to the United Nations, the number of displaced people across the

[16] https://www.worldbank.org/en/country/mozambique/overview , accessed 1 October

country has reached nearly 7 million - the highest number of internally displaced people in Africa. Hundreds of cases of conflict-related sexual violence have been documented. Most violations occur in the context of clashes between armed groups and the Armed Forces of the DRC.

All parties to the violence in the DRC have been implicated in the use of sexual violence as a weapon of war. The conflict and violence also limit women and girls' access to SRHR and GBV services, resulting in unintended pregnancies, unsafe abortions and further trauma.

Sexual and reproductive health and rights (SRHR) in SADC

Voice + Choice
Action and results for SRHR in SADC

In 2016, SADC member states updated the Protocol on Gender and Development to align with the SDGs. Each year since 2009, the SADC Gender Protocol Alliance has produced a Barometer to measure progress against the SADC Gender Protocol and related regional, continental, and global commitments. From 2019 the Barometer has focused on SRHR commitments.

Ministers of Health and Ministers responsible for HIV and AIDS endorsed the Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019-2030 in 2018. It is a policy and programming framework for the SADC Member States to accelerate the attainment of sexual and reproductive health and rights for all people in the region.

Southern African Development Community (SADC) Ministers of Health developed a **SADC Scorecard on sexual and reproductive health and rights (SRHR)**, a high-level strategic tool that tracks progress in achieving the 20 targets of the SADC SRHR strategy and the SDGs. SADC launched its 2nd Milestone Scorecard on Sexual and Reproductive Health and Rights (SRHR) on the margins of the joint meeting of Ministers of Health and Ministers responsible for HIV and AIDS on the 28th of November 2023 in Luanda, Republic of Angola.

The Scorecard provides an opportunity to highlight progress made and also the barriers, challenges, priorities, and strategies on SRHR in the region and to advocate for increased action in protecting, sustaining, and advancing SRHR gains.

UNFPA East and Southern Africa Regional Director Lydia Zigomo, speaking on behalf of the UN Agencies supporting the Together4SRHR programme, highlighted that support must be directed at SRHR programmes if the SADC region is to make progress towards ensuring that all people enjoy a healthy sexual and reproductive life and have sustainable access to quality SRHR services. She highlighted five critical areas of action required:

- Ensuring that SRHR is incorporated into the national essential package of services and medicines lists and as part of Universal Health Coverage (UHC) benefit packages while ensuring that the provision of quality integrated services is part of the Primary Health Care system.
- Promoting open and frank conversations on the impact that legal and policy barriers pose to SRHR, leading to high unintended pregnancies, unsafe abortion, gender-based violence, and ultimately, new HIV infections and continuing high maternal mortality.
- Building the resilience of our health systems to withstand future pandemics, the impact of climate change, conflicts, and other humanitarian shocks by ensuring that SRHR is included in national disaster preparedness strategies and plans and disaster preparedness is incorporated into the next generation of SRHR strategies and frameworks.
- The Global AIDS Report for 2023, under the theme "Let Communities Lead," urges us to advance SRHR by fully and reliably funding communities, making them central to all SRH policies and programmes so that they can lead efforts to advance and protect SRHR.
- The need to adopt a digital mind-set where we leverage advances in digital technologies to enhance the quality of care through client-responsive data systems.

Barometer Methodology

Measuring progress against government commitments

The Barometer measures progress against government commitments as expressed in vital normative frameworks, including the following:

- 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 and the SADC SRHR Scorecard.

Table 1.1: 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 1.1 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) goes well beyond what governments (20 indicators) report to SADC but that they are committed to 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 scorecard reports submitted by governments in which there are several gaps.

Qualitative data

- ***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, in particular showcasing the work of V&CSA Fund partners.

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 countries' successes, challenges and next steps.

Limitations

Data is not always available for every country, nor is it necessarily collected annually or bi-annually. Thus, in some cases, data may not have changed since the last Barometer.

The Barometer has a dedicated team of professionals who continue to produce it on an ever-shrinking budget, even as the need for evidence-based advocacy grows. We trust, however, that the data and analysis will continue to guide Alliance campaigns and provide baselines for the new grantees of the Voice and Choice Fund.

The SADC scorecard

Since the #VoiceandChoice Barometer launched, focusing specifically on SRHR, the Barometer has used 13 of the 20 indicators that governments track for which reliable data can be sourced across the 16 SADC countries to rank countries and assess which areas are performing better than others. This year, the Barometer analyses 20 indicators from the governments' reported data in the 2023 Milestone scorecard. 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 or 2023 figure as the baseline. The following tables show the progress for each country on the 20 indicators that the Barometer and the SADC Scorecard both measure.

This Barometer continues to evaluate government progress using the six colour-coded table to indicate performance levels, as illustrated below:

SDG target achieved
2023 milestones achieved
Targets not achieved but within -1% to -14.9%, sustain & expand efforts to achieve target
Targets not achieved and within -15% to -29.9% make considerable effort
Targets not achieved and 30% or more off target, make significant effort
Not applicable
No data or no milestone set

The SADC SRHR Scorecards for 2023 provides a detailed assessment of the progress made by SADC member states in achieving the targets set out in the SADC SRHR strategy 2019-2030. The scorecard applies this colour coding across 17 SRHR indicators for which data could be obtained. Gender Links colour-coded the following three indicators, which are not coded in the 2023 scorecards: the Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation; the minimum legal age of consent to marriage, 18 years for all irrespective; and the legal status of abortion.

Please see Tables 1.2 and 1.3 SADC SRHR Scorecards for 2021 and 2023 below.

Table 1.2: Overview of SRHR Indicators by country 2021

SADC SRHR scorecard	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Minimum legal age of consent to marriage, 18 years for all irrespective	18	21 with exceptions	18	18	18	18	18	18	Below 18	18	18	18	18	18	21 with exceptions	18
Adolescent birth rate, 10-19 years of age	104	43,7	32	109	87	55	103	4	24	153,8	82	56	46,2	123	29	69
Percentage of primary schools that provided life skills-based HIV and sexuality education in the previous academic year	82	93,3	100	No data	100	100	100	No data	100	95,5	100	100	80,6	65,1	100	100
Mother to child transmission of HIV	19,2	1,75	0	23,4	3,7	5,98	39,8	2,3	13,7	12,36	3,8	1	2,7	6,61	No data	8,7
Obstetric and gynaecological admissions due to treatment of abortion	N/A	61,3	12	No data	31	No data	No data	23	No data	34,1	9,38	10	No data	31	5,3	10
Density and distribution health workers per 10,000 population	19,3	35,5	19,4	2,3	26,48	6,5	11	2,5	33,8	4,4	62,1	170,9	35,2	7,7	17,72	11,5
Proportion of services within the essential package of SRHR services covered by the PHC facility	No data	45,8	No data	No data	100	No data	No data	No data	No data	No data	No data	100	No data	No data	100	No data
STI incidence rate	7,2	6,3	0,3	2	3,6	3,1	No data	0,02	No data	No data	4,48	0,4	4,55	No data	6,8	1,3
Maternal mortality	288	166	172	693	452	618	335	349	61	452	385	65	121	556	252	462
Neonatal mortality	24	17,9	24	27	20	34	20	20	10,2	28,5	20	9,1	21	25	27	31
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	14+	N/A	Yes	15+	Yes for 12+	Yes	No	No
Unmet need for family planning	35,7	17,3	32	27,7	15,2	18,4	16,1	19	9,6	22	12	No data	19	22	19,7	10
Percentage reduction in new HIV infections, females15-24	26	39,1	30	50	64	58,75	-159	63,6	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	N/A	52,8	No data	No data	N/A	N/A	No data	88,5	No data	No data	N/A	97	61,2	59	60	No data
Percentage of condom use with last high-risk sex among adolescent girls and young women 15-24 year of age	32,9	No data	70	24,3	71,4	77,1	3	64,5	No data	No data	52	51,3	47	33,5	41,4	56,4
Legal status of abortion (2 = Abortion on demand; 1 = Restricted abortion; 0 = Abortion not available)	1	1	1	1	1	1	0	1	1	2	1	1	2	1	1	1
Proportion of ever-partnered girls and women (ages 15 and above) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months	21,7	28	12	4,6	4,6	0,8	38	24,3	No data	36	33	No data	8,7	41,7	43	39,6
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	5,5	8,7	13,6	11,7	8,1	6,7	4,5	10
Percentage of maternal deaths due to abortion	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Proportion of facilities providing integrated SRH services	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
Proportion of women who have experienced sexual violence in last 12 months	4,5	2,9	10,1	25,4	0,2	No data	No data	14	No data	N/A	7	No data	No data	10,1	No data	7

Source: SRHR indicators table adapted from the 2nd SADC Milestone Scorecard 2021.[17]

[17] SADC SRHR SCORECARD 2021_EN_FR_PO Available at: 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 January 2025

Table 1.3: Overview of SRHR Indicators by country 2023

SADC SRHR scorecard	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe	SADC Median
Minimum legal age of consent to marriage, 18 years for all irrespective	18	21 with exceptions	18	18	18	18	18	18	18	18	21	18	18	18	21	18	N/A
Percentage of primary schools that provided life skills-based HIV and sexuality education in the previous academic year	No data	91,0	100,0	No data	100,0	99,0	100,0	100,0	100,0	100,0	95,5	100,0	100,0	88,1	100,0	100,0	100,0
Adolescent Birth Rate per 1,000 females	57,6	43,7	32,0	109,0	87,0	206,2	111,0	10,1	19,5	180,0	82,0	46,5	38,6	112,0	24,0	108,0	69,8
Proprotion of facilities providing integrated SRH services	98,0	46.1	66,0	No data	100,0	100,0	No data	100,0	100,0	96,6	No data	No data	100,0	N/A	100,0	99,0	100,0
Mother to child transmission of HIV	15,0	1,8	0,0	27,5	1,4	6,0	17,2	1,6	0,0	12,4	4,1	10,0	0,4	2,6	10,0	8,1	5,1
4a. Obstetric and gynaecological admissions due to treatment of abortion	No data	32,6	2,7	No data	28,0	61,0	2,9	3,7	No data	16,0	7,6	77,1	N/A	4,1	14,1	No data	14,1
Density and distribution health workers per 10,000 population	19,3	35,5	4,2	21,3	26,4	No data	1,1	21,9	116,5	1,9	62,1	110,9	35,2	11,0	17,7	11,5	21,3
Neonatal mortality (reduce new born deaths to 12 per 1,000 births in every country by 2030)	24,0	17,5	10,0	27,0	20,0	34,0	26,0	27,0	8,4	30,0	20,0	8,3	10,0	24,0	27,0	32,0	24,0
Proportion of services within the essential package of SRHR services covered by the PHC facility	77,8	45,8	No data	No data	100,0	100,0	No data	63,6	88,9	87,5	No data	44,4	100,0	No data	100,0	No data	88,2
Proportion of females who have received the recommended number of doses of HPV vaccine prior to age 15	N/A	0,5	N/A	No data	No data	72,4	No data	52,3	N/A	94,0	No data	82,7	92,0	64,0	38,0	95,0	72,4
Maternal Mortality Rate per 100,000 deliveries (population)	239,0	243,4	186,4	547,0	452,0	618,0	408,0	439,0	32.8	452,0	385,0	0,0	86,0	556,0	252,0	462,0	396,5
Unmet need for family planning (%)	38,0	No data	0,3	28,7	15,0	18,4	14,7	15,1	12,7	23,0	12,0	No data	11,8	21,0	20,0	8,4	15,1
Percentage of annual budgets allocated to health sector (Abuja Declaration receommends 15%) (based on 2019 baseline)	7,2	18,7	12,0	8,7	11,0	11,4	8,2	10,0	3,2	No data	11,8	5,1	8,1	7,3	8,0	11,0	8,7
Percentage reduction in new HIV infections (from 2010) for 15-24 male and female	45,0	66,0	30,0	58,0	72,0	74,0	-151,0	72,0	42,0	41,0	48,0	-118,0	57,0	68,0	53,0	78,0	55,0
Percentage of condom use with last high-risk sex among people aged 15-24	32,9	74,8	70,0	24,3	71,4	84,4	7,5	64,5	N/A	48,4	74,7	51,3	67,0	No data	42,0	84,1	64,5
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 (based on 2019 baseline)	21,7	26,2	12,0	5,0	4,6	No data	15,5	24,3	1,1	18,8	33,0	0,4	10,3	No data	47,0	39,6	15,5
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No	N/A
Legal status of abortion (2 = Abortion on demand; 1 = Restricted abortion; 0 = Abortion illegal)	1	1	1	1	1	1	0	1	1	1	1	1	2	1	1	1	N/A
4b. Percentage of maternal deaths due to abortion	6,9	0,0	6,9	No data	8,0	58,0	0,7	5,3	0,0	14,3	9,6	0,0	6,5	0,7	26,0	3,6	6,5
STI incidence rate - last 12 months	7,2	3,8	0,3	0,0	3,6	3,1	0,8	1,9	0,0	3,7	3,9	0,3	4,6	No data	0,3	1,9	1,9
Proportion of women who have experienced sexual violence in last 12 months	4,5	2,3	10,1	23,0	0,2	No data	12,2	14,0	0,2	6,0	7,0	No data	2,9	10,1	14,0	18,0	8,6

Source: SRHR indicators table adapted from the 2nd SADC Milestone Scorecard 2023.[18]

[18] SADC SRHR SCORECARD 2023 Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 6 October 2024).

Table 1.3 shows that the scorecard highlights improvements in several key indicators, particularly those with dark green scores by 2023. The scorecard highlights progress and ongoing challenges, emphasising the need for continued monitoring and adaptive approaches to ensure sustained improvements across all indicators. Only a few SADC member states have met some important commitments, such as those in the AU's Abuja and Malabo Declarations[19], through which countries committed to increasing their health budgets to a target of 15% of overall budget. The 2023 SADC Sexual and Reproductive Health and Rights (SRHR) Strategy Scorecard Report[20] indicates a median of 8.7% of national budgets allocated to the health sector, a drop from 9.5% in 2021.

Table 1.4: Performance of SADC SRHR indicators 2023 by colour code

Indicators	Dark green	Light green	Yellow	Amber	Red	No target set	N/A	No data	% Dark green (2021)	% Dark green (2023)
Minimum legal age of consent to marriage, 18 years for all	15	0	1	0	0	0	0	0	81%	94%
Percentage of primary schools that provided life skills-based HIV and sexuality education in the previous academic year	12	1	1	0	0	0	0	2	71%	75%
Adolescent birth rate, 10-19 years of age	10	3	1	0	2	0	0	0	63%	63%
Proportion of facilities providing integrated SRH services	9	0	0	0	0	0	1	6	0%	56%
Mother-to-child transmission of HIV	8	3	3	0	2	0	0	0	0%	50%
Obstetric& gynaecological admissions due to treatment of abortion	6	2	1	0	0	0	1	6	33%	38%
Density and distribution Health workers per 10000 population	5	4	0	2	4	0	0	1	25%	31%
Neonatal mortality	4	1	1	9	1	0	0	0	13%	25%
Proportion of services within the essential package of SRHR services covered by the PHC facility	4	0	0	1	1	0	0	10	20%	25%
Proportion of females who have received the recommended number of doses of HPV vaccine before age 15	3	1	0	1	3	0	3	5	7%	19%
Maternal mortality	2	2	1	2	9	0	0	0	0%	13%
Unmet need for family planning (contraception)	2	6	1	4	1	0	0	2	0%	13%
Percentage of annual budgets allocated to the health sector	1	2	3	6	3	0	0	1	0%	6%
Percentage reduction in new HIV infections, females 15 - 24	0	12	0	2	2	0	0	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	3	4	3	3	0	1	2	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	4	0	2	6	0	0	4	13%	0%
Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation	0	10	0	0	6	0	0	0	0%	0%
Legal status of abortion	0	1	14	0	1	0	0	0	0%	0%
Percentage of maternal deaths due to abortion	0	0	0	0	0	15	0	1	0%	0%
STI Incidence rate - number of new cases of reported STIs (Syndronic or etiological reporting) over the last 12 months	0	3	0	3	5	0	0	5	0%	0%
Proportion of women who have experienced sexual violence in the last 12 months	0	0	0	1	7	0	0	8	7%	0%

SRHR indicators table computed from the 2nd SADC Milestone Scorecard 2023.[21]

[19] Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods (2014); Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001).
[20] SADC Secretariat (2023). 2023 Milestone Scorecard. Fast-tracking the Strategy for SRHR in the SADC Region. https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English
[21] SADC SRHR SCORECARD 2023 Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 6 October 2024).

Table 1.4 provides a detailed analysis of various indicators measured by the SADC 2023 Milestone Scorecard. There has been significant improvement in achievement of several targets over the period from 2021 to 2023. Notably, the dark green scores indicating achievement of the target for the minimum legal age of consent to marriage for all individuals has increased from 81% to 94%, reflecting a 13% improvement.

Another area of substantial improvement is the proportion of facilities providing integrated sexual and reproductive health (SRH) services, which has risen from 0% in 2021 to 56% dark green scores in 2023. This increase indicates significant progress towards provision of comprehensive SRH services. Similarly, the number of countries where the rate of mother-to-child transmission of HIV has improved increased from 0% to 50%, highlighting significant strides in reducing HIV transmission rates.

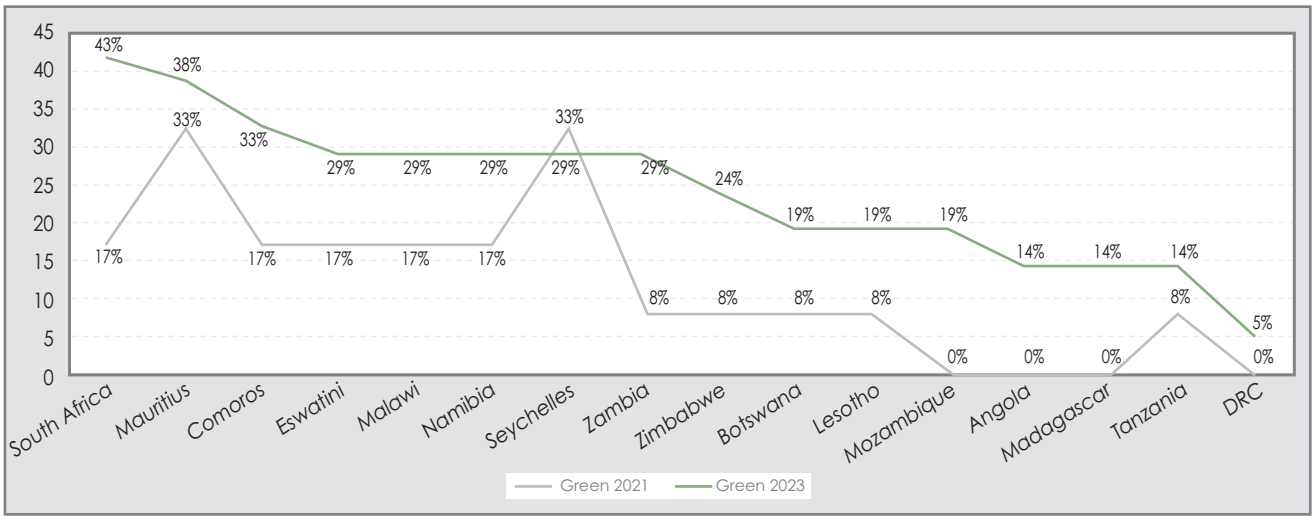
There has also been an increase in dark green scores for Neonatal mortality rates, increasing from 13% to 25% of countries. Additionally, the number of countries which have achieved the target for the recommended number of HPV vaccine doses before age 15 has increased from 7% to 19%, contributing to the prevention of cervical cancer.

However, achievement of some targets has declined. Dark green scores for the proportion of ever-partnered girls and women subjected to physical and/or sexual violence has decreased from 13% to 0%, and the countries which have achieved the target for the proportion of women who have experienced sexual violence in the last 12 months has dropped from 7% to 0%.

There has been no change in the number of countries with dark green scores for several indicators These include: the adolescent birth rate (10-19 years), which remains at 63%, and reduction in new HIV infections among females aged 15-24, which remains at 0% of countries to achieve this target. These stagnations suggest a need for enhanced efforts in adolescent reproductive health education and services to meet the SADC SRHR strategy's goals.

The analysis highlights significant improvements in key indicators, particularly in legal frameworks, service provision, and health outcomes. However, some areas, especially those related to violence and adolescent health, require continued focus and intervention. These findings underscore the importance of sustained efforts and targeted strategies to meet the commitments outlined in the SADC SRHR strategy 2019-2030. Continued monitoring and adaptive strategies will ensure progress across all indicators.

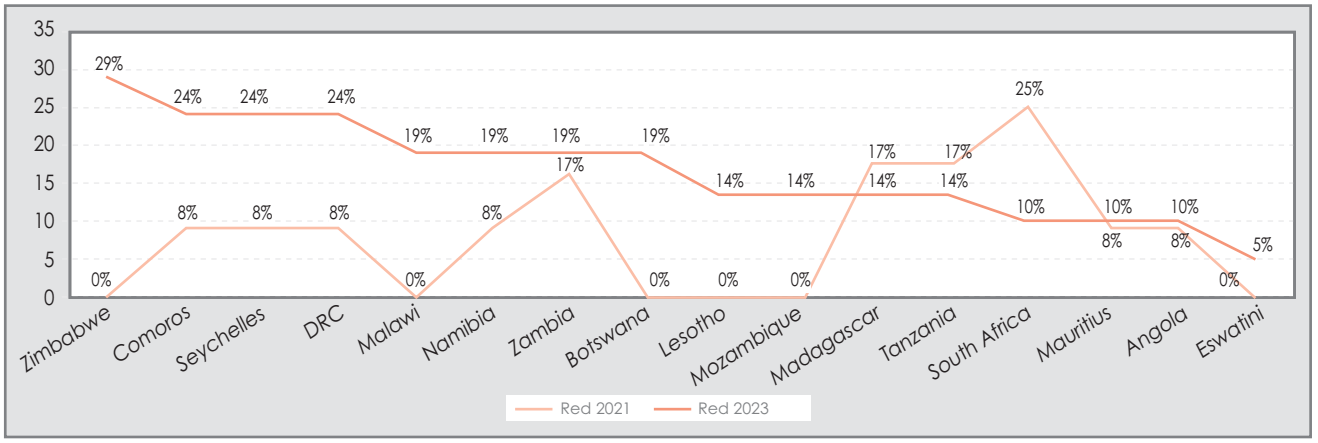
Figure 1.3: Dark green scores by country 2021 and 2023



Source: Gender Links: Computed from the SADC 2021 and 2nd Milestone Scorecard 2023

Figure 1.3 provides a detailed comparison of the Dark Green scores for specific indicators between the SADC 2021 and the 2nd Milestone 2023 Scorecard. It reveals that South Africa experienced the greatest change in the number of dark green scores (indicators for which the SDG target has already been achieved), rising from 17% in 2021 to 43% in 2023. This indicates significant progress. South Africa also had the highest number of dark green scores in 2023. This improvement is likely due to targeted interventions, increased funding, and strong government commitment to SRHR. Mauritius and Comoros have also made significant strides, increasing the number of dark green scores from 33% to 38% and 17% to 33%, respectively. The Democratic Republic of the Congo (DRC) had the lowest number of dark green scores in 2023 at 5%, highlighting potential challenges in their SRHR initiatives. Notably, Seychelles was the only country to experience a decrease in numbers of dark green scores, dropping from 33% in 2022 to 29% in 2023. This decline could suggest challenges in maintaining their SRHR programmes, possibly due to policy changes, funding issues, or other socio-political factors. Such a decrease might necessitate a review and reinforcement of their SRHR strategies to ensure continued progress.

Figure 1.4: Red scores by country 2021 and 2023 comparison



Source: Gender Links: Computed from the SADC 2021 and 2nd Milestone Scorecard 2023

The comparative analysis of the 2021 and 2023 Red scores (indicating that even the 2023 target was not achieved by 30% or more) by country shown in Figure 1,4 reveals significant changes in the state of achievement of SRHR targets. Zimbabwe saw the greatest increase in red scores, rising from 0 in 2021 to 29% in 2023. Other countries with notable increases include Comoros, Seychelles, and DRC, each growing from approximately 8 in 2021 to 24% in 2023. Malawi, Namibia, Zambia, Botswana, Lesotho, and Mozambique also experienced increases in red scores, indicating a regression in achievement of SRHR targets. Increases in red scores suggest that these countries face significant challenges in maintaining or improving their SRHR indicators. This could be due to factors such as policy changes, funding cuts, socio-political instability, or other barriers hindering progress. The rise in red scores is a concerning sign and highlights the need for targeted interventions and support to address these challenges and ensure that SRHR efforts are sustained and advanced.

For a more detailed analysis of the country scores, please Table 1.5 below.

Table 1.5: Overview of country SRHR scores by colour code 2021 and 2023

Country	Dark green 2021	Dark Green 2023	Light Green 2021	Light Green 2023	Yellow 2021	Yellow 2023	Amber 2021	Amber 2023	Red 2021	Red 2023	No target set for 2021	No target set for 2023	Not Applicable 2021	Not Applicable 2023	No data 2021	No data 2023
South Africa	17%	43%	0%	19%	0%	5%	0%	10%	25%	10%	25%	5%	0%	5%	0%	5%
Mauritius	33%	38%	8%	10%	8%	5%	8%	0%	8%	10%	25%	5%	0%	10%	8%	24%
Comoros	17%	33%	25%	10%	25%	10%	0%	5%	8%	24%	25%	5%	0%	5%	0%	10%
Eswatini	17%	29%	17%	19%	25%	19%	8%	14%	0%	5%	25%	5%	0%	0%	8%	10%
Malawi	17%	29%	33%	19%	33%	14%	0%	5%	0%	19%	25%	5%	0%	0%	0%	10%
Namibia	17%	29%	17%	10%	17%	10%	17%	14%	8%	19%	25%	5%	0%	0%	0%	14%
Seychelles	33%	29%	0%	5%	8%	5%	8%	10%	8%	24%	25%	5%	0%	0%	17%	24%
Zambia	8%	29%	0%	14%	25%	10%	17%	19%	17%	19%	25%	5%	0%	0%	8%	5%
Zimbabwe	8%	24%	25%	10%	25%	24%	17%	0%	0%	29%	17%	5%	0%	0%	8%	10%
Botswana	8%	19%	17%	19%	8%	14%	25%	10%	0%	19%	25%	5%	0%	0%	17%	14%
Lesotho	8%	19%	17%	19%	33%	5%	17%	14%	0%	14%	25%	5%	0%	0%	0%	24%
Mozambique	0%	19%	17%	19%	33%	10%	17%	14%	0%	14%	17%	5%	8%	0%	8%	19%
Angola	0%	14%	58%	24%	0%	10%	8%	19%	8%	10%	25%	5%	0%	5%	0%	14%
Madagascar	0%	14%	42%	29%	8%	0%	8%	14%	17%	14%	25%	5%	0%	0%	0%	24%
Tanzania	8%	14%	8%	24%	25%	5%	17%	14%	17%	14%	25%	5%	0%	5%	0%	19%
DRC	0%	5%	33%	29%	25%	5%	8%	10%	8%	24%	25%	0%	0%	0%	0%	29%

SRHR indicators table computed from the 2nd SADC Milestone Scorecard 2023

Table 1.5 provides a detailed analysis of the comparative performance of SADC countries based on the provided indicators. Mauritius and Seychelles are among the best-performing countries. Mauritius has consistently performed well, with an increase in dark green scores from 33% in 2021 to 38% in 2023 and a slight increase in light green scores from 8% to 10%. The country's strong healthcare system, effective policy implementation, and high government commitment to SRHR issues contribute to its success. Despite a slight decrease in dark green scores from 33% to 29%, Seychelles remains one of the best-performing countries due to its sound public health services, which provide free health care for all citizens and, in particular, comprehensive SRHR services, including pregnancy testing, contraception, and antenatal care.[22] On the other hand, the Democratic Republic of Congo (DRC) and Angola are among the poorer-performing countries. DRC has shown a slight increase in dark green scores from 0% in 2021 to 5% in 2023, a decrease in light green scores from 33% to 29%, and an increase in red scores from 8% to 24%. The country faces significant challenges, including political instability, limited healthcare infrastructure, and high levels of poverty, which hinder progress in achieving SRHR targets. Angola's performance is similarly lower, with an increase in dark green scores from 0% to 14%, a decrease in light green scores from 58% to 24%, and an increase in red scores from 8% to 10%.

South Africa and Comoros have shown the most improvement. South Africa has made remarkable progress, with an increase in dark green scores from 17% in 2021 to 43% in 2023, an increase in light green scores from 0% to 19%, and a decrease in red scores from 25% to 10%. This improvement is likely due to targeted interventions, increased funding, and strong govern-

[22] https://www.heard.org.za/wp-content/uploads/2015/11/Seychelles-country-fact-sheet.pdf

ment commitment to SRHR issues. Comoros has also made significant strides, increasing dark green scores from 17% to 33%. However, the increased red scores for Comoros from 8% to 24% indicate areas requiring attention and improvement.

During the launch of the SADC 2nd Milestone Scorecard, the SADC Deputy Executive Secretary for Regional Integration, Angele Makombo N'tumba, applauded Member States for their commitment to devising strategies and approaches to address maternal and neonatal mortality and promote a multi-sectoral approach to addressing the scourge of gender-based violence. She emphasised the need to ensure that every woman and every adolescent girl and young woman has access to contraceptives so that they can reach their full potential.[23]

She said "the strategy and scorecard are driven by the SADC Vision 2030, which aims for a region in which all people can have 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."[24]

Regional Indicative Strategic Development Plan (RISDP) 2020 to 2030

The RISDP is SADC's key strategic framework that outlines the body's objectives and priorities for promoting regional development and integration. It is a comprehensive 10-year development agenda for addressing social, economic, political, and governance issues in the region with 24 strategic objectives and 48 key outcomes.

Its three core pillars are:

- Industrial Development and Market Integration.
- Infrastructure Development in Support of Regional Integration.
- Social and Human Capital Development, anchored in a firm Peace, Security, and Good Governance foundation.

Gender is cross-cutting, and Strategic Objective 1 in this section is enhanced gender equality, women's empowerment and development, and elimination of gender-based violence.

The SADC RISDP 2020-2030 goals reflect those of international and regional commitments, particularly the United Nations 2030 Agenda for Sustainable Development and the African Union's (AU) Agenda 2063.[25]

SADC is approaching the halfway mark of its 10-year regional strategy, the Regional Indicative Strategic Development Plan (RISDP) 2020 to 2030. This presents an opportunity for SADC and its member states to evaluate the strategy's implementation to determine if it is progressing towards its objectives.

The **Southern African Gender Protocol Alliance** is a "network of networks" that campaigned for adopting the SADC Protocol on Gender and Development, which was updated in 2016 to align with the Sustainable Development Goals (SDGs). Attesting to the vital role of civil society in campaigning for gender justice in the region,

[23] SADC Launches 2nd Milestone Scorecard on Sexual and Reproductive Health and Rights to accelerate the attainment of sexual and reproductive health and rights for the people of the SADC Region | SADC (no date). Available at: https://www.sadc.int/latest-news/sadc-launches-2nd-milestone-scorecard-sexual-and-reproductive-health-and-rights (Accessed: 13 October 2024).
[24] Ibid
[25] Southern African Development Community (SADC) Regional Indicative Strategic Development Plan (RISDP) 2020-2030, Gaborone, Botswana, 2020.

the SADC Gender Protocol is the only one of the 26 SADC Protocols that has been updated. It is the only Protocol with a Monitoring, Evaluation, and Results Framework.

The Alliance launched the 2024 Africa Women's Political Participation Barometer in the wings of the 44th SADC Heads of State Summit in August in Harare, Zimbabwe. The Alliance members engaged with SADC and member states on various issues, including mechanisms for non-state actors (NSA) to engage with member states.

A Regional Dialogue for Non-State Actors (NSAs)

The Gender Protocol Alliance, represented by Gender Links in the group of regional civil society organisations comprising the Partnership for Social Accountability (PSA) Alliance, has co-convened regional dialogues to track and discuss the RISDP 2020-2030 implementation. The first virtual event in June 2021 raised awareness about the RISDP 2020-2030 and allowed NSAs to exchange ideas and formulate recommendations. In 2022 and 2023, a growing number of co-conveners held hybrid (in-person and virtual) events to highlight the importance of socially accountable public resource generation and management in SADC's development, contributing to increased NSA consultation by SADC structures in participating countries, the approval of the SADC Regional NSA Engagement Mechanism, and development of a SADC PF Scorecard to assess alignment of legislation with the PFM Model Law.

In 2024, the PSA Alliance convened the RISDP NSA Dialogue from 14 to 15 August, just ahead of the SADC Heads of State and Government Summit (17-18 August) in Harare, Zimbabwe. The event interrogated the RISDP 2020-2030 performance four years into its implementation. It provided insights and recommendations on how and where SADC and its member states can increase investment in human and social development and generate and ensure the sound use of financial resources. Additionally, the co-conveners took stock of the achievements of the RISDP NSA Dialogues, reflected on current efforts to engage civil society in SADC processes, and developed action plans to guide future national and regional activities.

> Accountable public resource management is critical to ensuring consistent support for research and development in all industries, including the social sectors

The dialogue brought together over 200 participants from 10 of SADC's 16 Member States, both in person and virtually, including diverse representation from civil society organisations, smallholder farmers' associations, trade unions, youth organisations, faith-based organisations, media outlets, SADC Secretariat representatives, SADC Parliamentary Forum members, and government officials. The theme of the Dialogue mirrored that of the 44th SADC Summit of Heads of State and Government, *Promoting innovation to unlock opportunities for sustained economic growth and development towards an industrialised SADC*, highlighting the need to generate and nurture innovative approaches to advance sustainable growth in the region. Accountable public resource management is critical to ensuring consistent support for research and development in all industries, including the social sectors. Accessible, inclusive, and high-quality education, healthcare, and agricultural services support the creation and growth of livelihoods and entrepreneurial activities among the people of the SADC region, reducing poverty and uplifting communities and nations.

Gender Links, coordinator of the Gender Protocol Alliance, represented the Alliance at the dialogue, highlighting the importance of accountability and reporting for impact, focusing on feminist principles of monitoring, evaluation and accountability.

Accountability and reporting for impact, with a focus on feminist principles

i. Emphasis is placed on transparency, including raising awareness of instruments and budget tracking with a gender-based analysis.
ii. Participants called for inclusivity in monitoring and evaluation processes involving communities and women's rights organisations.
iii. There was a recommendation for empowerment through campaigning and capacity building on the roles of elected leaders.
iv. A proposal was made for intersectional reporting approaches to collect better decision-making data.
v. There was an emphasis on responsiveness to the specific needs of women in different country contexts.
vi. A call was made for communities' legal empowerment and training law enforcement agencies to be gender-sensitive.

SADC has developed several frameworks, including the SRHR scorecard, which measures progress toward achieving the targets laid out in them. However, accountability and reporting for impact needs to move beyond numbers. These feminist principles apply to SRHR in particular because of the 'controversial' nature of these rights, where measuring change is illustrated in changing power dynamics, agency and control of women's bodies. Reporting for impact must be grounded in women's lived experience, demonstrating how women and LGBTQI+ people's lives have changed.

Safe Abortion Alliance of Southern Africa (SAASA)

Safe Abortion Alliance of Southern Africa
SAASA
#VoiceandChoice
an affiliate of the Southern Africa Gender Protocol Alliance

Lack of access to safe abortion continues to be one of the driving factors of maternal mortality in the SADC region. The region is guided by the Maputo Protocol (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa) adopted by the African Union in 2003. It is the first treaty anywhere in the world to recognise abortion, under certain conditions, as a reproductive right of women.

Laws on abortion in SADC range from being legal on demand, as in South Africa and Mozambique, to complete criminalisation in Madagascar. Advocating for access to legal and safe abortion is, therefore, a priority in the SADC region.

Voice and Choice Fund members initiated the Safe Abortion Alliance of Southern Africa (SAASA)[26] at the Learning and Sharing Summit in November 2023. They met again in Harare in August 2024, where they drafted an action plan for the coming year and agreed to broaden their membership to all 16 countries in SADC and in Johannesburg in November 2024 where they developed a strategy for the alliance.

[26] https://vcsafund.org/saasa/

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16 Days march in Eswatini. Photo: Thandokuhle Dlamini

Menstrual Health, Family Planning and Maternal Health

2

Ezulwini Mayors walk in Eswatini, South Africa. Photo: Gender Links

Key points

- Despite progress SADC is not on course to achieve some key SDG, SADC Gender Protocol and SADC SRHR strategy targets. Some countries are doing better than others.
- The maternal mortality ratio (MMR) remains high in SADC. The regional average has remained static at 397 deaths per 100 000 deliveries. Only Mauritius and Seychelles have achieved the SDG target of MMR lower than 70 per 100 000 live births.
- Four countries have met the target for Neonatal mortality rate of below 12 per 1000 live births.
- Seven SADC countries have now removed VAT on menstrual products and seven provide free sanitary wear in schools.
- Fewer than half of the population has access to basic handwashing facilities at home. Namibia has the highest coverage (45%), and Lesotho has the lowest (6%).
- Contraceptive prevalence rate (CPR) in the SADC region ranges from 59% in Botswana to a low 17% in Angola. Seven countries meet or exceed the global average of 49%.
- Angola has the highest unmet need for contraception with 38% of women of reproductive age (15-49 years) having a need for family planning not met. Only Zimbabwe is below the global average of 10%.
- Eleven countries in SADC have now included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 67% in Mauritius and 65% in Tanzania to a low of 13% in Malawi.
- Seven SADC countries have national cervical cancer screening programmes. However, large-scale coverage remains a challenge, ranging from 3% in Mozambique to 52% in South Africa, for women who have ever been screened for cervical cancer.
- Botswana is the only SADC country that has met and exceeded the Abuja commitment of 15% of the state's annual budget for health.
- Only Lesotho spends more than 10% of its GDP on health.

Introduction

Sexual and reproductive health is an essential aspect of well-being that affects individuals throughout their lives, from infancy to old age. While both women and men have specific health needs in this area, women tend to face more significant challenges due to their primary roles in childbirth and caregiving. Throughout their lives, women require various services that address their reproductive health needs. These include menstrual health and hygiene, access to contraception and family planning, antenatal care, safe delivery services, post-natal support, prevention and treatment of sexually transmitted infections (including HPV), as well as early diagnosis and management of reproductive health issues such as breast and cervical cancer. Addressing these needs is essential for promoting overall health and well-being for women at every stage of life.[1]

Since the International Conference on Population and Development (ICPD) held in 1994, Sexual and Reproductive Health and Rights (SRHR) have been acknowledged as vital to women's human rights and dignity, which are essential for development. Safeguarding sexual and reproductive health is also a human rights issue, and neglecting these matters has far-reaching effects, including influences on infant and child mortality rates as well as HIV prevention and treatment.

At the international level, significant advances have been made. The global contraceptive prevalence rate has increased by 25% worldwide. There has been a sharp decline in adolescent births, and the global maternal mortality rate has also declined. However, the progress has been gradual and inconsistent. Hundreds of millions of women globally are still not utilising modern contraceptives to avoid unintended pregnancies, and the global targets for reducing maternal and neonatal mortality have not been achieved.[2]

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

At the regional level, SADC heads of state adopted the SADC SRHR Strategy and Scorecard 2019-2030, aligned with the SDGs. In 2023, SADC released the second milestone scorecard, reflecting progress, stagnation and regression across 20 SRHR indicators. Progress in critical areas such as maternal and neonatal mortality and women's unmet need for contraception has been slow or has regressed. Budget allocations remain stagnant.

This chapter evaluates advances in women's sexual and reproductive health and rights (SRHR) through 18 indicators related to menstrual health, neonatal health, family planning, maternal health, access to water and sanitation, as well as proportion of budget committed to health. The chapter illustrates that the journey toward achieving the targets outlined in the Sustainable Development Goals (SDGs) and the SADC SRHR scorecard is not straightforward, and even when progress is made, there is always a risk of rollback if governments are not alert and fully dedicated to reaching and maintaining these goals. In instances with a decline, it is crucial to investigate and comprehend the reasons behind it and implement new strategies that tackle both ongoing and emerging challenges to the realisation of SRHR.

[1] UNFPA, Sexual and reproductive health, https://www.unfpa.org/sexual-reproductive-health , accessed 4 February 2025
[2] World Health Organization, 2014 International Conference on Population and Development, https://www.unfpa.org/icpd , accessed 10 September 2022

Table 2.1: SRH indicators in 2024

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	2019 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2019 Policy	2012 Policy	2019 Policy	2018-22 Guidelines	2008 Policy	2010-15 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	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes
Access to at least basic sanitation (%)[3] (2017 figures)	52	81	36	16	64	50	15	49	95	37	36	100	78	31	36	35
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 prevalence rate amongst *all women* aged 15-49 (%) any method[5]	17	59	21	27	53	52	42	50	44	29	53	No data	52	38	38	51
% women of reproductive age (15-49) with unmet need for family planning[6]	38	No data	19	29	15	18	15	15	13	23	12	No data	21	21	30	8
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[7]	74	No data	71	85	89	93	93	91	No data	85	83	No data	85	85	87	93
Maternal Mortality Ratio (per 100,000 live births)[8]	239	243	186	547	452	618	408	439	33	452	385	64	86	556	252	462
Antenatal Care Visits (At least one visit) %[9]	82	94	95	82	99	91	89	97	No data	87	97	No data	94	90	99	96
Antenatal Care Visits (At least four visits) %[10]	61	73	64	No data	74	77	60	51	No data	49	63	No data	76	65	64	72
Births attended by skilled health staff (% of total)[11]	50	100	97	No data	88	87	46	96	100	68	88	100	97	85	80	86
Postnatal care coverage mother %[12]	23	No data	91	No data	88	84	55	84	No data	36	69	No data	84	51	70	82
Neonatal mortality (per 1,000 live births)[13]	24	18	10	27	20	34	26	27	8	30	20	8	10	24	27	32
Nursing and midwifery personnel per 10,000 of the population[14]	13	31	No data	12	31	No data	No data	5	30	5	34	73	No data	No data	22	21
Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 15[15]	N/A	22	N/A	No data	No data	64	N/A	13	67	57	No data	62	36	65	39	54
Health expenditure as proportion of GDP[16]	3	6	6	4	7	10	4	7	6	9	9	5	8	3	7	3
% annual budget allocated to health sector[17]	7	19	12	9	11	11	8	10	3	No data	12	5	8	7	8	11

Source: Gender Links computations and UNAIDS 2023 data, https://aidsinfo.unaids.org, accessed 25 July 2024

[3] World Health Organisation data bank, accessed 2 February 2025
[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 2 February 2025, no new data (2020)
[5] UNFPA, World Population Dashboard, accessed 2 February 2025
[6] SADC SHR scorecard, accessed 2 February 2025
[7] UNFPA, World population dashboard accessed 2 February 2025
[8] SADC SHR scorecard, accessed 2 February 2025
[9] UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , Data as of November 2024, accessed 2 February 2025
[10] Ibid
[11] Ibid
[12] Ibid
[13] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 2 February 2025
[14] WHO, The Global Health Observatory, https://data.who.int/indicators/i/B54EB15/5C8435F, accessed 3 February 2025
[15] https://immunizationdata.who.int/global/wiise-detail-page/human-papillomavirus-(hpv)-vaccination-coverage?ANTIGEN=15HPVC_F&YEAR=&CODE=, accessed 17 February. 2025.
[16] World Bank, World Development Indicators, accesses 2 February 2025
[17] SADC SHR scorecard, accessed 2 February 2025

SADC launched its second milestone scorecard with 2023 data. We have used data from the scorecard for the following indicators in this chapter:

- Maternal Mortality Ratio (per 100,000 live births).
- Neonatal mortality (per 1,000 live births).
- % women of reproductive age with unmet need for family planning.
- % annual budget allocated to health.

Table 2.1 shows that:

- Seven SADC countries, (up from six in 2022) - Lesotho, Mauritius, Malawi, Namibia, Seychelles, South Africa and Zimbabwe - have now removed VAT on menstrual products. Seven countries provide free sanitary wear in schools - Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe.
- The regional average of unmet need for family planning in Southern Africa remains high at approximately 15%, which exceeds the global average of 9%. The lowest unmet need is in Zimbabwe, at 8%, while Angola has the highest rate, currently estimated at 38% of women of reproductive age.
- The contraceptive prevalence rate (CPR) for all women aged 15-49 using all methods ranges from 17% in Angola to 59% in Botswana. Seven countries (Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa and Zimbabwe) are above the global average of 49%.
- Maternal mortality remains high in SADC. The regional average has remained static at 397 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. Lesotho has the highest MMR with 618 deaths per 100 000 live births. Seven other countries (DRC, Eswatini, Madagascar, Malawi, Mozambique, Tanzania and Zimbabwe) have more than 400 maternal deaths per 100 000 live births.
- Four SADC countries (Comoros, Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 (or fewer) neonatal deaths per 1,000 live births.
- Eleven SADC countries have now included Human Papillomavirus (HPV) in their national vaccination programmes. Coverage varies significantly, from 13% in Malawi to 67% in Mauritius and 65% in Tanzania.
- Botswana is the only SADC country that has met and exceeded the Abuja commitment of 15% of the state's annual budget for health. Mauritius and Seychelles only spend 3 and 5 percent respectively of annual budget on health.
- Only Lesotho spends more than 10% of its GDP on health. Angola, Tanzania and Zimbabwe spend only 3% of their GDP on health.

SADC launched its second milestone scorecard with 2023 data

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 SDGs, and aims to achieve ten SRHR outcomes.

Status of SRHR policies in SADC

Over the last 20 years, 13 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines on SRHR, though many are now outdated. Challenges remain, particularly around policy barriers affecting access to safe contraception which contributes to high rates of unintended pregnancies and unsafe abortions.

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
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
Seychelles	Reproductive Health Policy for Seychelles	2012
Madagascar	Reproductive Health and Family Planning Law	2017
Eswatini	National Policy on Sexual and Reproductive Health National Health Sector Strategic Plan	2019
Namibia	National Integrated Sexual Reproductive Health and Rights Policy	2019
South Africa	National integrated SRHR Policy	2019
Malawi	National Reproductive Health and Rights Policy, National Youth Friendly Health Services Strategy	2022
SRHR guidelines		
Botswana	Policy guidelines and service standards for sexual and reproductive health, Adolescent Sexual and Reproductive Health Strategy	2015
Tanzania	SRHR guidelines and National Adolescent Reproductive Health Strategy, National Adolescent Health and Development Strategy, Five-Year Costed Implementation Plan for Family Planning 2018-2022	2018
No dedicated SRHR policy		
DRC	National Multi-sectoral Strategic Plan for Family Planning	2014-2020
Angola	Included in the Constitution	1975
Comoros	National Health Development Plan	2010-2015

Source: Audit of SRHR policies and laws, Gender Links, additional online research

Table 2.2 shows that 13 SADC countries have either stand-alone SRHR laws and policies or SRHR guidelines, however, most of these are outdated.

Africa Centres for Disease Control and Prevention (Africa CDC) Reproductive Health Strategy Priorities 2022-2026: The African Union Heads of State revised and then endorsed the revised Maputo Plan of Action, 2016 - 2030 at the 27th AU summit in Kigali, Rwanda in 2016. The plan's overall goal is for joint effort between African Governments, civil society, the private sector and development partners for the implemen-

tation of the continental policy framework on SRHR to end preventable maternal, new-born, child and adolescent deaths, expand contraceptive use, reduce levels of unsafe abortion, end child marriage, eradicate harmful traditional practices including female genital mutilation and prevent gender-based violence and ensure access of adolescents and youth to SRH by 2030 in all countries in Africa.[18]

The plan focuses on the following elements of SRHR: Adolescent Sexual and Reproductive Health (ASRH); maternal health and new-born care; safe abortion care; family planning; prevention and management of sexually transmitted infections including HIV; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing mid-life concerns of men and women; health and development; the reduction of gender-based violence; interpersonal communication and counselling; and health education. The plan is premised on nine action areas: political commitment, leadership and governance; health legislation; health financing/investments; health services strengthening/human resource development; partnerships and collaborations; information and education; accountability/monitoring and evaluation; investment in the vulnerable and marginalized populations and improved adolescent and youth SRHR.

The Africa CDC recognises that outbreaks of infectious diseases and other public health threats directly and indirectly cripple SRH services

In 2022, the Africa Centres for Disease Control and Prevention (Africa CDC) officially launched its Reproductive Health Strategy Priorities 2022-2026[19]. The Africa CDC was established in 2017 primarily to help Africa to respond effectively to outbreaks of infectious diseases and other public health threats. The Africa CDC recognises that such outbreaks directly and indirectly cripple SRH services, and supporting SRH services during these emergency situations is not prioritised. Countries affected by humanitarian crises disproportionately contribute to global maternal and new-born mortality and morbidity. The overall goal is to improve maternal and reproductive health in Africa and contribute to the reducing the maternal mortality ratio to less than 70 per 100, 000 live births. The Africa CDC has identified five intermediate outcomes:

1. Minimum of 10-15% of country health budget allocated to Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCAH).
2. Reduction of Adolescent pregnancy rate by 50%.
3. Improved availability and uptake of HPV vaccine for the primary prevention of cervical cancer.
4. Improved availability and use of Heat Stable Carbetocin for the reduction of maternal deaths from post-partum haemorrhage.
5. Proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months reduced by 50%.

Amongst the strategies that the Africa CDC has identified is supporting member states to develop and implement a sustainable Community Health Worker workforce, and expand community Health Worker capacity to support scale up of interventions in RH priority areas.

[18] African Union, Maputo Plan of Action 2016 - 2030 for the operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights, Addis Ababa. African Union Commission 2016.
[19] Africa CDC. Reproductive Health Strategic Priorities 2022-2026. 2022. Addis Ababa; Africa CDC.
[20] UNICEF Menstrual Hygiene, accessed 2 February 2025

Menstrual health

UNICEF recognises that every month, nearly two billion people across the world menstruate. The onset of menstruation is a critical phase for adolescents. However, 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. As a result, millions of girls, women, transgender men and non-binary persons are unable to manage their menstrual cycle in a dignified, healthy way."[20]

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. Missing five days of school or of work every month is substantial hence the need to find interventions to assist these girls and young women.

Lesotho Thabo Morena handing out sanitary pads at Mamantso Council in Mafeteng, Lesotho. Photo: Gender Links

Period poverty

For millions of women and girls, managing menstrual health is challenging due to a lack of access to affordable products, clean water, and adequate sanitation facilities. This lack of resources, often referred to as period poverty, hinders their daily lives, limits opportunities, and affects their rights and freedoms. This causes anxiety and denies girls of dignity and confidence which impacts on many other aspects of their lives.

Period poverty encompasses more than just the cost of menstrual products; it also includes restricted access to the facilities and education necessary for managing menstrual health effectively. In essence, period poverty imposes significant barriers on women and girls - but it does not have to remain this way. Period stigma, the elevated prices of menstrual products, and the shortage of water and sanitation facilities drive period poverty around the world.

Women and girls use cow dung for sanitary pads in rural Zimbabwe[21]

Africanews reported in 2022 that girls in rural Zimbabwe are compelled to use cow dung for sanitary care as inflation impacts the cost of feminine hygiene products. The Ministry of Women and Youth Affairs states that 67% of girls miss school during their menstrual cycles due to a lack of sanitary products and clean sanitation facilities. Girls with disabilities often end up dropping out of school entirely.

For example, in the rural area of Domboshawa, located 30 km north of Harare, a study by SNV Netherlands Development Organisation found that 72% of girls lack access to commercially available sanitary products.

At an equivalent of US$2 per pack, most of the country's three million girls who menstruate and live below the poverty line find sanitary pads unaffordable. Families are faced with the dilemma of choosing between buying feminine hygiene products and purchasing food, with most opting for food.

One grandmother interviewed expressed, "Sanitary pads are a luxury I cannot afford for my girls," and explained the process involving cow dung.

"I collect the dung, shape it, and allow it to dry to facilitate blood absorption. The girls do not apply the cow dung directly to their skin. I wrap multiple layers of cloth around it to prevent itching when placed on their underwear. Then I demonstrate how to close their private parts to manage the bleeding."

She adds, "The girls experience heavy flows with cycles that generally last six days. We prefer this method since cow dung absorbs a significant amount of blood. Once it's soaked, we dispose of it discreetly by burying it. Our Shona culture forbids men from seeing such items."

In addition to missing school, health professionals warn that these practices can foster the spread of salmonella, E. Coli, and various bacteria that may lead to reproductive health issues.

Although the government of Zimbabwe has attempted to alleviate the situation by eliminating taxes on all sanitary products, period poverty is worsened by inflation, which exceeds 191%, according to the Zimbabwe National Statistics Agency.

Source: Africanews

A range of civil society players, including NGOs, CBOs as well as the private sector, are joining efforts to make safe sanitary wear available to poor girls. This includes reusable pads and menstrual cups. There are also government efforts to make sanitary wear more available as well as to make bud-getary support available for schools to provide sanitary wear.

Removing value-added tax (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 VAT on sanitary products. There are a growing number of countries in the SADC region that have removed VAT on sanitary products. There are also countries that are making budgetary support available for schools to provide sanitary wear to girls in poor areas.

Providing free sanitary products to school girls, particularly in rural areas will improve educational performance and advance their overall health.

[21] Africanews, https://www.africanews.com/2022/07/11/zimbabwe-girls-resort-to-cow-dung-for-sanitary-pads/ accessed 11 February 2025

Table 2.3: VAT exempted and free menstrual products in SADC

Country	VAT on sanitary wear exempted	Free sanitary wear in schools[22]
Mauritius	Yes (2017)[23]	Yes (2018)[24]
Lesotho	Yes (2019)[25]	Yes (2021)[26] - Motion passed but implementation lacking
South Africa	Yes (2019)[27]	Yes (2019)[28]
Zimbabwe	Yes (2020)[29]	Yes (2020)[30]
Namibia	Yes (2021)[31]	No
Seychelles	Yes (2020)[32]	Yes (2022)[33]
Zambia	No	Yes (2019)[34]
Botswana	No	Yes (2017)[35]
Malawi	Yes (2022)[36]	No
Angola	No	No
Comoros	No	No
DRC	No	No
Eswatini	No	No
Madagascar	No	No
Mozambique	No	No
Tanzania	No, removed 2018, reinstated 2019	No

Source: Constructed by Gender Links from sources in footnotes

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

Piggs Peak councillor, Sbongile Magagula, distributing sanitary pads to students in Eswatini. Photo: Thandokhule Dlamini

[22] Largely of rural schools and indigent populations
[23] https://borgenproject.org/period-poverty-in-mauritius/, accessed 2 February 2025
[24] Ibid
[25] https://borgenproject.org/period-poverty-in-lesotho/ accessed 2 February 2025
[26] Ibid
[27] https://www.globalcitizen.org/en/content/south-africa-sanitary-pads-tax-lifted/ accessed 2 February 2025
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[29] BDO. Latest VAT and customs developments in Zimbabwe. Indirect Tax News - February 2020. https://www.bdo.global/en-gb/microsites/tax-newsletters/indirect-tax-news/issue-1-2020/zimbabwe-latest-vat-and-customs-developments-in-zimbabwe/ accessed 2 February 2022
[30] Fair Planet. Empowering Lesotho's girls: The fight against period poverty. https://www.fairplanet.org/story/zimbabwe-free-sanitary-wear-program-for-rural-schoolgirls/ accessed 2 February 2025
[31] Namibia eliminates Tampon Tax removing VAT on all Menstrual Health Products. 18 March, 2021. https://www.epfweb.org/node/ accessed 2 February 2025
[32] Pointe, Elsie. Six sanitary and hygiene products join essential commodities list, 30 May 2020 https://www.nation.sc/articles/4826/six-sanitary-and-hygiene-products-join-essential-commodities-list accessed 2 February 2025
[33] State House Office of the President of the Republic of Seychelles. Seychelles successfully launches national programme to provide free access to sanitary products for all school girls. January 13, 2022. https://www.zawya.com/en/press-release/seychelles-successfully-launches-national-programme-to-provide-free-access-to-sanitary-products-for-all-school-fripfpki accessed 2 February 2025
[34] Jere, J. Focus on Menstrual Health Keeps Zambian Girls in School October 17, 2019. https://www.voanews.com/a/africa_focus-menstrual-health-keeps-zambian-girls-school/6177759.html accessed 2 February 2025
[35] Shick, A. The fight against period poverty in Botswana, August 4, 2022. https://borgenproject.org/period-poverty-in-botswana/ accessed 2 February 2025
[36] Emojong. T. MHH Country Spotlight: Malawi. March 30, 2022. https://www.afripads.com/blog/mhh-country-spotlight-malawi/ accessed 2 February 2025

South Africa: Local community advocacy

The Organisation for Young Women's Dignity (TOFYWD), a Voice and Choice Southern Africa grantee, has worked with local government to raise awareness on menstrual health and hygiene and address Gender-Based Violence (GBV).

TOFYWD held an Annual Women's Day Soccer Tournament in collaboration with the City of Johannesburg Department of Sport and Recreation, reaching 164 individuals with educational sessions and sanitary pad distribution. They have conducted Menstrual health and hygiene education programmes at two secondary schools, reaching over 1,400 adolescent girls and young women with information and sanitary pad distribution.

TOFWYD has successfully engaged men and boys by including a male influencer as a speaker on menstrual health. His role has been instrumental in reducing the stigma surrounding menstruation, emphasising that these topics concern everyone, not just women. This shift has fostered a more supportive and open environment for discussing menstrual health issues within the community.

Additionally, the male influencer's active participation in discussions on GBV has helped challenge traditional gender stereotypes. By advocating for more balanced gender roles, his engagement has broadened the scope of the project's discussions, fostering an inclusive understanding of gender issues.

The project has successfully expanded its audience to include influential community leaders, such as the local police Commissioner, who had not previously been involved. Their participation has enhanced the project's visibility and brought added support and credibility.

This impact is evidenced by a noticeable increase in community awareness and understanding of menstrual health and GBV, reflected in the positive feedback received and increased requests for information and resources. The programme has reached 1,467 participants across various locations. This outreach highlights the growing community awareness and demand for ongoing education and support on these critical issues.

Beneficiaries of dignity packs and Menstrual Hygiene Education, TOFYWD, .
Credit: Farai Nyamazana

Source: TOFYWD report to Gender Links

Period stigma

Period stigma, which refers to the discrimination faced by people who menstruate, encompasses various forms of prejudice. This can include lack of access to sanitary supplies and verbal shaming, where menstruating individuals are labelled as "dirty" or "unclean." Such stigma can significantly diminish the quality of life for those affected.

The spectrum of discrimination can manifest in several insidious ways. This might begin with seemingly innocuous jokes, which, while intended to be humorous, often draw from outdated stereotypes and serve to belittle the experiences of those who menstruate. Such comments can reinforce societal norms that trivialise menstrual experiences, making it more challenging for

individuals to discuss their needs openly. Moreover, the perpetuation of unfounded beliefs contributes significantly to this discrimination. For example, if someone displays emotional sensitivity, sharpness, or assertiveness during their menstrual cycle, they may be unfairly accused of having "PMS" (premenstrual syndrome). This label reduces a person's complex emotions and behaviours to mere hormonal fluctuations, dismissing the legitimacy of their feelings. As a result, such accusations not only undermine the individual's emotional experience but also perpetuate a harmful stigma that surrounds menstruation, making it difficult for society to acknowledge and support the realities of those who menstruate.

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

Zimbabwe: Involving men and boys in destigmatising menstrual health

Ree Inspiration for Girl-child Empowerment (RIGE), A Voice and Choice Southern Africa Grantee, conducted programmes encouraging men to promote women's access to SRHR services and products. Activities also included engagement of duty bearers and partners that support provision of SRHR services in Bindura rural ward 10, in central Zimbabwe. The background was that in Bindura rural - ward 10, young women faced limited access to sexual and reproductive health (SRH) services due to cultural barriers, lack of support from men, and insufficient knowledge about these services. There are no platforms for women to freely discuss SRHR issues. Additionally, officials from the Ministry of Health and Child Care and other partners are unaware of the SRHR challenges affecting girls and women in this area. Men in ward 10 are also unaware of their crucial roles in supporting women's access to SRHR.

Rige menstrual health programme. Photo: Gender Links

Through speak-out sessions on access to SRHR services and products, father-daughter dialogues on menstrual health (online), menstrual health dialogues with men, and a menstrual health advocacy online campaign, RIGE managed to draw men into SRHR matters concerning women. Through this project, RIGE facilitated good rapport between women in Bindura ward 10, duty bearers, and SRHR service providers. It established male gender champions who are confident about encouraging fellow men to support women's access to SRHR services and products.

Source: RIGE report to Gender Links

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 has huge gaps in access to basic water and 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.[37]

Access to safe water, sanitation, and hygiene is a fundamental human right and essential for individual health, welfare, and the economic and social development of communities and nations. However, millions of people around the world still lack these basic services. Women are particularly affected, as they are often primarily responsible for collecting water and managing household hygiene. Additionally, women face significant challenges due to inadequate sanitation facilities, mainly because of their reproductive roles and the unique WASH-related needs that arise throughout their lives.

Poor access to WASH facilities also increases women and girls' vulnerability to violence.[38] 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.

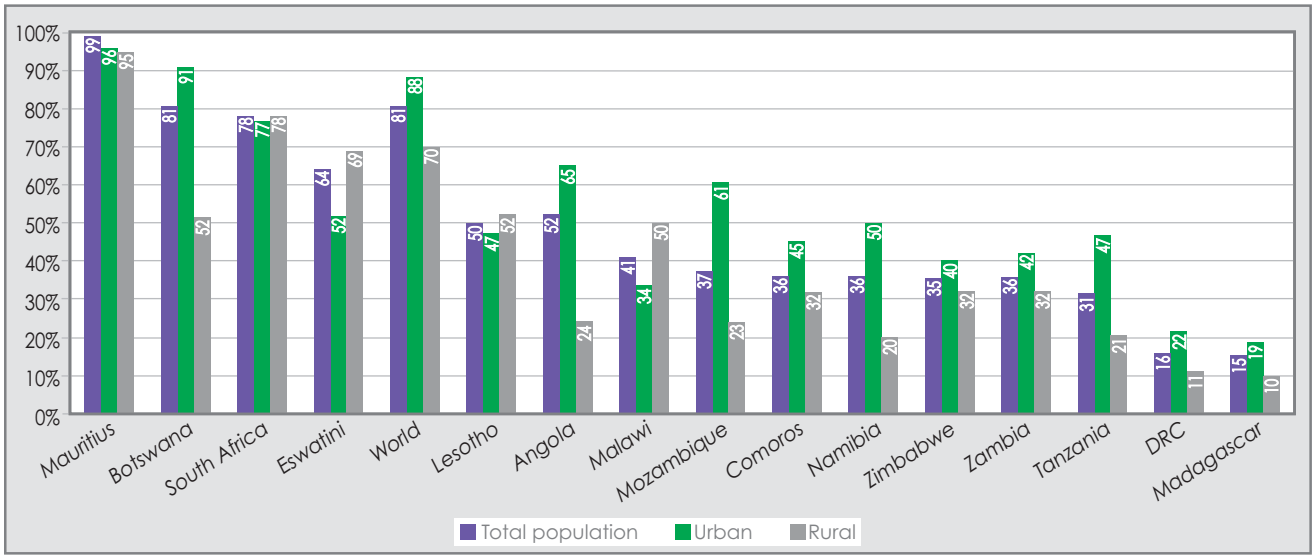
Women walk long distances to collect water in Madagascar. Photo: Zotonantenaina Razanadratefa

[37] UNICEF, Sanitation and hygiene. Available at: https://www.unicef.org/esa/sanitation-and-hygiene, accessed: 12 February 2025.
[38] House, S., Suzanne Ferron, Marni Sommer and Sue Cavill (2014) Violence, Gender & WASH: A practitioner'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 expanding access to Water, Sanitation, and Hygiene (WASH) services across the region, yet this advancement has been slow and uneven in many countries. Although the available data does not break down access by sex, data highlights a significant disparity between urban and rural areas. In rural communities, women are typically the primary caretakers responsible for sourcing and delivering water for their households, underscoring their critical role in managing essential resources.

Figure 2.1: Proportion using at least basic sanitation services - % population/urban/rural



Source: World Bank country data.[39]

Figure 2.1 illustrates the percentage of the population with access to at least basic sanitation services across the SADC region. Mauritius has almost universal coverage, while Madagascar has the lowest coverage with just 15% of the population having access to basic sanitation services.

The figure reveals a significant gap in access between urban and rural populations, with most countries exhibiting lower coverage in rural areas. However, rural residents in Lesotho, Eswatini, Malawi, and South Africa enjoy higher coverage than their urban counterparts. In nine nations (Malawi, Mozambique, Comoros, Namibia, Zimbabwe, Zambia, Tanzania, Madagascar and DRC), fewer than half of the population have access to at least basic sanitation.

Access to hygiene

Access to basic hygiene, including proper hand washing and effective sanitation, is crucial for preventing disease transmission and enhancing overall health.

[39] World bank country data, accessed 2 February 2024

Infections account for approximately 25% of the 2.8 million deaths that occur among new-borns globally each year. Over 95% of neonatal deaths caused by sepsis occur in low- and middle-income countries. Promoting good hand hygiene is an affordable and effective strategy to prevent infections in infants, making it a viable intervention in low- and middle-income settings. Enhancing hand hygiene practices could considerably lower infection rates and associated neonatal mortality.

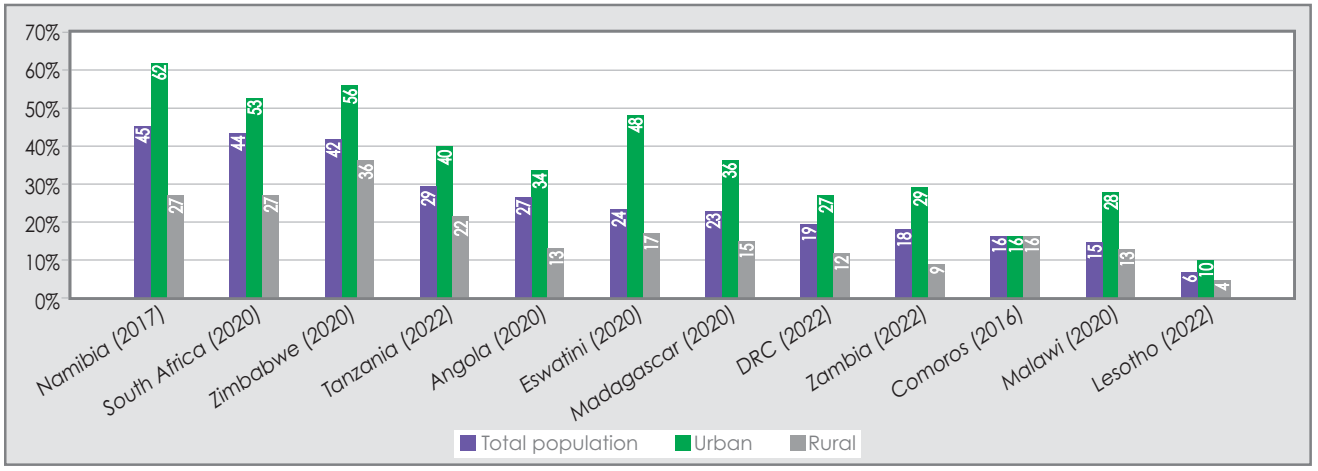
Barriers to access

- **Lack of resources**: Developing nations may lack the financial resources to invest in water treatment plants and sanitation facilities.
- **Lack of knowledge**: People may not know how to practice good hygiene or believe their actions make a difference.
- **Lack of facilities**: People may not have access to clean water or handwashing facilities.[40]

Progress towards the SDG target on hygiene is monitored through indicator 6.2.1b, which measures the proportion of the population with handwashing facilities and soap and water at home.

Data on access to basic handwashing facilities at home have only been recorded since 2010, and they are not available for all countries or years. The data indicate that progress has been exceptionally slow, and coverage remains low. Similar to access to sanitation, there are significant gaps between urban and rural areas in most countries.

Figure 2.2: Proportion (%) of population with basic handwashing at home in SADC



Source: World Health Organisation[41]

Figure 2.2 shows the percentage of the population in the SADC countries that has access to basic handwashing facilities at home. In all SADC countries, fewer than half of the population has access to these facilities. Namibia has the highest coverage (45%) and Lesotho the lowest (6%). The data highlights a significant disparity in access between urban and rural populations; all countries, except Comoros, demonstrate lower coverage in rural areas.

[40] UNICEF, accessed 5 February 2025
[41] World Health Organisation, accessed 4 February 2025

Family planning (FP)

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

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

Access to contraception

Access to voluntary family planning and reproductive health (FP/RH) services is essential for promoting safe motherhood and fostering healthy families. These services empower individuals and couples by providing them with a variety of modern contraceptive options, enabling them to make informed decisions about their reproductive health. With the ability to plan and space births effectively, couples can better prepare for parenting, ensuring that they have the necessary emotional and financial resources to nurture and support their children. This access not only contributes to the well-being of families but also enhances the overall health and prosperity of communities, helping to reduce maternal and infant mortality rates and improve quality of life for all.

Contraception is essential for women aiming to prevent unplanned or unwanted pregnancies. Access to contraceptives enhances maternal health and increases child survival rates. It also reduces the overall number of abortions, especially unsafe ones. Furthermore, contraception empowers women and supports social and economic development and security.

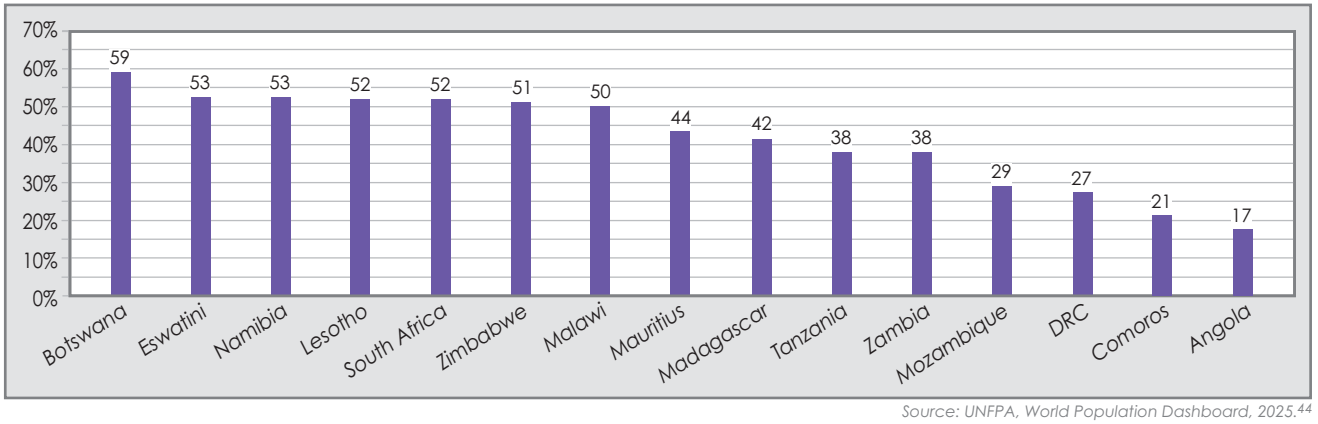
Explanation of contraception - Basic Health Center in Tsaralalana, Madagascar.
Photo: Zotonantenaina Razanadratefa

Contraceptive prevalence rates (CPR)

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

[42] This is often reported for married/in union women only, which is how we have reported on it previously. In this report we use the broader definition, which includes all women of reproductive age using any method of contraception.
[43] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 4 February 2025

Figure 2.3: Contraceptive prevalence rate (%) amongst all women aged 15-49 any method



Source: UNFPA, World Population Dashboard, 2025.[44]

Figure 2.3 shows that the CPR in the SADC region ranges from 59% in Botswana to a low of 17% in Angola. Seven countries (Botswana, Eswatini, Lesotho, Namibia, Malawi, South Africa and Zimbabwe) meet or exceed the global average of 49%.

Unmet contraception need

Women with unmet need for family planning are those who are sexually active but not using any form of contraception. They express a desire to avoid having more children or to delay their subsequent pregnancy. This unmet need highlights the disparity between women's intentions to prevent pregnancy and their actual contraceptive practices.

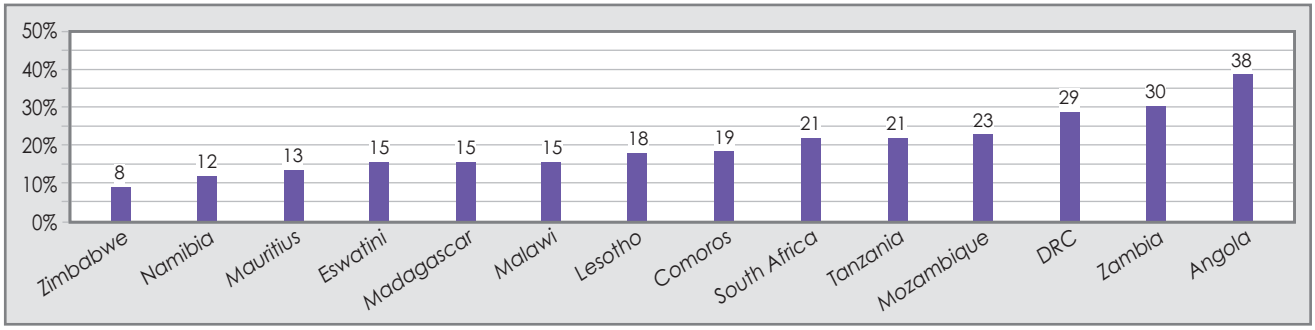
Among the various forms of contraception available, not all are appropriate for every situation. The most suitable contraceptive method is influenced by multiple factors, including a person's overall health, age, frequency of sexual activity, number of sexual partners, future reproductive aspirations, and family history of specific health issues. Providing everyone with access to their preferred contraceptive options upholds several human rights, such as the right to life and liberty, the ability to voice opinions and make decisions, and the right to work and receive an education. Furthermore, this access generates significant health and societal advantages.[45]

More than one out of every ten married women worldwide and one out of every 23 women in sub-Saharan Africa have unmet family planning needs. Despite this, studies concerning sub-Saharan Africa and the community-level factors that may influence the unmet need for family planning are scarce.[46] One study, conducted using data from between 2015 and 2020, assessed factors associated with the unmet need for family planning in sub-Saharan Africa.[47]

The study identified individual and community factors. "Women's age, education, age at cohabitation, 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 (the proportion of women with no formal education), and region were among the community-level factors associated with 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."[48]

[44] UNFPA, World Population Dashboard, accessed 2 February 2025
[45] World Health Organisation, accessed 2 February 2025
[46] 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 2 February 2025
[47] Ibid
[48] Ibid

Figure 2.4: Unmet need for family planning rate (%) all women aged 15-49



Source: SADC SRHR scorecard, 2021.[49]

Figure 2.4 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 38% of women of reproductive age (15-49 years) having a need for family planning not met. Only Zimbabwe's rate is below the global average of 10%.

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

As we further discuss family planning matters, it is essential to mention the FP2030.

FP2030

FP2030, established in 2021, is the only global partnership focused on family planning (FP). This singular focus unites a wide range of partners across disciplines and sectors, putting family planning at the centre of global health, development, and gender equality.[50]

FP2030 has seven key priorities to improve access to FP:

1. Advance recognition of family planning by expanding partnerships and leveraging the 2030 agenda, leveraging their global network of family planning advocates while building bridges to movements advancing other 2030 goals such as maternal health, universal health care, and climate change, to broaden our impact.
2. Promote increased, diversified, and efficient use of sexual and reproductive health financing to ensure sustainability. Increase financing for family planning by engaging with both traditional and non-traditional funding sources, from national governments to the private sector to high-net-worth individuals.
3. Prioritise the rights of adolescents and youth and of marginalised and stigmatised groups to improve their sexual and reproductive health outcomes. Foster partnerships that elicit and value these voices, as they are the best experts in building programmes that work for them.
4. Support scale-up of evidence-based practices to accelerate impact. FP2030 has taken over coordination of the High Impact Practices for Family Planning, working to gather the best evidence for what works to increase the use of voluntary, rights-based family planning. Promote the use of these evidence-based, scalable, and sustainable approaches to increase contraceptive use in a wide variety of settings and with diverse groups of people.

[49] SADC SHR scorecard, accessed 2 February 2025
[50] https://www.fp2030.org/ accessed 2 February 2025

5. Resource local actors to solve local issues *(cross-cutting priority)*. Sustain and intensify support to local women- and youth-led organisations, and foster movement-building across communities, countries, and regions.
6. Leverage and expand the use of data for evidence-informed decision-making *(cross-cutting priority)*. Continue to collect and share data related to family planning, increasing scope to explore the use of qualitative evidence. Seek new, better indicators to gauge the needs of vulnerable, marginalised, and underserved groups.
7. Improve the performance of our people, systems, and processes to drive results *(cross-cutting priority)*. Invest in resources and tools.

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.

The rights of women to make informed decisions about their own bodies is a fundamental aspect of achieving gender equality and ensuring universal access to sexual and reproductive health and rights. This right is crucial with three key areas significantly impacting women's empowerment and autonomy.

Firstly, access to reproductive health care services is essential for women to manage their reproductive health effectively. This includes a wide range of healthcare services, such as access to prenatal care; to safe childbirth options; to postnatal care, and access to safe abortion services when necessary. When women can seek and obtain these services without barriers, they are better equipped to make choices regarding their bodies and futures.

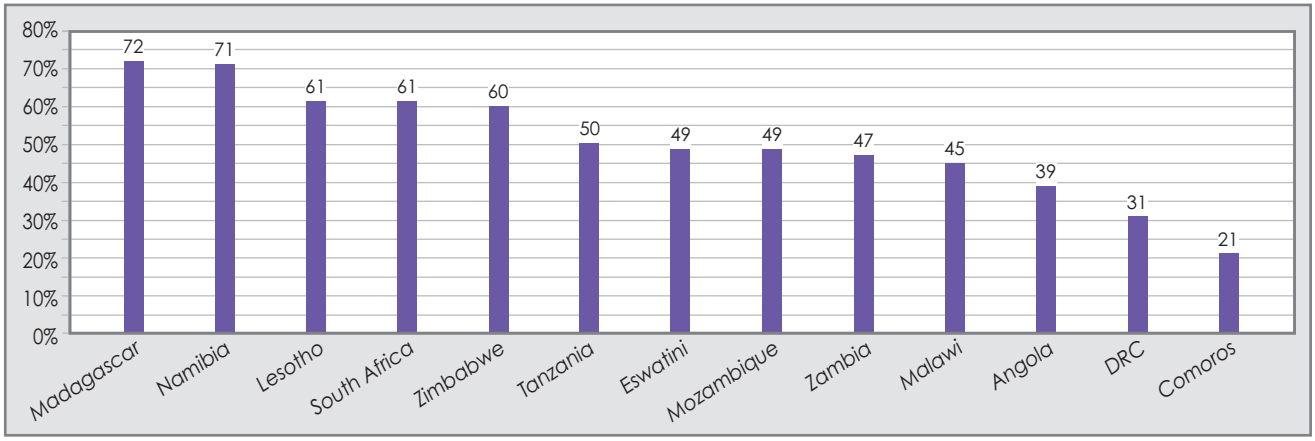
Secondly, the ability to utilise contraceptives plays a vital role in empowering women to control their reproductive lives. This encompasses not only access to a variety of contraceptive methods but also education about their options, the ability to make informed choices, and the right to use contraceptives free from stigma or coercion. Effective contraceptive use allows women to decide if and when to have children, thereby contributing to their overall health and socioeconomic stability.

Lastly, the importance of consensual sexual relations cannot be overstated. Women must have the right to engage in sexual activity based on their own desires and consent, free from pressure or coercion. This also includes the right to say no, seek safe and pleasurable sexual experiences, and discuss matters of sexual health openly with partners.

Together, these three areas - access to reproductive health care, contraceptive use, and consensual relations - form the cornerstones of reproductive rights. Empowering women in these aspects not only furthers individual agency but also strengthens collective societal progress toward gender equality.

The rights of women to make informed decisions about their own bodies is a fundamental aspect of achieving gender equality and ensuring universal access to SRHR

Figure 2.5: Female decision-making on SRHR (%)



Source: UNFPA, World Population Dashboard, 2007-2022.[51]

Figure 2.5 shows that there is no country in which all women have control over decision-making on SRHR. Only five countries are above the global average of 57% and eight are below the average for East and Southern Africa of 52%.

Madagascar has the highest proportion of women involved in decision-making on SRHR at 72%, followed by Namibia (71%), South Africa (61%), Lesotho (61%) and Zimbabwe (60%).

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 women's health during pregnancy, childbirth and postpartum. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being.

[51] https://www.unfpa.org/data/world-population-dashboard Accessed 4 February 2025

Maternal mortality

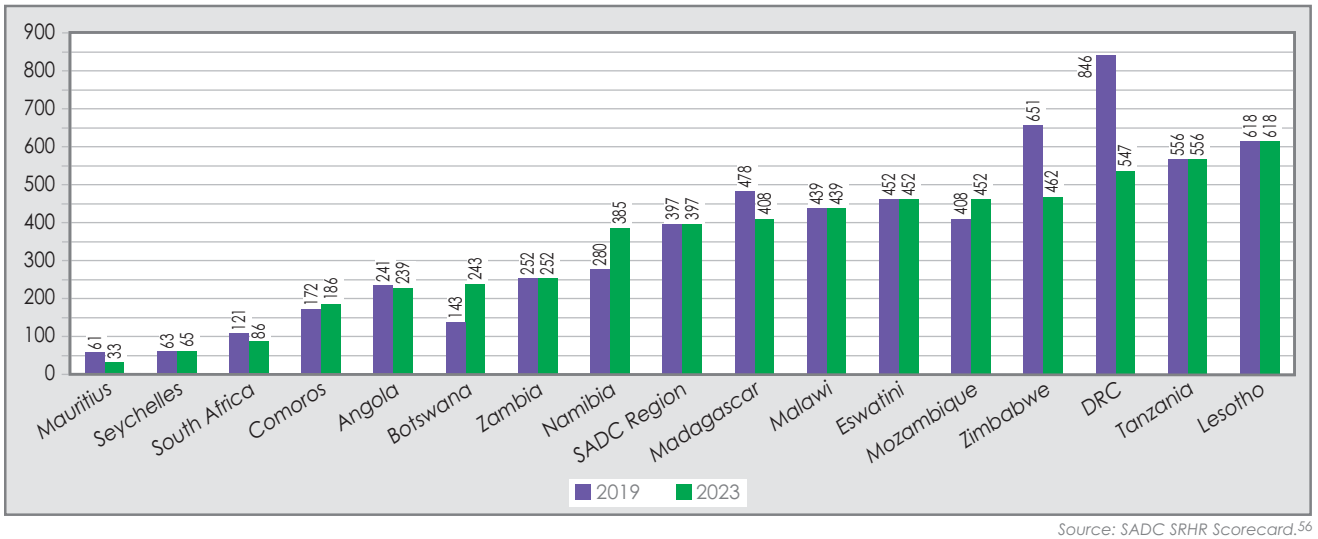
Maternal mortality pertains to fatalities resulting from complications related to pregnancy or child-birth. A significant number of maternal deaths can be avoided with prompt intervention by a qualified healthcare provider in a conducive setting. The principal direct factors leading to maternal harm and death include: severe blood loss, infections, elevated blood pressure, HIV, unsafe abortion practices, and obstructed labour, alongside indirect factors such as anaemia, malaria, and cardiovascular disease.[52]

There has been a significant decrease in maternal deaths worldwide over the last twenty years. The global maternal mortality rate (MMR) dropped from 339 deaths per 100,000 live births in 2000 to 223 deaths per 100,000 live births in 2020.[53] Low-income countries have a significantly higher MMR (462 per 100,000) compared to 11 per 100,000 in high-income countries. In Sub Saharan Africa, the MMR decreased from 802 in 2000 to 536 in 2020.[54]

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

Assessment of data on deaths in women aged 20 4o 49 in three sites that are analysing longitudinal population based HIV and AIDS data has shown that even in an era of widely available access to ART, there is increased risk of direct maternal mortality in women living with HIV than in women that are not living with HIV. The three sites are Karonga in Malawi, Kisesa in Tanzania and uMkhanyakude in KwaZulu Natal, South Africa. The study estimated that HIV-infected women have 5.2 times the rate of direct maternal mortality compared with HIV-uninfected women (95% CI 2.9-9.5). It concluded that there is a need to improve access to quality maternity care for women living with HIV.[55] This is very critical for many countries in SADC which still have very high HIV prevalence.

Figure 2.6: Maternal Mortality ratio per 100,000 live births 2019 2023



Source: SADC SRHR Scorecard.[56]

[52] Ibid
[53] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 15 February 2025
[54] The Conversation, accessed 12 February 2025 https://theconversation.com/most-maternal-deaths-are-preventable-how-to-improve-outcomes-in-south-africa-181282#
[55] Calvert, C. et al, Direct maternal deaths attributable to HIV in the era of antiretroviral therapy: evidence from three population-based HIV cohorts with verbal autopsy. AIDS 34(9):p 1397-1405, July 15, 2020. | DOI: 10.1097/QAD.0000000000002552, https://journals.lww.com/aidsonline/fulltext/2020/07150/direct_maternal_deaths_attributable_to_hiv_in_the.13.aspx accessed 21 February, 2025.
[56] SADC SHR scorecard, accessed 2 February 2025

Figure 2.6 shows uneven progress in reducing maternal deaths in SADC between the baseline SADC SRHR scorecard in 2019 and the second milestone 2023. Maternal mortality remains high in SADC. The regional average has remained static at 397 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 South Africa, Angola, Madagascar, DRC and Zimbabwe but increased in Mauritius, Comoros, Botswana, Namibia and Mozambique. Overall, maternal mortality remains a significant concern in the region. Lesotho is the country with the highest MMR of 618 deaths per 100 000 live births.

Impact of climate change on maternal and neonatal mortality

Climate change poses a significant and fundamental threat to human health, particularly impacting vulnerable populations such as pregnant women and new-borns who are more susceptible to its adverse effects.

In 2023, using a systematic search strategy based on the concepts of 'climate/air pollution hazards' 'maternal health' and new-born health, researchers sought to identify published systematic and scoping reviews investigating the impact of different climate hazards. The study sought to thoroughly examine and synthesise the existing epidemiological evidence regarding the primary climate-related risks that affect maternal and new-born health (MNH). The focus included exploring how rising temperatures, extreme weather events, and shifting environmental conditions linked to climate change can influence pregnancy outcomes, maternal wellbeing, and the health of new-borns.[57]

Climate change hazards impact food production of small holding farmers' crops in Limpopo, South Africa. Credit: Sandiswa Manana

[57] Conway F, Portela A, Filippi V, Chou D, Kovats S. Climate change, air pollution and maternal and newborn health: An overview of reviews of health outcomes. J Glob Health 2024;14:04128

Table 2.4: Overview of identified MNH outcomes, categorised by climate hazard

Category of hazard	Associated maternal health outcomes	Associated foetal and peri-natal health outcomes	Associated new-born health outcomes
High temperatures	Hypertensive disorders of pregnancy	Miscarriage	Low birth weight
	Gestational diabetes	Stillbirth	Small-for-gestational age
	Mental health	Congenital anomalies	Hospitalisation, morbidity, mortality
	Access to health services	Preterm birth	Sudden infant death syndrome
Ambient air pollution	Hypertensive disorders of pregnancy	Miscarriage	Low birth weight
	Gestational diabetes	Stillbirth	Small-for-gestational age
	Mental health	Congenital restriction and anomalies	Hospitalisation, morbidity, mortality
Disasters (hydro-meteorological)	Access to health services	Preterm birth	Sudden infant death syndrome
	Mental health, mortality	Miscarriage	Low birth weight
		Preterm birth	Mortality and morbidity later in life
		Mortality	
Water quality and accessibility	Hypertensive disorders of pregnancy	Not documented	Not documented

Source: Journal of Global Health.[58]

This review offers an initial overview of the risks climate change poses to maternal, perinatal, and new-born health, emphasising how the climate crisis could jeopardise recent advances in reducing maternal and new-born mortality and morbidity.

The study notes a pressing need to bolster the evidence base through primary research, primarily by increasing studies from low- and middle-income countries and improving review methodologies to address MNH and climate epidemiology requirements.

Additionally, there is a significant shortage of evidence concerning specific climate hazards and numerous maternal, perinatal, and new-born outcomes. Nevertheless, multiple studies consistently indicate links between the effects of heat and air pollution on birth outcomes, especially preterm births. It is crucial now for policymakers to take action and ensure funding addresses the specific needs of MNH in the context of climate change hazards.

Access to maternal health services

The World Health Organisation (WHO) now recommends that pregnant women have at least eight antenatal care (ANC) contacts with healthcare providers throughout their pregnancy.

This updated guideline aims to improve maternal and foetal health outcomes by increasing the frequency of interactions between pregnant women and healthcare professionals.[59]

[58] Ibid
[59] World Health Organisation, accessed 5 February 2025

Table 2.5: Provision of antenatal and postnatal care

Country	ANC: at least one visit			ANC: at least four visits			% women (age 15-49) who received postnatal care within 2 days after birth		
	National	Rural	Urban	National	Rural	Urban	National	Rural	Urban
Angola	82	63	92	61	39	74	23	12	31
Botswana	94	94	94	73	70	76			
DRC	82	77	90						
Comoros	95	93	97	64	63	68	91	90	92
Eswatini	99	99	99	74	73	76	88	85	94
Lesotho	91	91	92	77	74	80	84	82	87
Madagascar	89	88	96	60	57	74	55	52	69
Mozambique	87	83	97	49	41	68	36	33	43
Malawi	97	97	99	51	49	59	84	83	91
Namibia	97	97	97	63	61	64	69	69	69
South Africa	94	96	92	76	80	73	84	81	85
Tanzania	90	89	92	65	61	76	51	47	60
Zambia	97	96	99	64	65	61	70	64	82
Zimbabwe	93	92	96	72	73	68	82	78	91

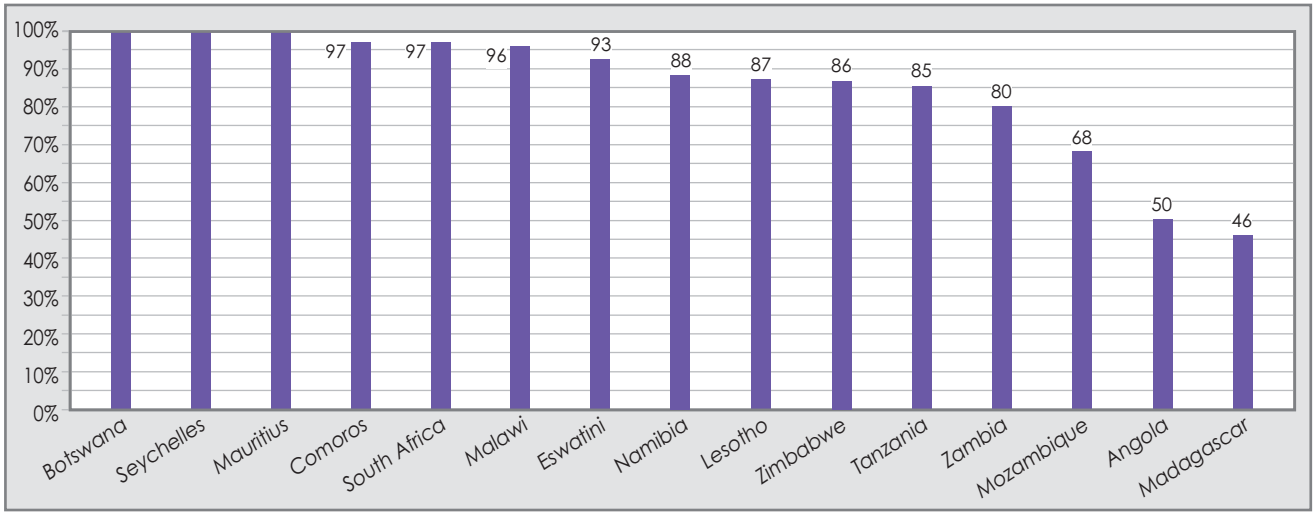
Source: Maternal and New-born Health Coverage Database updated November 2024

Table 2.5 shows that no country in the region has all women attended to at least once during pregnancy by skilled health personnel. Angola and DRC have the lowest proportion having at least one visit to a skilled health worker, with just 82% of pregnant women having access to this service. Eswatini has the highest proportion of women attending at least one visit, with close to full coverage for both rural and urban women.

A much lower proportion of women have at least four antenatal visits. However, in five countries (Botswana, Lesotho, Eswatini, South Africa, and Zimbabwe), over 70% of pregnant women have at least four antenatal visits. The table illustrates that the urban/rural divide is significant in almost all countries, partly due to the distances pregnant women have to travel to access clinics.

The proportion of women (age 15-49) who received postnatal care (PNC) within two days after birth is low, with no country achieving 100% coverage. Coverage of these services ranges from 23% in Angola to 90% in Comoros. In two countries (Angola and Mozambique) less than half the women who have given birth receive postnatal care within two days of giving birth.

Figure 2.7: Births delivered by skilled health personnel (%)



Source: Maternal and New-born Health Coverage Database updated November 2024.[80]

[60] https://data.unicef.org/topic/maternal-health/newborn-care/ , accessed 5 February 2025

Figure 2.7 illustrates the disparities in access to skilled birth attendants during delivery across SADC countries. Mauritius, Seychelles and Botswana stand out as the only nations where every woman has guaranteed access to qualified healthcare professionals during childbirth. In stark contrast, Angola and Madagascar face significant challenges in maternal healthcare, with alarmingly low percentages of pregnant women receiving assistance from skilled attendants during delivery. Specifically, only 50% of women in Angola and a mere 46% in Madagascar have access to such vital support, highlighting critical gaps in healthcare services that could impact maternal and infant health outcomes.

In many communities, cultural beliefs significantly influence the uptake of these services. For instance, some cultures hold the belief that pregnancy should remain confidential until a particular stage to protect the mother and unborn child from potential harm, such as witchcraft, from surrounding families and communities. This fear often leads to pregnant women delaying or avoiding antenatal clinic visits, despite the known benefits of regular ANC.[61] Adolescent mothers and those with an unwanted or unplanned pregnancy, who may not even realise that they are pregnant, are also at risk of delayed antenatal care.

The WHO's guidelines emphasise the importance of early and regular antenatal care to detect and manage potential complications, provide nutritional and health advice, and ensure a positive pregnancy experience. The first contact is recommended within the first 12 weeks of gestation, followed by subsequent contacts at 20, 26, 30, 34, 36, 38, and 40 weeks. Increased ANC visits are associated with a reduced likelihood of stillbirths and other complications.[62]

Addressing cultural barriers and promoting the benefits of antenatal care through community engagement and education can help improve adherence to these guidelines, ensuring better health outcomes for both mothers and their babies.

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.[63] About a third of all neonatal deaths occur within the first day after birth, and close to three-quarters occur within the first week of life.[64]

The leading causes of neonatal mortality include:

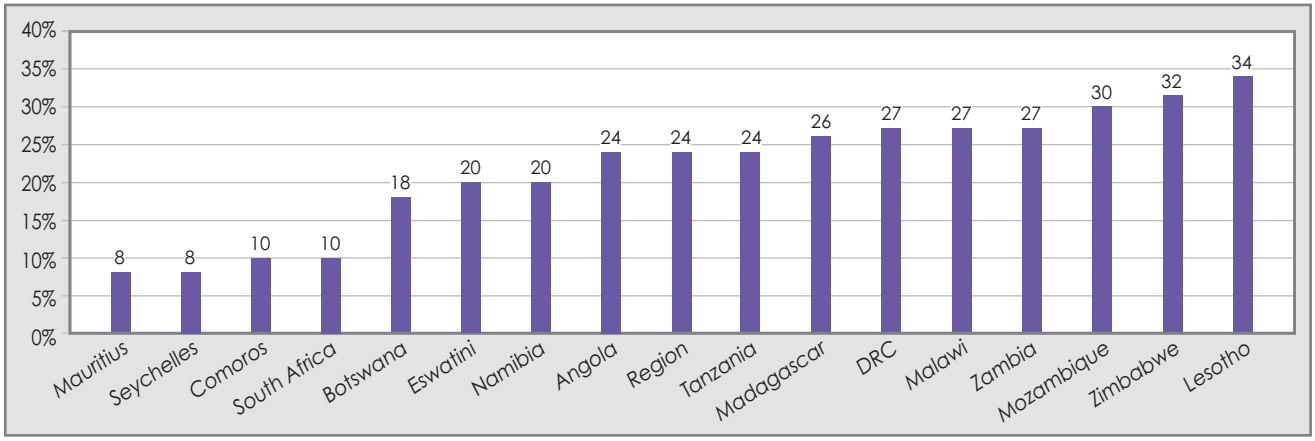
- *Preterm Birth* - Babies born before 37 weeks of gestation often face complications due to underdeveloped organs, especially the lungs, leading to respiratory issues.
- *Birth Asphyxia* - A lack of oxygen during delivery can result in serious complications, causing damage to vital organs and potentially leading to death.
- *Infections* - Neonates are particularly vulnerable to infections such as sepsis, pneumonia, and meningitis, which can be life-threatening if not treated promptly.

[61] Ibid
[62] Ibid
[63] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf , accessed 5 February 2025
[64] https://data.unicef.org/topic/child-survival/neonatal-mortality/ , accessed 5 February 2025

- *Congenital Anomalies* - Birth defects or genetic disorders can affect the baby's health significantly, leading to mortality either immediately after birth or within the neonatal period.
- *Low Birth Weight* - Babies weighing less than 2,500 grams at birth are at increased risk for various complications that can contribute to death.
- *Complications of Maternal Health* - Conditions such as hypertension, diabetes, and infections in pregnant women can impact foetal health and increase the risk of neonatal mortality.
- Inadequate Access to Healthcare - Lack of skilled birth attendants, prenatal care, and neonatal care facilities can contribute significantly to higher neonatal mortality rates.[65]

Efforts to improve maternal healthcare, access to quality neonatal care, and addressing the social determinants of health play crucial roles in reducing neonatal mortality rates globally.

Figure 2.8: Neonatal mortality rate per 1000 live births



Source: SADC SRHR Scorecard.[66]

The regional average for neonatal deaths is 24 per 1000, up from 23 in 2019. Figure 2.8 shows that four SADC countries SADC countries (Seychelles. Mauritius, Comoros and South Africa) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate of 34 deaths per 1,000 live births.

Reproductive cancers

Human papillomavirus (HPV) and Cervical cancer (CC)

Cervical cancer (CC), primarily caused by oncogenic types of human papillomavirus (HPV), is a significant global public health issue, especially in countries that have fragile health systems. It has a long latent period, which creates opportunities for early detection through effective screening. Currently, cervical cancer is the fourth most common preventable disease among women, with about 569,847 new cases annually, and it comprises 7.9% of all female cancer cases.

[65] World Health Organisation, accessed 5 February 2025
[66] SADC SHR scorecard, accessed 2 February 2025

Sub-Saharan Africa is particularly affected, accounting for approximately 80% of late-stage cases, with a morbidity rate of 35 new cases and mortality of 23 deaths per 100,000 women per year. Cervical cancer is a leading cause of death in resource-constrained countries, responsible for 311,000 deaths per year, with projections indicating a 42% increase in fatalities by 2030 if stronger prevention strategies are not implemented.

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 ano-genital 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.

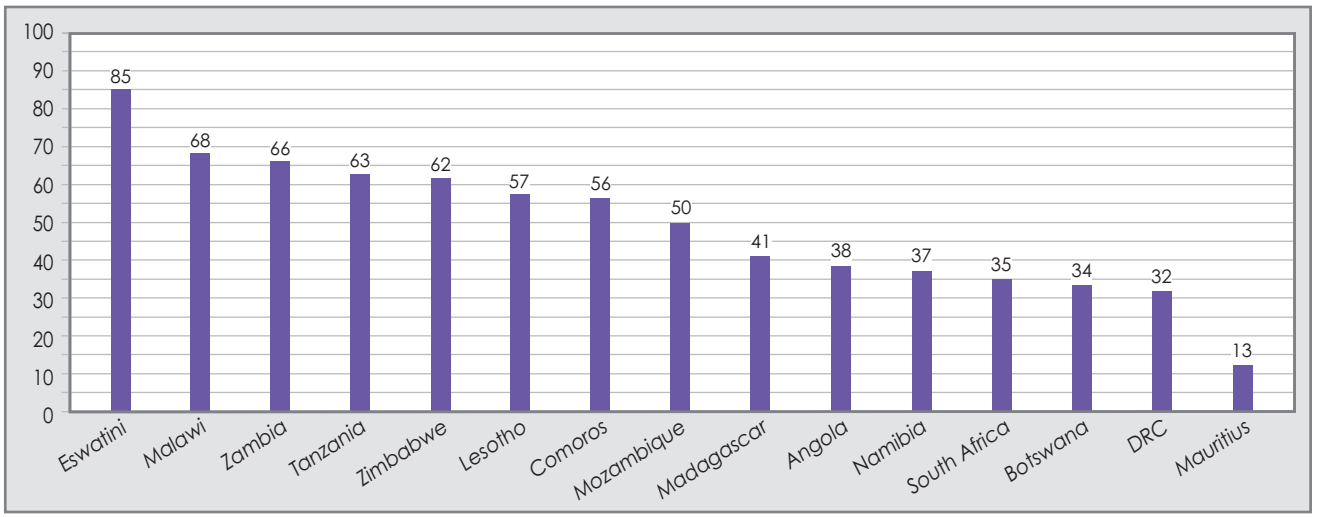
HPV types 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide. HPV vaccines that prevent HPV 16 and 18 infections are now available and have the potential to reduce the incidence of cervical and other ano-genital cancers.[68]

In May 2018, the WHO 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.
- 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.[69]

Cervical cancer is a leading cause of death in resource-constrained countries, responsible for 311,000 deaths per year

Figure 2.9: Incidence of cervical cancer due to HPV in SADC (2020 estimates)



Source HPV information centre.[70]

[67] https://www.cdc.gov/hpv/parents/about-hpv.html , accessed 5 February 2025
[68] Ibid
[69] World Health Organisation, accessed 5 February 2025
[70] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 10 March 2023.

The incidence of cervical cancer attributable to HPV is extremely high in many SADC countries. Figure 2.9 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 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 thirteen.

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 be controlled with appropriate treatment and palliative care.

Primary prevention: HPV Vaccination

The 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. One of the recommendations of the WHO is for states to include HPV vaccination as part of the national vaccination programme.[71]

Table 2.6: HPV vaccination programmes

Country	HPV included in national vaccination programme	Proportion of females who received recommended dose by age 15[72]
Mauritius	Yes (2016)	67%
Tanzania	Yes (2018)	65%
Lesotho	Yes (2012. Reintroduced 2022)	64%
Seychelles	Yes (2014)	62%
Mozambique	Yes (2021)	57%
Zimbabwe	Yes (2018)	54%
Zambia	Yes (2019)	39%
South Africa	Yes (2014)	36%
Botswana	Yes (2015)	22%
Malawi	Yes (2019)	13%
Eswatini	Yes (2023)	No data
Madagascar	No	No data
Angola	No	No data
Comoros	No	No data
DRC	No	No data
Namibia	No	No data

Source: Asempah, E., Ikpebe, E. Accelerating HPV vaccination in Africa for health equity.[73]

Table 2.6 shows that eleven countries in SADC have included HPV in their national vaccination programme, though coverage varies across countries. There is a high of 67% in Mauritius and low of 13% in Malawi. These programmes are critical given the high prevalence of cervical

[71] World Health Organisation, accessed 2 February 2025
[72] SADC SRHR Scorecard, accessed 2 February 2025
[73] Asempah, E., Ikpebe, E. Accelerating HPV vaccination in Africa for health equity. glob health res policy 9, 37 (2024). https://doi.org/10.1186/s41256-024-00380-https://ghrp.biomedcentral.com/articles/10.1186/s41256-024-00380-z accessed 20 February, 2025

cancer linked to HPV in the region, aligning with WHO's target to eliminate cervical cancer as a public health issue by 2030 through expanded vaccination, screening, and treatment initiatives.

It is clear from Table 2.6 that quite drastic action is needed to increase vaccination coverage. There have been times when HPV vaccine has not been available. Recommendations that have been made to increase coverage include:[74]

- incentivise vaccine manufacturers to increase production and distribution of the vaccine and make it available, affordable, and accessible to low resourced regions;
- support a regional strategy of vaccine purchasing and distribution to support low-resource countries;
- design culturally tailored community-based interventions to reach marginalised and vulnerable communities with monitoring and evaluation to identify gaps and inequalities in vaccination coverage;
- involve men in immunisation outreach; and
- develop sustainable financing of vaccination through incremental shift to domestic and continental funding sources.

Cervical cancer highlights disparities in health and gender. In 2020, approximately 100,000 women in the African Region were diagnosed with this illness, and nearly 70,000 of them succumbed to it. This accounts for 21% of the global mortality from cervical cancer. Over 50% of the cases in this region occur in women who are HIV-positive, who face a six-fold increase in the likelihood of developing this disease. This situation illustrates the ongoing inequities that result from high HIV prevalence.[75]

Secondary prevention: Cervical cancer screening

A secondary prevention strategy is cervical cancer screening to identify early precancerous lesions.. However, many women, especially those in rural areas, have limited access to and, therefore, utilisation of screening services.

A qualitative synthesis of 60 mixed studies published from 1 January 2013 to mid-2022 examined the drivers, enablers, and detractors of cervical cancer prevention and management in sub-Saharan Africa. Studies were selected following Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines. A thematic analysis was conducted and themes were identified.

The study found that screening and early detection programmes for cervical cancer are shaped by factors at various levels. **Individual-level** factors included insufficient knowledge regarding cervical cancer and screening literacy, along with a low perception of risk, attitudes, susceptibility, fear of test results, and sociodemographic characteristics among women. **Interpersonal** factors involved community embarrassment, relationships between women and health workers, support and encouragement, the presence of peers or relatives to model preventive behaviours, and mothers' connections with others. At the **organisational level**, influential factors were associated with providers, including their cervical cancer screening practices, training, type of profession, counselling skills, gender, recommendations from experts, and work commitments. **Community-level** factors that impacted cervical cancer screening included stigma, social and cultural norms, social networks, and beliefs. Factors at the **system and policy levels** included the absence of nearby facilities, geographic isolation, resource distribution and logistics management, screening costs, promotional policies, ownership and management, lack of a decentralised cancer policy, and inadequate supportive infrastructure.[76]

[74] Ibid
[75] WHO, HPV Vaccination in Africa: A Game-changer for Women's and Girls' Health, CPHIA 2023, accessed 5 February 2025
[76] Atnafu et al., Drivers of cervical cancer prevention and management in sub-Saharan Africa: a qualitative synthesis of mixed studies, Health Research Policy and Systems (2024)

Table 2.7: Screening for cervical cancer

Country	Crude cervical cancer incidence per 100 000 women	National screening programme exists	Screened ever	Screened in last five years
South Africa	36	Yes	52%	43%
Mauritius	19	Yes	42%	25%
Zambia	35	Yes	20%	17%
Malawi	43	Yes	19%	15%
Tanzania	35	Yes	13%	11%
Madagascar	27	Yes	8%	5%
Mozambique	33	Yes	3%	3%
Botswana	31	No	50%	39%
Namibia	29	No	39%	29%
Seychelles	No data	No	32%	26%
Angola	19	No	25%	20%
DRC	17	No	20%	18%
Zimbabwe	40	No	20%	19%
Eswatini	58	Np	19%	15%
Lesotho	50	No	17%	14%
Comoros	39	No	11%	9%

Source: HPV Information Centre country profiles.[77]

Table 2.7 shows that seven 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% women are screened with a high-performance test by 35 years of age and again by 45 years of age.

The table shows that in most countries where there is a cancer screening programme, coverage is higher than where there is no programme in place.

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."[78] Sexual and reproductive health services are considered essential and are therefore included in this definition. Protecting people from the financial 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.

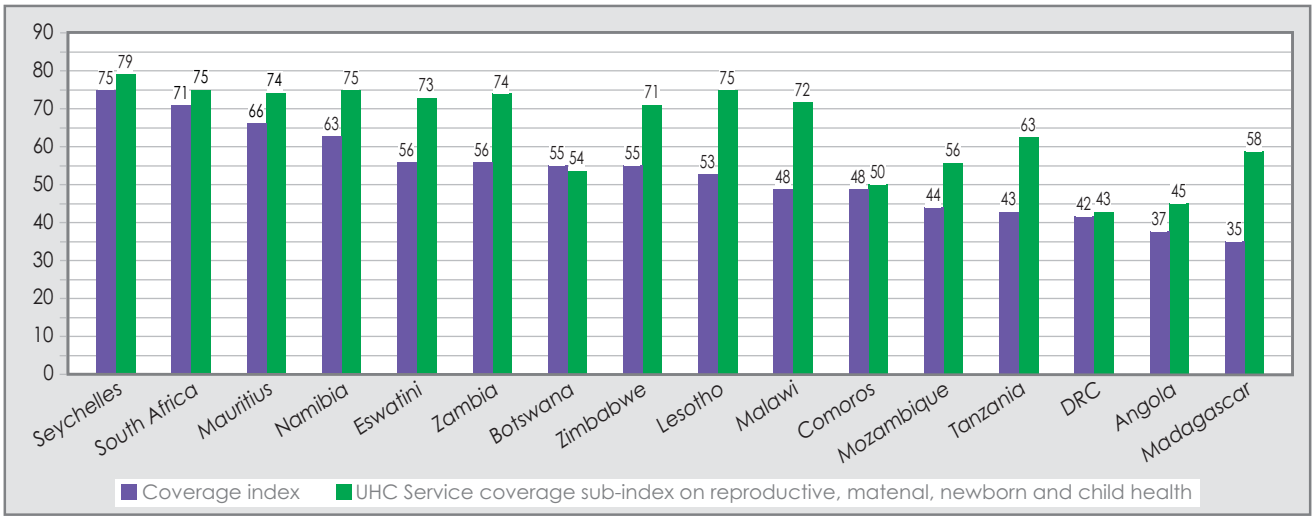
[77] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, Gómez D, Muñoz J, Bosch FX, de Sanjosé S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 10 March 2023.
[78] WHO, Fact Sheet: Universal Health Coverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021

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, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access.

Figure 2.10: UHC: Service coverage index and access to reproductive, maternal, new-born and child health services



Source: World Bank data.[79]

Figure 2.10 shows that no country in SADC provides universal health care. The universal health coverage index ranges from 75 in Seychelles to 35 in DRC. Only Seychelles and South Africa are above the global average of 67. Mauritius and Namibia have an index of between 60 and 65 while Madagascar, Malawi, Tanzania, Comoros, Mozambique, Angola and DRC are below 50 on the UHC index.

Access to reproductive, maternal, new-born, and child health (RMNCH) services is a component of UHC service coverage. It is higher than the overall coverage in all countries except Botswana. Seychelles (79) South Africa (76) and Lesotho (75) have the highest RMNCH index ratings, while DRC (43) has the lowest.

Expenditure in the health sector

Health spending encompasses all costs associated with delivering health services, family planning initiatives, nutrition programmes, and emergency health assistance, but does not cover expenses related to drinking water and sanitation.

Health expenditure is an important indicator of a government's commitment to the health and wellbeing of its citizens. Increasing expenditure on health is associated with better health outcomes, especially in low-income countries. When a government commits proportionally less

of its total expenditure on health, this may indicate that health, including nutrition, is not regarded as a priority.

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.[80]

Table 2.8 shows that Botswana is the only SADC country that has met, and exceeded the recommended Abuja Declaration goal of 15%, of the state's annual budget to improve the health sector. Seven countries allocate between 10% and 14% of their annual budget on health; seven countries spend between 6% and 10% and two countries spend less than 6% of the annual budget on the health sector. Only Lesotho spends more than 10% of its GDP on health.

Table 2.8: Health financing analysis

Country	% annual budget allocated to the health sector	Health expenditure as % of GDP
Botswana	**19**	6
Comoros	12	6
Lesotho	12	**10**
Namibia	12	9
Eswatini	11	7
Zimbabwe	11	3
Malawi	10	7
DRC	9	4
Madagascar	8	4
Mozambique	8	9
South Africa	8	8
Zambia	8	7
Angola	7	3
Tanzania	7	3
Seychelles	5	5
Mauritius	3	6

Source: SADC SRHR Scorecard, WHO Databank.[81]

Performance event on sexual reproductive health and rights in South Africa. Photo: Gender Links

[80] The Balance, accessed 10 February 2025
[81] SADC SHR scorecard, accessed 2 February 2025

Next steps

This chapter shows that with just five years to go for states to reach the targets set in the SADC Gender Protocol and the SDGs, SADC states are far behind.

The current global context is characterised by rising nationalism and of the far-right rolling back women's rights, increasing war and conflict and the climate crisis in the context of dwindling support and resources for women's rights work.

Women's rights in general, and SRHR in particular, are under threat. The rise in nationalism has led to tightened borders and restrictions on migration, which can further marginalise women, especially those from minority or immigrant backgrounds. Nationalist rhetoric often promotes traditional gender roles, leading to backlash against women's rights. As nations grapple with identity politics, issues such as reproductive rights and gender equality can become points of contention, risking setbacks in hard-won gains. This also has dire impacts on funding for the global South - shifts to the right in previously progressive countries like the Netherlands and Sweden are resulting in cuts in funding to women's rights organisations in the global South. The intersection of these crises creates a dire situation that threatens women's immediate survival and challenges the long-term advancement of women's rights and gender equality.

This moment requires the women's movement to restrategise to address these challenges.

- **Build alliances** with other progressive organisations and movements facing similar challenges. This enhances advocacy and ensures that well-intentioned actions or messaging do not cause unintended negative consequences.
- **Documenting** opposition helps raise awareness within the broader community, including allies outside the region, about the ongoing struggles faced by LGBTQI+ individuals in SADC. This also encourages public support and solidarity.
- **Collaboration with stakeholders** - such as policymakers, educators, and healthcare providers - is a critical tactic for fostering support and driving meaningful change in the legal landscape.

Policy and Advocacy

- Lobby to update dated policies in line with international standards on SRHR and the SADC SRHR strategy and scorecard.
- Monitor implementation of frameworks and policies and hold governments accountable.

Menstrual health

- Lobby governments to scrap VAT on menstrual products and provide free sanitary wear in schools, especially in rural and underprivileged areas.
- Lobby governments to invest 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.
- Work with men, traditional and community leaders to combat period poverty and stigma.

Maternal health

- Conduct research on the reasons for the persistently high levels of maternal mortality, particularly in the context of increasing war and conflict and climate change.
- Lobby governments to 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.

- Lobby governments to subsidise Family Planning Services and Products: Making contraception and family planning services affordable or free helps reduce financial barriers, especially for low-income groups. Governments could subsidize contraceptives, offer free maternal health services, and ensure that high-quality care is accessible to all, particularly in rural areas.

HPV and cervical cancer

- Lobby governments to 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 programmes 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

- Lobby governments to invest in and develop partnerships to facilitate roll out of UHC including SRHR services.
- Promote Integrated Healthcare Services: Integrating family planning and maternal health services into primary healthcare allows countries to use existing infrastructure more efficiently. This integration ensures that women can access multiple services in one visit, making it more convenient and reducing costs associated with separate visits.

Investment and expenditure

- Lobby government to recommit to increasing investment in the health sector to 15% of their annual budget in line with the Abuj Declaration goal.
- Lobby governments to increase budget allocation for family planning and maternal health services by dedicating a higher portion of health budgets to family planning and maternal health, governments can ensure that essential services - such as contraception, prenatal, and postnatal care - are widely available. Evidence shows that targeted investment in these areas leads to lower maternal and infant mortality rates, as well as better health outcomes for women and families.

Utilise Conditional Cash Transfers

Initiatives that provide financial incentives to women to use maternal healthcare can boost participation. Conditional cash transfers have proven effective in enhancing the use of prenatal and postnatal care and promoting consistent family planning appointments in various low-income areas around the world.

Leverage Donor and International Funding

Collaborating with global entities like UNFPA, the World Bank, and the Global Financing Facility (GFF) can enable SADC nations to obtain both technical assistance and financial resources for maternal and reproductive health initiatives. These collaborations can offer funding for critical areas, including education on adolescent sexual health, the supply chain for contraceptives, and training programmes focused on maternal health.

Strengthen Data Collection for Targeted Interventions

Establishing and improving health information systems to collect data on family planning and maternal health helps in planning and resource allocation. Reliable data allows for targeted interventions, ensuring that resources go where they are most needed and can have the greatest impact, such as adolescent reproductive health services or maternal health education in underserved areas.

Community Engagement and Education

Engaging local communities and traditional leaders in family planning and maternal health initiatives can reduce cultural barriers and promote understanding. Public awareness campaigns focused on the benefits of family planning, safe delivery, and maternal health can shift cultural perceptions and increase service demand, justifying sustained investment in these areas.

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Adolescent Sexual and Reproductive Health and Rights (ASRHR)

3

Students at LEAP academy in Langa Cape Town commit to a menstrual health campaign under the guidance of Chantelle Goliath, executive director of New Heritage Foundation. Photo: Colleen Lowe Morna

Key points

- Adolescent sexual and reproductive health and rights (ASRHR) are critical for the well-being and development of young people in Southern Africa who face high rates of HIV, child marriages and adolescent fertility.
- Comprehensive Sexuality Education (CSE) equips young people with the knowledge, attitudes, and skills to make informed decisions about their health, well-being, and relationships.
- Nine countries have laws and policies that allow adolescents to access SRH services, including contraception, without third-party authorisation.
- A study by the Stop Stock-outs Project (SSP), '*Contraceptive Supply Chain: Stock-outs and their Causes*', revealed that stock-outs of contraceptives are prevalent in South Africa.[1]
- The region's health systems need to be strengthened to be able to withstand emergencies such as potential pandemics and continue to provide adolescent friendly services.
- An example of such strengthening is a cutting-edge mobile app to provide adolescent and youth-friendly health services (AYFHS) and information that has been launched by South Africa's Department of Health.
- Adolescents girls and young women generally have high unmet need for contraception. In South Africa, for instance, there is a higher unmet need (31% among adolescent girls aged 15-19 and 28% among young women aged 20-24 years)[2] than amongst all women where the unmet need is about 20%.
- Mozambique has the region's highest adolescent fertility rate (AFR), with 165 births per 1,000 women aged 15 to 19. High AFR correlates with high rates of child marriages and early pregnancies.

[1] Nqumako, P. (no date) Study finds a decline in access to contraceptives in SA. Available at: https://www.iol.co.za/dailynews/news/study-finds-a-decline-in-access-to-contraceptives-in-sa-b501f311-7477-43ac-b3da-3fea77a77df8 (Accessed: 20 January 2025).

[2] The HERStory Series: Access, use, and perceptions of contraception services among adolescent girls and young women in South Africa | SAMRC (no date). Available at: https://www.samrc.ac.za/policy-briefs/herstory-series-access-use-and-perceptions-contraception-services-among-adolescent (Accessed: 20 January 2025).

Introduction

Adolescent girls receiving sanitary pads. Photo: Gender Links

Adolescent Sexual and Reproductive Health and Rights (ASRHR) are critical for the well-being and development of young people in Southern Africa. The region faces significant challenges, including high rates of HIV among adolescents, child marriages, adolescent pregnancies, and violence against children. Adolescents aged 10-19 comprise 23% of the population in sub-Saharan Africa (SSA).[3] with over 80% of HIV-infected adolescents in the world living in this region. The adolescent pregnancy rate stands at 19.3%, the highest globally.[4] Child maltreatment is widespread, often rooted in the low societal status of children and influenced by cultural, social, and religious beliefs.[5]

The state of ASRHR in the region is still recovering from the severe impact of the COVID 19 pandemic which complicated the delivery of ASRHR services. School closures and strained healthcare systems disrupted access to education and essential health services, exacerbating existing inequalities. Adolescents faced increased barriers to accessing contraception, HIV testing, and mental health support. Countries like South Africa and Namibia have taken steps to integrate mental health services into primary healthcare and launch awareness campaigns. Still, more resilient health systems are needed to ensure continuous access to care.

Comprehensive Sexuality Education (CSE) is essential in improving ASRHR. CSE equips young people with the knowledge, attitudes, and skills to make informed decisions about their health, well-being, and relationships. It promotes gender equality, challenges harmful cultural norms, and empowers young people to exercise their rights fully. Effective CSE is age-appropriate, scientifically accurate, and culturally relevant, providing a foundation for healthy and respectful relationships.

Despite the clear benefits of CSE, its implementation in Southern Africa faces numerous obstacles. Political resistance, cultural beliefs, and institutional challenges hinder the widespread adoption of CSE programmes. Some strategies that are being employed to overcome these barriers are: involving local communities in adapting CSE to integrate indigenous knowledge; enhancing the roles of teachers, parents, and students; improving funding and training, and fostering political support.

It is critical that all countries have legislation and policies that enable the provision of SRH services to adolescents. This chapter shows that not all countries have such policies in place. It also shows that there are variations in the age at which adolescents can legally access contraceptives without third party authorisation.

These gaps contribute to high adolescent fertility and early and unintended pregnancy rates. Girls who experience early and unintended pregnancy are at risk of unsafe abortions as well as poor physical and mental health, their babies are at risk of low birth weight. Many girls who become pregnant drop out of school which limits their economic opportunities.

In conclusion, investing in ASRHR is vital for the future of Southern Africa. Governments can foster a generation capable of contributing to the region's economic and social development by ensuring that young people are educated, healthy, and empowered. Comprehensive policies and programmes that support ASRHR will help create a brighter and more prosperous future for all SADC member states.

[3] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[4] ibid
[5] ibid

Table 3.1: Key Adolescent Sexual and Reproductive Health and Rights (ASRHR) indicators

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum reflects international standards	Yes[6]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives[7]	16	12	No data	18	15	No data	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)[8, 9]	18	18	13	18	18	16	14	16	16	18	14	18	16	18	16	18
Legal age to consent to sex (F)[10, 11]	16	18	13	14	18	16	14	16	16	18	14	18	16	15	16	18[12]
Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation	No	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No
Adolescent fertility rate (births per 1000 women, 15-19 years of age)[13]	136	48	56	107	68	89	118	117	24	165	63	52	61	123	116	93
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[14]	58	44	32	109	87	206*	111	10	20	180	82	47	39	112	24	108

*Note this is the figure in the 2023 SADC SRHR score card. In the 2021 score card this was 55. It is very unlikely that such dramatic change occurred within two years and is more likely that the difference is the result of a data quality issue.

Table 3.1 shows:

- Botswana, Madagascar, Namibia, South Africa and Tanzania provide access to contraceptives to adolescents from the age of 12 years.
- Mozambique has the region's highest adolescent fertility rate (AFR), 165 births per 1000 women aged 15 to 19. Six other countries have AFRs which are above 100 births per 1000 adolescents.
- Nine countries have laws and policies that allow adolescents to access SRH services without third-party authorisation.
- Set at 13 years for both girls and boys, Comoros has the lowest age of consent for sex in the region, followed by Namibia and Madagascar at age 14 each.
- The minimum age for consent to sex is lower than the age for access to contraceptives in the DRC.

ASRHR and life after COVID-19 pandemic

The COVID-19 pandemic significantly disrupted adolescents' access to education in the SADC region. Extended school closures led to substantial learning losses and widened educational inequalities. Many students, especially those from disadvantaged backgrounds, struggled with remote learning as they did not have digital devices and internet connectivity. Although some SADC countries distributed learning materials and provided radio and television lessons, these efforts were insufficient to fully mitigate the impact, leaving many adolescents at risk of falling behind academically.

The response to the pandemic strained healthcare systems, making it difficult for adolescents to access essential services, including sexual and reproductive health care. A study in South Africa

6 UNFPA regional data, https://www.unfpa.org/data/AO Accessed 10 June 2021.
7 Gender Links, Audit of SADC ASRHR Policies and Laws 2021.
8 https://esaro.unfpa.org/sites/default/files/pub-pdf/lates_technical_brief_harmonization_2.pdf
9 List of Ages of Consent in Africa (no date). Available at: https://www.ageofconsent.net/continent/africa (Accessed: 13 November 2024).
10 https://esaro.unfpa.org/sites/default/files/pub-pdf/lates_technical_brief_harmonization_2.pdf
11 List of Ages of Consent in Africa (no date). Available at: https://www.ageofconsent.net/continent/africa (Accessed: 13 November 2024).
12 UNICEF Statement on Zimbabwean law raising the age of consent to 18 years (no date). Available at: https://www.unicef.org/zimbabwe/press-releases/unicef-statement-zimbabwean-law-raising-age-consent-18-years (Accessed: 13 November 2024).
13 World Bank Open Data. Available at: https://data.worldbank.org (Accessed: 13 November 2024).
14 SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).

showed that the pandemic response shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services, particularly for adolescents living with HIV (ALHIV)[15]. Adolescents faced increased barriers to accessing contraception, HIV testing, and mental health support, exacerbating existing health challenges. Countries like South Africa and Namibia integrated mental health services into primary healthcare and launched awareness campaigns to address these issues. Despite these efforts, the pandemic highlighted the need for more resilient health systems to ensure adolescents can access the care they need, even during crises.

The situation remains challenging as COVID-19 continues to circulate globally. Dr Maria Van Kerkhove of WHO emphasised that "COVID-19 is still very much with us and circulating in all countries".[16] The WHO's third round of the Global Pulse Survey[17] on the continuity of essential health services during the pandemic revealed that 92% of participating countries, including all 16 SADC countries, reported service disruptions, particularly in primary care, emergency care, and elective surgeries. The report underscores the need for long-term strategies to build resilient health systems and improve preparedness for future public health emergencies, including technical assistance in health worker recruitment, community engagement, and access to essential medical supplies.

New viruses like human metapneumovirus (HMPV) are emerging, adding to possible pandemic challenges. As HMPV surges in Asia and Europe, the WHO has called for reinstating restrictions implemented during the COVID-19 pandemic. These warnings suggest that SADC countries must remain vigilant and make concerted efforts to ensure pandemic preparedness in all forms. Using technology to enhance ASRHR is one way of preparing against pandemic restrictions, which often limit access to information. The following example shows how South Africa is using a tailored mobile app to enhance access to youth-friendly services.

South Africa: A progressive web App for youth-friendly health services

The Department of Health in South Africa has officially reactivated its B-Wise platform by launching a cutting-edge mobile app tailored to provide adolescent and youth-friendly health services (AYFHS) and information.

B-Wise is an interactive digital platform developed by the Department of Health in partnership with stakeholders, including the President's Emergency Plan for Aids Relief (PEPFAR), to improve the uptake of health services among adolescents and young people in South Africa, especially HIV prevention, mental health, family planning, and contraceptive use, to make informed choices about their sexual and reproductive health. This development reinforces the South African government's commitment to empowering young people with accessible, reliable, and youth-centred appropriate health resources.

The B-Wise app brings innovative features, including interactive tools for sexual and reproductive health and rights, health and wellness promotion, education, and HIV and TB prevention. Young people in South Africa continue to face healthcare access and information barriers. The reactivation of B-Wise and the introduction of this innovative app addresses these challenges head-on, providing a digital space where youth can access life-saving health information and services without stigma or barriers.[18]

[15] 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
[16] COVID-19 making worrying comeback WHO warns, amid summertime surge | UN News (2024). Available at: https://news.un.org/en/story/2024/08/1152866 (Accessed: 17 January 2025).
[17] Global pulse survey on continuity of essential health services during the COVID-19 pandemic. Available at: https://www.who.int/publications/m/item/global-pulse-survey-on-continuity-of-essential-health-services-during-the-covid-19-pandemic-Q4 (Accessed: 16 January 2025).
[18] Department of Health Launches New B-Wise App to Empower Youth Health Access | Health Devdiscourse. Available at: https://www.devdiscourse.com/article/health/3174214-department-of-health-launches-new-b-wise-app-to-empower-youth-health-access (Accessed: 28 November 2024).

Comprehensive sexuality education (CSE) frameworks and indicators

Sustainable Development Goal (SDG) 4: Ensure inclusive and equitable 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 occur in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and aim to improve gender equality.
- 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), and 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 are committed to accelerating 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 the 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 lives and futures. This includes ensuring that adolescents and young people in and out of school access 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.
- There is a need to build and strengthen the skills of those working in broader youth and community interventions to expand capacity within member states to reach out-of-school youth.
- Stakeholders should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

Knox Thumbumuzi Cup Launch in Mbabane, Eswatini. Photo: Thandokuhle Dlamini

The urgent need for comprehensive sexuality education in Southern Africa is highlighted by the high rates of HIV among young people, child marriages, adolescent pregnancies, unsafe abortions, and violence against children[19]. Adolescents aged 10-19 comprise 23% of the sub-Saharan African (SSA) population[20], with over 80% of HIV-infected adolescents in the world living in this region. The adolescent pregnancy rate is 19.3%, the highest in the world.[21] Child maltreatment is widespread, often stemming from the low societal status of children and influenced by cultural, social, and religious beliefs.

Effective CSE equips children and young people with crucial decision-making skills to navigate challenges related to relationships and sexuality. It addresses gender inequality and power dynamics within communities, challenging cultural norms that perpetuate violence. CSE empowers young individuals to protect their health, well-being, and dignity by providing them with a comprehensive knowledge, attitudes, and skills toolkit. It is essential for exercising full bodily autonomy, which includes the right to make choices about one's body and having the information necessary to make those choices meaningfully.[22]

CSE aims to equip children and adolescents with the knowledge, skills, and values that they need for sexual and reproductive health. However, implementing and adapting CSE in sub-Saharan Africa remains challenging. Despite progress in policy development and implementation, significant barriers persist, including political resistance, cultural beliefs, and institutional challenges.[23] It is important that political support is mobilised so that sufficient funding is allocated and training conducted. Teachers, parents, and students all play crucial roles for effective CSE implementation. The involvement of local communities in the adaptation process makes a crucial contribution to integrating indigenous knowledge. Communities play a vital role in ensuring that youth are educated, healthy, and empowered, contributing to a brighter future for all SADC member states.

To clarify CSE, the UNFPA has identified ten common myths and truths. These demonstrate the impact that CSE has on ASRHR. They are:

1. *Myth:* Sexuality education grooms children for sexual abuse.
   Truth: It teaches children about threats such as predation and sexual abuse, empowering them to seek help.
2. *Myth:* Abstinence-only education is more effective than sexuality education.
   Truth: Research shows that abstinence-only education does not reduce adolescent birth rates or sexually transmitted infections, rather, it is associated with higher risks regarding these issues.
3. *Myth:* Sexuality education encourages children to have sex early or to have more sexual partners.
   Truth: Research shows that it often leads young people to delay having sex, as well as to have safer sex and fewer sexual partners.

[19] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[20] ibid
[21] ibid
[22] Comprehensive sexuality education | United Nations Population Fund. Available at: https://www.unfpa.org/comprehensive-sexuality-education (Accessed: 20 January 2025).
[23] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[24] 10 myths - and truths - about comprehensive sexuality education (no date). Available at: https://www.unfpa.org/stories/10-myths-%E2%80%93-and-truths-%E2%80%93-about-comprehensive-sexuality-education (Accessed: 20 January 2025).

4. *Myth:* Sexuality education goes against culture and religion.
   Truth: The content of comprehensive sexuality education is tailored to fit local contexts and is taught with the support of cultural leaders in the community.
5. *Myth:* Sexuality education promotes LGBTQIA+ "lifestyles" among students.
   Truth: It does not endorse or campaign for any "lifestyle" other than promoting health and well-being for everyone, everywhere. That said, it also acknowledges the need to safeguard the rights of gender-diverse and LGBTQIA+ people.
6. *Myth:* Sexuality education sexualises children and deprives them of their "innocence".
   Truth: Children will confront issues related to sexuality at some point, whether we like it or not, so they must be informed and prepared to deal with them. CSE provides them with age-appropriate knowledge and skills that help them avoid teen pregnancy, understand consent, make responsible choices, and recognise predation and abuse.
7. *Myth:* Sexuality education introduces sexually inappropriate material to young people too early.
   Truth: CSE must be scientifically accurate, non-judgemental, age and developmentally appropriate. Without such education, children will be vulnerable to conflicting and damaging messages from their peers, social media and other sources.
8. *Myth:* Sexuality education promotes masturbation.
   Truth: CSE does not encourage masturbation. Children start to explore their bodies through sight and touch at a very early age. Educators let them know that this is standard practice.
9. *Myth:* Sexuality education is trying to legalise paedophilia.
   Truth: CSE protects children and never calls for the decriminalisation of adults having sex with children or the abolition of the age of consent. The sexual abuse of children is a crime that CSE helps to defeat.
10. *Myth:* Sexuality education is not relevant for children.
    Truth: Sexuality is inherent to human experience throughout a person's life. CSE is a lifelong process that is relevant to all ages. Long before younger children think about having sex, this type of education can help them learn about their bodies, emotions, family life, relationships, the basic principles of consent and what to do if they experience or see abuse.

Source: UNFPA.[25]

Here are some examples of CSE work in the SADC region:

CSE in Namibia: achievements, barriers, and future directions

Comprehensive sexuality education has been mainstreamed in Namibia since independence in 1990 through government programmes, such as the School Health and Life Skills Education programmes[26]. High rates of adolescent pregnancy, increasing HIV infections, high levels of discrimination against people living with HIV, and stigmatisation, motivated the adoption and rollout of CSE in the school Life Skills Education curriculum. In addition, with 66% of the population below the age of 30 and 43% of new HIV infections occurring among young people aged 15-24, the scale-up of the programme in schools was considered necessary. The Government also introduced 'My Future is My Choice' as an extra-curricular programme in the late 1990s in response to the impact of HIV and AIDS in the education sector. This reinforced and deepened related content in teaching life skills, biology and life science.

[25] ibid
[26] Wekesah, F.M. et al. (2019) 'Comprehensive Sexuality Education in Sub-Saharan Africa. Nairobi, Kenya: African Population and Health Research Center (APHRC), Accessed 17 November 2024

Information on sexual health, which was designed to reach young people at a secondary level and develop their skills to make safe choices related to their sexual health, included themes such as risky behaviours. In 2004, the 'Window of Hope' programme was developed for primary school students as an after-school activity to increase their self-esteem, build their knowledge and skills to protect themselves against HIV and develop compassion for those living with the virus. The official scale-up of the Life Skills Education programme started in 2012/13 through the curriculum review and was boosted following the signing of the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa (also referred to as the ESA Commitment) in December 2013. Scaling-up initiatives included strengthening and refining the curriculum; developing teaching and learning materials; teacher training; the appointment of Life Skills Education teachers; integrating sexual and reproductive health services and Life Skills Education components into the School Health programme; awareness raising among key stakeholders, and strengthening the monitoring of Life Skills Education in the national Education Management Information System (EMIS).

However, in 2021, resistance from faith-based organisations claiming that the programme was 'promoting sexual promiscuity among young people' pressurised the Government into rejecting the Ministerial Commitment. Some life-skills teachers have expressed a lack of confidence and discomfort in dealing with sensitive sexuality-related topics, and some parents are resistant to communicating with their children about these themes. Following negative publicity and misinformation about the Life Skills Education programme, the Ministry of Education, Arts and Culture organised a special meeting, inviting over 120 faith-based and religious leaders to clarify any misconceptions around CSE, to ensure better understanding and to gain their support. The government has been committed to engaging with partners to advocate for CSE.

Source: UNESCO.[58]

While many SADC countries have adopted the East and Southern Africa[28] (ESA) Ministerial Commitment, which emphasises CSE and youth-friendly health services, Comoros has not joined this initiative.

Comoros: Approach to CSE

Comoros differs from other SADC countries in its approach to CSE and youth-friendly sexual and reproductive health services. Comoros focuses on integrating ASRHR within its broader health and education strategies, which are often influenced by cultural and religious contexts. This difference highlights the need for tailored strategies that respect cultural contexts while ensuring that young people receive comprehensive and accurate information to make informed decisions about their health and well-being.

Comoros differs from other SADC countries... it focuses on integrating ASRHR within its broader health and education strategies

[27] Namibia | Comprehensive Sexuality Education | Education Profiles (no date). Available at: https://education-profiles.org/sub-saharan-africa/namibia/~comprehensive-sexuality-education (Accessed: 17 November 2024).
[28] Fulfilling our promise to girls in Eastern and Southern Africa | UNICEF Eastern and Southern Africa (no date). Available at: https://esaro.unfpa.org/en/news/fulfilling-our-promise-girls-east-and-southern-africa-will-give-voice-and-secure-their-equal (Accessed: 19 January 2025).

The country's approach tends to be more conservative, emphasising abstinence and traditional values.[29] This can limit the scope and effectiveness of CSE programmes, as they may not fully address young people's diverse needs and realities. With a long history of political instability, Comoros has had fewer dedicated ASRHR programmes and resources[30] compared to other SADC countries that have embraced the ESA Commitment. The government also lacks sufficient youth-friendly health services, making it difficult for teens to access sexual and reproductive health care.[31] Thus, access to youth-friendly health services in Comoros has been limited.

The UN 2021 country programme document[32], reveals that sexually transmitted infections remain a concern among youth (2020 prevalence and behavioural survey); the HIV prevalence rate among young people aged 15-24 years is 0.07 per cent, slightly higher than the national rate of 0.05 per cent. Many challenges remain, including:

- gaps in young people's access to accurate and comprehensive information and services, leading to unsafe sexual practices;
- the absence of a multi-sectoral youth policy which would promote an enabling environment for adolescent sexual and reproductive health;
- weak adolescent-friendly health services;
- a lack of capacity among duty bearers to effectively promote adolescent sexual and reproductive health;
- gaps in school programmes that focus on life skills, including comprehensive sexuality education and bodily autonomy, and
- gaps in leadership and peace-building skills to navigate the complexities of adolescence.

A notable effort is collaboration between local NGOs and international organisations to provide youth-friendly health services and education in the Comoros. Some of the key organisations working to improve youth-friendly health services in Comoros include:

1. Médecins Sans Frontières (MSF) - Known for its work in providing medical care, MSF also engages in health education and awareness campaigns, including those related to sexual and reproductive health.[33]
2. UNAIDS - This organisation focuses on HIV prevention and treatment, advocating for comprehensive health education and services for adolescents.[34]
3. Maeecha is a local NGO that works on education, literacy, and health care services, including water, sanitation, and hygiene (WASH).[35]
4. AIDS and Rights Alliance for Southern Africa (ARASA) promotes human rights and HIV and AIDS education, improving young people's access to health services and information.[36]

These organisations collaborate with local communities and government agencies to enhance the delivery of CSE and ensure that adolescents have access to the necessary health services and information.[37] These programmes aim to increase awareness about sexual and reproductive health, promote gender equality, and reduce the incidence of STIs and unintended pregnancies. Additionally, community-based initiatives engage parents, religious leaders, and educators to support the delivery of CSE in a culturally sensitive manner.

[29] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).
[30] Mohamed, K.S. et al. (2021) 'An Overview of Healthcare Systems in Comoros: The Effects of Two Decades of Political Instability', Annals of Global Health, 87(1). Available at: https://doi.org/10.5334/aogh.3100.
[31] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).
[32] https://www.unfpa.org/sites/default/files/portal-document/ENG_DP.FPA_.CPD_.COM_.7%20-%20Comoros%20CPD%20-%20Final%20-%202Jul21.pdf
[33] List of Ngos, Charities and non-profits in Comoros (no date). Available at: https://ngobase.org/c/KM/comoros-ngos-charities (Accessed: 19 January 2025).
[34] ibid
[35] ibid
[36] ibid
[37] Ibid

Zimbabwe: Women in Communities (WICO)

Women in Communities, a Voice and Choice Southern Africa Fund (VCSAF) grantee, is implementing a project designed to bridge the generational gap in addressing sexual and reproductive health and rights (SRHR) and HIV in Shurugwi district, Midlands, Zimbabwe. The initiative, titled "I Am My Daughter's Keeper," focuses on addressing teenage pregnancies, school dropouts, HIV and STI transmission, as well as period poverty. The goal is to foster community participation and improve communication between adolescents and their parents and guardians on SRHR and HIV issues. Key strategies include:

- Involving parents and guardians in school discussions on SRHR and HIV.
- Creating one-on-one platforms for intimate discussions between learners and parents.
- Engaging community-based organisations (CBOs) and media partners to reach target groups.

Challenges faced include low male participation and the sensitivity of the topics. However, the project saw improved learner participation, reduced absenteeism, better behaviour among boys, reduced stigma, and increased confidence among learners. Parents gained insights into ASRHR and HIV, enhancing their ability to guide their children.

The project emphasises the importance of developing comprehensive ASRHR policies, training school health masters, and engaging the community.

Results

The initiative has significantly improved learner participation by providing sanitary ware for girls, which has reduced absenteeism. This provision has encouraged attendance and fostered a more supportive environment for female students. School heads have reported enhanced student behaviour, noting increased respect toward girls from male peers.

Moreover, the project has successfully reduced the stigma surrounding menstruation, allowing learners, particularly girls, to feel more confident and open about discussing their menstrual hygiene and using sanitary pads. This newfound confidence has been further bolstered by empowering parents with insights into ASRHR and HIV topics. As a result, parents are better equipped to guide and support their children in making informed health decisions.

The initiative has also provided a sustainable model for addressing ASRHR and HIV issues through collaborative efforts involving parents, demonstrating its potential for long-term impact. The project has specifically boosted girls' confidence and assertiveness, enabling them to navigate challenges more effectively.

Parent involvement has been remarkably high, with active participation in the campaign. This engagement has been highlighted in the Sun Newspaper and on WICO's social media platforms, showcasing families' commitment to this cause. Additionally, twelve School Health Masters have been trained to create stigma-free school environments, further promoting inclusivity and respect.

Results from the monitoring and evaluation have shown positive changes in behaviour and attitudes towards SRHR and HIV. These include:

- Initial baseline surveys and interim project reviews highlighted issues like high absenteeism due to periods.
- The WICO programme has contributed to positive changes, such as reduced absenteeism related to menstrual periods.
- The evaluation showed that girls are now more comfortable discussing their periods and using sanitary pads, even with boys.
- Parents and guardians have embraced the programme, appreciated the dialogues and become more supportive.
- School authorities noted positive changes in learners' behaviour, with students focusing more on their schoolwork rather than on their physical changes.

Source: WICO.[38]

Overall, comprehensive sexuality education is essential for the health and well-being of adolescents in the SADC region. While significant progress has been made, challenges remain in ensuring that all young people have access to high-quality CSE. By addressing these challenges and building on successful models, SADC countries can improve the sexual and reproductive health outcomes of their adolescents and promote their rights and empowerment.

Access to contraceptives and age of consent to sex

Adolescents in the SADC region have the same reproductive health rights as adults, which means they should have access to reproductive health services without any barriers. However, requiring third-party authorisation to access adolescent sexual and reproductive health services, such as contraceptives and information, prevents young people from exercising their fundamental human rights. Adolescents are vulnerable to rape and other sexual violence as well as to early sexual debut, including within the context of child marriage. This means that they are vulnerable to contracting HIV and other sexually transmitted infections (STIs) as well as to unsafe abortions and early childbearing.

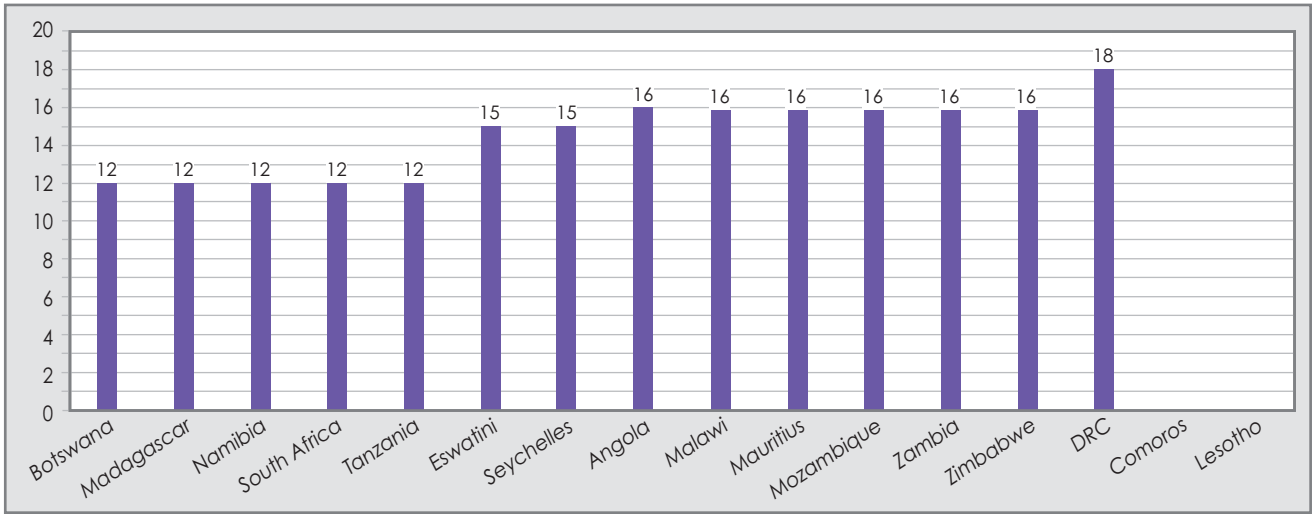
Promoting sexual health is essential for achieving Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote well-being for all ages.

Specifically, **Target 3.7** aims to ensure universal access to sexual and reproductive healthcare services, including family planning, information, and education, and the integration of reproductive health into national strategies and programmes by 2030.

To achieve this SDG, countries must align their laws and policies regarding access to contraceptives and the age of consent to sex. Creating a supportive legal and policy environment is vital for preventing early and unintended adolescent pregnancies and fatherhood, thereby safeguarding the health and rights of young people in the SADC region.

[38] Women in Communities presentation at the Voice and Choice Zimbabwe Summit November 2024:

Figure 3.1: Age of access to contraception



Source: GL Mapping of SRHR Policies and Laws updated 2021

Figure 3.1 shows that five SADC countries- Botswana, Madagascar, Namibia, South Africa and Tanzania-provide contraceptives to young people from the age of 12. Seychelles and Eswatini begin at age 15. The remaining countries permit contraception from age 16, with the Democratic Republic of Congo (DRC) as an outlier, allowing it only from age 18. In the case of DRC, this creates a significant gap since the legal age for girls to consent to sex is 14, resulting in a four-year delay in accessing this fundamental right.

No data is available for Lesotho and Comoros on the age of consent to contraceptives. However, the 2023 SADC 2nd Milestone Score-card[39], indicates that the unmet contraceptive need among individuals aged 15-49 in these countries was 18% in Lesotho and 32% in Comoros. Legislators must urgently review the age of consent for contraception to address the rising incidence of early pregnancies in the region.

According to data published in 2024 by Track 20, which assesses opportunities for family planning programming among adolescents and youth in **Comoros**, adolescents or youths in Comoros who use a modern method of contraception are 2% of all women, while adolescents or youth who have an unmet need for modern contraceptives are 7.3% of all women.[40]

Contraceptive methods, Lesotho. Photo: Ntolo Lekau

[39] SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).
[40] https://www.track20.org/download/pdf/Youth%20Briefs/English/Comoros%20Youth%20Opportunity%20Brief.pdf

The largest group of adolescents and youth with an unmet need for modern contraception are married youth (20-24), who comprise 4% of women of reproductive age (WRA). Programming focused on this population, therefore, has the potential to make a significant contribution to increased national contraceptive prevalence.[41]

In **South Africa**, about one in five women of reproductive age (15-49 years) have an unmet need for contraception, and among Adolescent Girls and Young Women (AGYW), there is an even higher unmet need (31% among adolescent girls aged 15-19 and 28% among young women aged 20-24 years)[42]. The following case study illustrates, however, that there are many barriers in access to contraceptives.

South Africa: Study finds a decline in access to contraceptives

A study by the Stop Stock-outs Project (SSP), *'Contraceptive Supply Chain: Stock-outs and their Causes'*, revealed that stock-outs of contraceptives were prevalent across the country. The study focused on the Eastern Cape, KwaZulu-Natal, and the North West provinces between April 2022 and June 2023.

The study examined the availability of various types of contraceptives. SSP, together with the Ritshidze project, surveyed public health users to assess their experiences of accessing contraceptives. In the Eastern Cape and KwaZulu-Natal provinces, almost all women and girls who were surveyed did not receive the contraceptives they requested.

Throughout the monitoring period, injectable contraception was reported as the least accessible, followed by external condoms and the implant. The study investigated the relationship between the supply chain and contraceptive stock-outs. It found that medicinal stock-outs are widespread across South Africa.

The study used interviews with public health facility managers to establish the causes of poor access and the mitigation measures in place. The project reported that when facility managers were interviewed about the measures implemented to address stock-outs, most Eastern Cape and KwaZulu-Natal managers reported receiving guidance on how to respond to stock-outs. However, managers in the North West said they had not received such advice.

The survey showed that healthcare providers made efforts to ensure that healthcare users did not leave facilities without medicines. It also stated that healthcare providers offered users alternative medicines or referred users to facilities with stock. The survey also highlighted the unavailability of termination of pregnancy services. Most of the surveyed facility managers in all three provinces reported that they referred health-care users seeking these services to other facilities.

> Poor national procurement planning continues to be the main driver of contraceptive shortages and stock-outs

"Our findings are that poor national procurement planning continues to be the main driver of contraceptive shortages and stock-outs. At the provincial level, causes of stock-outs included budgetary limitations, dependence on manual paper-based systems, and poor management of stock controls. The report recommends that the national and provincial health departments urgently address the use of manual data systems for payment and stock management.

Source: IOL.[43]

[41] Ibid
[42] The HERStory Series: Access, use, and perceptions of contraception services among adolescent girls and young women in South Africa | SAMRC (no date). Available at: https://www.samrc.ac.za/policy-briefs/herstory-series-access-use-and-perceptions-contraception-services-among-adolescent (Accessed: 20 January 2025).
[43] Nqumako, P. (no date) Study finds a decline in access to contraceptives in SA. Available at: https://www.iol.co.za/dailynews/news/study-finds-a-decline-in-access-to-contraceptives-in-sa-b501f311-7477-43ac-b3da-3fea77a77df8 (Accessed: 20 January 2025).

In South Africa, young people are taking bold steps to improve adolescent sexual and reproductive health, breaking down stigma and advocating for better services. Veronica Molefe's journey from a 17-year-old seeking information to a passionate health advocate exemplifies youth challenges and triumphs in this critical area.

South Africa: Breaking the stigma: Improving SRHR services for youth

Veronica Molefe, a young woman and leader in providing sexual and reproductive health services through Shout-It-Now in South Africa, shares her journey, highlighting the challenges young people face in South Africa to access to SRHR services. Despite her proactive approach at age 17, when seeking information about contraception and HIV prevention, she experienced judgement and stigma from healthcare providers, a reality that persists for many adolescents today.

"One of my friends became pregnant, and it wasn't clear whether she had used contraception or not. It got me thinking I wasn't sexually active yet, but I wanted to be prepared for when the time came. So, I went to my local clinic, just a street away from my home, to ask for information on contraception and HIV prevention options. What followed was disheartening. The nurse asked me invasive questions: "Why do you want those things? Are you sleeping around? Children like you should be in school, not here." "I felt judged and ashamed. All I wanted was information, but I left empty-handed. Fortunately, my mom stepped in, and we found another clinic that provided the support I needed," Molefe explained. She added: "That was 10 years ago, but sadly, this is still the reality for many young people in South Africa today."

The statistics are alarming, with 150,000 girls aged 10 to 19 experiencing unintended pregnancies in 2022/2023, compounded by high HIV infection rates, particularly among young women. The stigma surrounding sexual health often prevents youth from accessing available services, with many health facilities lacking a welcoming atmosphere. Molefe emphasises the need for youth-friendly health services that respect and support young people, as offered by Shout-It-Now, which recruits younger staff and utilises peer ambassadors to foster a non-judgemental environment. The call to action stresses the importance of collaborative efforts across society to destigmatise sexual and reproductive health, leading to open discussions and empowering youths to take charge of their health.

Source: MSN news.[44]

It is essential that all countries have progressive laws and policies that support the availability of SRHR services to youth, enabling adolescents to access sexual and reproductive health services independently, without the need for third-party authorisation.

[44] Madwantsi, V. (1732532372) Breaking the stigma: improving sexual and reproductive health services for youth in South Africa. Available at: https://www.msn.com/en-za/news/other/breaking-the-stigma-improving-sexual-and-reproductive-health-services-for-youth-in-south-africa/ar-AA1ul8QB?ocid=msedgntp&pc=DCTS&cvid=6535064e8e724db58d8f6deeaebcb780&ei=14 (Accessed: 25 November 2024).

Table 3.2: Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation

Botswana	Yes
Eswatini	Yes
Lesotho	Yes
Madagascar	Yes
Malawi	Yes
Mozambique	Yes
Namibia	Yes
South Africa	Yes
United Republic of Tanzania	Yes
Angola	No
Comoros	No
Dem. Rep. of Congo	No
Mauritius	No
Seychelles	No
Zambia	No
Zimbabwe	No

Source: SADC Scorecard 2023.[45]

Table 3.2 illustrates which SADC countries have legal and policy frameworks providing adolescent access to sexual and reproductive health (SRH) services without requiring third-party authorisation and which do not. It shows that Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, and Tanzania have laws supporting this access. In contrast, it shows that Angola, Comoros, the Democratic Republic of Congo, Mauritius, Seychelles, Zambia, and Zimbabwe do not have similar laws and policies.

Extracts of laws from Lesotho and South Africa show a progressive shift toward prioritising children's and adolescents' autonomy and rights in health-related matters.

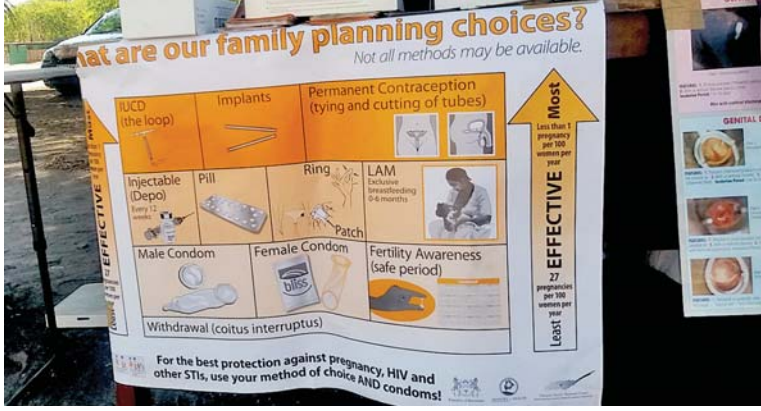
Figure 3.2: Examples of progressive laws on adolescent health matters

The Lesotho Children's Protection and Welfare Act 2011 provides at:	The South African Children's Act 38 of 2005 includes provisions on consent to medical treatment and surgical procedures, HIV testing and counselling, and access to contraceptives:
Section 232(2): ***A child may consent to medical treatment provided the child is -*** (a) at least 12 years of age; and (b) of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation. ***Section 233(2):*** ***Consent for HIV test on a child may be given by -*** (a) the child, if the child is 12 years or older.	***Section 129*** ***(2) states that a child may consent to his or her own medical treatment or to the medical treatment of his or her child if -*** (a) the child is over the age of 12 years; and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. ***(3) A child may consent to the performance of a surgical operation on him or her or his or her child if -*** (a) the child is over the age of 12 years; and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and (c) the child is duly assisted by his or her parent or guardian. ***Section 134 states that:*** ***(1) No person may refuse -*** (a) to sell condoms to a child over the age of 12 years; or (b) to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. ***(2) Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or caregiver of the child if -*** (a) the child is at least 12 years of age; (b) proper medical advice is given to the child; and (c) a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child. ***(3) A child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect, subject to section 105.***

Source: The extract was taken from The Lesotho Children's Protection and Welfare Act 2011 and the South African Children's Act 38 of 2005

[45] SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).

Figure 3.2 shows that The Lesotho Children's Protection and Welfare Act 2011 and the South African Children's Act 38 of 2005 outline specific provisions regarding children's rights concerning medical treatment and contraceptive access. Both Acts allow children aged 12 and above to consent to medical treatments and surgical procedures, provided they demonstrate sufficient maturity and mental capacity to understand the implications involved. The legislation specifies that children can consent to their medical treatment, including HIV testing and the provision of contraceptives, without requiring parental consent, as long as they are given appropriate medical advice and a medical examination has been conducted. Additionally, it mandates confidentiality for children seeking information and services related to contraceptives, ensuring their rights are respected in health matters. These Acts highlight a shift towards recognising children's autonomy in significant health-related decisions and reinforce the importance of informed consent.



ASRHR teenage pregnancy and parent child materials in Kgotla, Botswana.
Credit: Kgalalelo Gambule

SADC countries need to ensure adolescent autonomy and access to essential health services. This includes providing comprehensive sexual and reproductive health education, promoting mental health awareness, and removing barriers to accessing care. By empowering young people to make informed decisions about their health, SADC countries can foster a healthier, more informed generation. Investment in youth-friendly health services and policies that respect adolescents' rights will improve individual well-being and contribute to the overall development and resilience of communities throughout the region.

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. For instance, Guttmacher lists several indicators of effective youth-friendly services.

Effective Youth-Friendly Services

Whether services are provided in a clinical setting, a youth-oriented site, in schools or in the community, specific youth-friendly characteristics are essential for effective services.

- Providers should be trained to work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs.
- Services must be confidential, non-judgemental and private.
- Clinic opening hours should be convenient for adolescents and young people: Late afternoons (after school), evenings and weekends.
- Services should be accessible to all adolescents and young people, regardless of age, marital status, sexual orientation or ability to pay.
- Effective referral systems should be in place.
- Adolescents and young people should have opportunities to be involved in designing, implementing, and evaluating the programme.
- Services should seek to involve and gain the support of those critical in young people's lives and the local community, such as partners, parents/ guardians and schools.

Source: Guttmacher.[46]

[46] https://www.guttmacher.org/sites/default/files/report_downloads/demystifying-data-handouts_0.pdf

Lesotho YWCA: Promoting the right to health for young women and girls

The Lesotho Young Women's Christian Association (YWCA) has launched a project to enhance young women's health rights through CSE and improved access to SRHR services. This initiative addresses several critical issues observed in the community, including:

- Lack of understanding regarding gender-based violence and limited awareness of sexuality education.
- Limited knowledge and awareness among students about comprehensive sexuality education.
- Under-reporting of child protection issues and gender-based violence, as confirmed by child and gender reports.
- Ineffective implementation of laws and policies by various stakeholders.

The project targets communities in three districts: Mafeteng, Maseru, and Berea. Its primary focus is on creating a safe environment for promoting SRHR, particularly for adolescent girls and young women. The YWCA's objectives include reducing gender-based violence, improving health outcomes, and ensuring access to quality health services through community empowerment and advocacy.

To achieve these objectives, the YWCA has undertaken several key activities. Six school dialogues on SRHR were conducted in high schools, with two sessions held in each district. Three community dialogues and three dialogues with community leaders and stakeholders were organised on SRHR, with one of each kind of dialogue per district. Information, education, and communication (IEC) materials were developed and distributed, including brochures and flyers. Surveys were administered to assess initial knowledge and attitudes. Furthermore, clubs were established in each district to engage males in promoting gender equality and SRHR.

The YWCA has achieved several milestones to date. School dialogues were conducted in five schools across Mafeteng, Maseru, and Berea. Three district dialogues were held with District Child Protection Teams (DCPTs) in these districts. Two community dialogues were organised to promote the rights and health of young women and girls. Men's and boys' clubs were established and trained using the male engagement model to transform boys into men who support gender equality. Additionally, two radio slots were secured to raise awareness about SRHR issues.

Nonetheless, the project has faced several challenges. Less than half of the targeted beneficiaries were reached, falling short of the goal to reach 2,730 individuals. Low turnout at community gatherings required aligning activities with existing events on the chiefs' timetables, causing delays. Collaboration with private schools was delayed due to slow responses to suggested dates. To address these challenges, the YWCA proposed several solutions. Despite their low enrolment rates, they plan to work with more private schools to reach the target number of beneficiaries. Project activities will be aligned with other planned community events to increase attendance. Meetings with school committees and principals will be held to explain the project's relevance to their curriculum, generating more interest and securing more time for activities in schools. The project's reach within the designated districts will be broadened to meet target numbers.

Conclusion

The Lesotho YWCA's project demonstrates a comprehensive approach to promoting the right to health for young women and girls through CSE and improved access to SRHR services. Despite facing challenges, the project has made significant strides in community engagement, education, and advocacy. Continued efforts to address barriers and expand the project's reach will be crucial for its success and sustainability. This case study highlights the importance of community-based initiatives in addressing SRHR issues and the need for ongoing support and collaboration among stakeholders to achieve lasting impact.

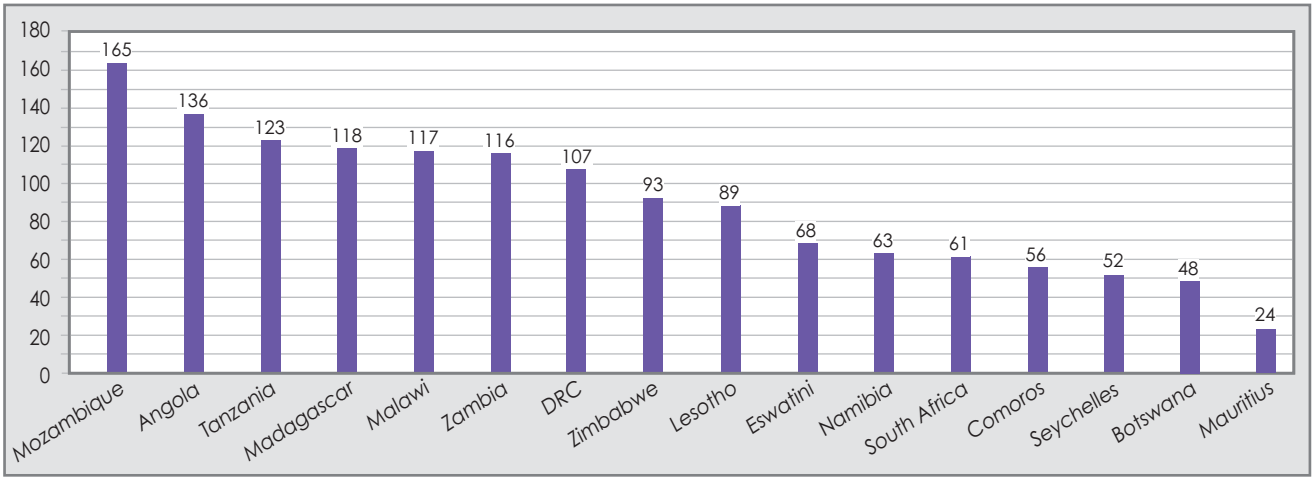
Source: VCSAF.[47]

[47] Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).

Early unintended pregnancy in the SADC region

Early unintended pregnancy remains a significant challenge in the SADC region, profoundly impacting the lives of adolescents.[48] Early pregnancies often result from limited access to comprehensive sexuality education, contraceptives, and reproductive health services. These early pregnancies can lead to adverse health outcomes, disrupt educational and career opportunities, and perpetuate cycles of poverty and gender inequality. Addressing this issue requires targeted interventions to improve access to sexual and reproductive health services and empower young people with the knowledge and resources to make informed decisions about their reproductive health.

Figure 3.3: Adolescent fertility rates (per 1000 women 15-19)



Source: World Bank 2022 Statistics.[49]

Figure 3.3 illustrates the state of adolescent fertility in the SADC region using the most recent data from 2022 provided by the World Bank. Mozambique has the region's highest adolescent fertility rate (AFR), with 165 births per 1,000 women aged 15 to 19. Several other countries also exhibit high fertility rates, including Angola, Tanzania, Madagascar, Malawi, Zambia, and the Democratic Republic of Congo (DRC). High adolescent fertility rates are often associated with elevated rates of child marriages and early pregnancies.[50] These factors contribute to a cycle of poverty and limited educational and economic opportunities for young women.

Addressing these high fertility rates requires comprehensive strategies, including improving access to education, enhancing reproductive health services, and implementing policies that protect the rights of adolescents.

High adolescent fertility rates are often associated with elevated rates of child marriages and early pregnancies

[48] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[49] World Bank Open Data. Available at: https://data.worldbank.org (Accessed: 13 November 2024).
[50] WHO, 2012. Early marriages, adolescent and young pregnancies. https://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_13-en.pdf

Teenage pregnancy in Seychelles. Photo: Gender Links

By understanding these dynamics, policymakers and stakeholders can better target interventions to reduce adolescent fertility rates and improve the well-being of young people in line with the SADC SRHR Strategy 2019-2030 goals. These figures suggest that bold steps need to be taken to reduce the high AFR in the region. Lessons from other countries show that the implementation of sexual and reproductive health policies, educational and vocational programmes, empowerment initiatives, training activities, school retention programmes and behaviour change campaigns significantly contribute to addressing high adolescent fertility.[51]

Studies suggest that inter alia, socio-economic status, lack of parental communication and support, early marriage, religion, and low educational status of adolescents are contributing factors to high adolescent fertility rates.[52] The following case study illuminates the challenges of teenage pregnancies in Mozambique.

Teenage pregnancy in Mozambique

Mozambique has one of the highest adolescent fertility rates in the SADC region and the world, with approximately 165 births per 1,000 women aged 15-19.[53] This high prevalence is influenced by various socio-economic, cultural, and educational factors, making it a significant public health concern. Some of these factors are:

- Poverty is a significant driver of teenage pregnancies. Many adolescents engage in early sexual relationships due to economic pressures and the need to support their families[54].
- Low levels of education are strongly associated with higher rates of teenage pregnancies. Girls who drop out of school are more likely to become pregnant[55].
- In many communities, early marriage and childbearing are culturally accepted and even encouraged. This cultural acceptance leads to high rates of teenage pregnancies[56].
- Limited access to contraceptives and reproductive health services is a significant barrier. Adolescents often face challenges in obtaining contraceptives due to stigma, lack of information, and healthcare provider biases.[57]

[51] Cadena K, Hernandez PB, Inchauste G. Preventing teenage pregnancy: a priority for the well-being of women in Mexico. Available from: https://www.
[52] https://blogs.worldbank.org/latinamerica/preventing-teenage-pregnancy-priority-well-being-women-mexico (Updated April 13, 2022; Accessed October 19, 2022).
Maharaj, N.R. (2022) 'Adolescent pregnancy in sub-Saharan Africa - a cause for concern', Frontiers in Reproductive Health, 4. Available at:
[53] https://doi.org/10.3389/frph.2022.984303.
Maharaj, N.R. (2022) 'Adolescent pregnancy in sub-Saharan Africa - a cause for concern', Frontiers in Reproductive Health, 4. Available at:
[54] https://doi.org/10.3389/frph.2022.984303.
Mekonen, E.G. (2024) 'Pooled prevalence and associated factors of teenage pregnancy among women aged 15 to 19 years in sub-Saharan Africa: evidence from
[55] 2019 to 2022 demographic and health survey data', Contraception and Reproductive Medicine, 9(1), p. 26. Available at: https://doi.org/10.1186/s40834-024-00289-5.
[56] ibid
[57] ibid
Jonas, K. et al. (2016) 'Teenage pregnancy rates and associations with other health risk behaviours: a three-wave cross-sectional study among South African school-going adolescents', Reproductive Health, 13(1), p. 50. Available at: https://doi.org/10.1186/s12978-016-0170-8.

Effects of teenage pregnancy

The effects of teenage pregnancy in Mozambique and the rest of SADC are profound and multifaceted, impacting the health, education, and socio-economic status of young mothers:

- Teenage mothers face higher risks of complications during pregnancy and childbirth, including preterm birth, low birth weight, and maternal mortality than older women do[58]. These health risks are exacerbated by inadequate prenatal care and poor health infrastructure.
- Teenage pregnancy often leads to school dropout, limiting educational and career opportunities for young mothers. This disruption perpetuates the cycle of poverty and reduces the socio-economic mobility of young women. In Mozambique, 70 per cent of pregnant girls, of whom many were still enrolled in primary school past puberty due to late enrolment, dropped out of school.
- The economic burden of teenage pregnancy is significant. Young mothers are less likely to complete their education and secure stable employment, leading to long-term financial instability.[59]
- Teenage mothers often face social stigma and discrimination, which can lead to social isolation and mental health issues. The stigma associated with teenage pregnancy can also affect the self-esteem and prospects of young mothers.[60]

A secret pregnancy in the Comoros: One teen's story

Sara* was 17 when she found out she was pregnant. Living in a rural village in the Comoros, she carried the entire pregnancy in secret and then gave birth in a hospital bathroom. "Our society does not accept getting pregnant out of wedlock," she explained recently to UNFPA. "I was going out with a young man who was 20 years old," she recalled. They rarely used condoms, she said. "My cycles were regular, and I was happy to calculate the day of ovulation to take precautions. But it was not effective." In November of last year, she realised that she was pregnant. "I did not know what to do," she said. "I was completely lost… My father is a religious man and would not accept that it happened to his eldest daughter. I thought he would kill me."

**Not her real name* *Source: UNFPA.*[61]

Across SADC, the struggle of pregnant girls and adolescent mothers to stay in school is fraught with challenges. The story of Constância, a once high-achieving student who faced insurmountable barriers after becoming a mother in Mozambique, highlights the systemic and social obstacles many young girls encounter in their pursuit of education.

[58] Amoadu, M., Hagan, D. and Ansah, E.W. (2022) 'Adverse obstetric and neonatal outcomes of adolescent pregnancies in Africa: a scoping review', BMC Pregnancy and Childbirth, 22(1), p. 598. Available at: https://doi.org/10.1186/s12884-022-04821-w.
[59] ibid.
[60] ibid
[61] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).

Mozambique: Pregnant girls and adolescent mothers struggle to stay in school

Constância had an unblemished academic record. She never failed a grade and reached the 12th grade at age 17, a milestone that few adolescent girls achieve in Mozambique because of the many systemic and social barriers they face to attend school. But in grade 12, Constância had a child. She started missing classes because she had to breastfeed her daughter and had no one to support her with childcare. As a result, she failed some exams and dropped out without completing the grade. When she found out she was pregnant, she moved in with her boyfriend, a 25-year-old man. Once she gave birth to their daughter, she started taking contraceptives to avoid getting pregnant again. Her boyfriend was against this, so she hid it from him. When her menstrual period became irregular, he accused her of having an abortion. He became angry and threatened to stop giving her money for the household and her expenses, including the money she used to pay for her education.

Constância decided to leave her boyfriend's home and returned to her family's home with her daughter. In 2021, at 18, she could not re-enrol in school because she no longer had money to pay for fees and other costs. Her parents committed to getting the money to pay for her enrolment in the 2022 academic year. "I want to return to the same school where I was already studying because I'm used to it," she said. "The school is far, and I spend much money on transportation." Like other adolescent girls and women who spoke with Human Rights Watch, Constância, now 19, hoped her circumstances would improve. "The child's father will take on his responsibilities again, and the baby will stay with my mom," she said.

Source: Human Rights Watch.[62]

Addressing teenage pregnancy

Mozambique has implemented several initiatives to address the high rates of teenage pregnancy and to mitigate its effects:

- The Mozambican government has integrated CSE into the school curriculum to provide adolescents with accurate information about sexual and reproductive health. This education aims to reduce the incidence of teenage pregnancies by promoting safe sexual practices.
- Efforts have been made to establish youth-friendly health services that provide confidential and non-judgemental care to adolescents. These aim to improve access to contraceptives and reproductive health information.
- Programmes that engage community leaders, parents, and adolescents are crucial for changing cultural norms and reducing stigma. Community education initiatives help create a supportive environment for young people to make informed decisions about their reproductive health.
- Financial support and educational opportunities for young mothers can help them continue their education and improve their socio-economic status. Programmes that offer scholarships, childcare support, and vocational training are essential for empowering young mothers.

Conclusion

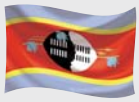
The prevalence of teenage pregnancy in Mozambique, as well as in other countries of SADC, highlights the need for comprehensive strategies to address the underlying socio-economic, cultural, and educational factors. By implementing effective interventions and creating a supportive environment, Mozambique and other countries can reduce the incidence of teenage pregnancies and improve the health and well-being of young people.

[62] Martínez, E. (2024) '"Girls Shouldn't Give Up On Their Studies"', Human Rights Watch [Preprint]. Available at: https://www.hrw.org/report/2024/02/13/girls-shouldnt-give-their-studies/pregnant-girls-and-adolescent-mothers-struggles (Accessed: 19 November 2024).

SADC Gender Protocol Alliance work on ASRHR in the region

The Southern Africa Gender Protocol Alliance, coordinated by Gender Links, is a regional network that advocated for adopting the SADC Protocol on Gender and Development in 2008. Since then, the Alliance has produced an annual Barometer to monitor progress toward achieving gender equality across the SADC region, aligning its findings with the Protocol's targets. It operates through six thematic clusters: Governance and Constitutional and Legal Rights; Sexual and Reproductive Health; Economic Justice and Education; Climate Change and Sustainable Development; Media, Information, and Communications; and LGBTIAQ+. One notable partner within the Alliance's SRHR cluster is the Southern Africa Aids Dissemination Service (SAfAIDS), which promotes SRHR rights through various regional and local programmes. The work of the Alliance and its partners demonstrates a strong commitment to advancing gender equality and SRHR in the region.

Selected SAfAIDS ASRHR programmes in the region



In **Eswatini**, SAfAIDS is implementing the "*Liphimbo Lami*" programme to empower and engage Adolescent Girls and Young Women (AGYW). This initiative focuses on increasing AGYW's access to social protection and economic empowerment programmes and encouraging their involvement in national HIV and SRH programming and policy implementation processes.

It is also running a project titled "*Empowering Adolescent Girls, Young Women, and Men for an Effective, Integrated Gender and Adolescent-Responsive System for HIV Prevention among Adolescents and Young People*." This project has two key objectives:

- To enhance access to CSE and SRHR for adolescent girls and young women at the community level.
- To improve the integrated delivery of SRHR and HIV services so that they effectively meet the needs of adolescent girls and young women, as indicated by user satisfaction.

In **Zambia**, SAfAIDS[63] works through *Her Future, Her Choice (HFHC)*, a project to strengthen SRHR, targeting adolescent girls and young women in and out of school. The project was developed to respond to the gender inequality and women's rights violations undermining access to comprehensive, rights-based sexual and reproductive health information and services for adolescent girls and young women (10-24 years).

Through the *Gender, Adolescent Pregnancy and Social Norms (GAPS) Programme*, SAfAIDS is collaborating with the Government of Zambia and other partners to create a future where adolescent girls and young people in select geographical areas of the Eastern and Southern Provinces of Zambia can lead empowered and healthy lives. The programme focuses on providing them with access to and opportunities for making their own sexual and reproductive health choices.

Source: SAfAIDS.[64]

[63] 'Our Programmes - SAfAIDS' (no date). Available at: https://safaids.net/our-programmes/ (Accessed: 19 November 2024).
[64] 'Our Programmes - SAfAIDS' (no date). Available at: https://safaids.net/our-programmes/ (Accessed: 19 November 2024).

With funding from the FCDO, Gender Links is working with Women of the South Speak Out (WOSSO) Fellows, a cohort of young women from the global south, to amplify the voices of women and girls and advocate for women's rights. Collaborating with the Voice and Choice Southern Africa Fund grantees, the fellows are making their voices heard by targeting conferences and spaces where discussions and critical decisions about gender equality and women's rights are made. They engage with policymakers, stakeholders, and community leaders to highlight women and girls' challenges in the SADC region and advocate for policies that promote gender equality and protect women's rights. Through these efforts, the WOSSO Fellows are raising awareness and driving tangible change in their communities, ensuring that the perspectives and needs of women and girls are prioritised in regional and global discussions. The following article highlights a recent advocacy initiative.

Southern Africa: Young women call for a safe future[65]

Young women have made an impassioned plea to the Southern African Development Community Parliamentary Forum (SADC PF) to secure a "safe and productive future" for the largest segment of the region's population.

WOSSO Fellows and VCSAF representatives reminded lawmakers that "youth constitute 60% of the population of SADC, and young women are slightly more than half of these youth; in other words, they are the largest single demographic in our region. Yet young women constitute the majority of those who are unemployed, missing in decision-making, and whose rights are violated through GBV."

The submission profiled the harrowing case of a young woman, age 16, who fell pregnant as a result of rape in what is supposed to be a "place of safety" in Lesotho. She HIVE, a Voice and Choice Southern Africa Fund grantee had arranged for her removal from an abusive home situation and placement in the "place of safety", to be safe. In a rare landmark case, She Hive succeeded in winning a court order using existing laws for the young woman to have a safe abortion.

Most women in the region, they noted, "seek unsafe options which include drinking a range of plant or chemical based concoctions or inserting a stick, root or wire into the cervix. Being poor, rural and young are all associated with a higher risk of unsafe abortion." While Africa accounts for about one-quarter of unsafe abortions globally, it accounts for about two-thirds of abortion-related deaths.

The advocacy team included two WOSSO Fellows: Veronika Haimbili, an independent consultant from Namibia, and Vimbai Rugare Nyika, from the Women's Action Group in Zimbabwe, in partnership with Refiloe Harris from She HIVE Association.[66] All three are members of the recently launched Safe Abortion Alliance of Southern Africa (SAASA)[67], a growing network of individuals and organisations campaigning for women's right to voice and choice.

SAASA responded to a call by the SADC PF Standing Committee on Gender Equality, Women's Advancement, and Youth Development (GEWAYD)[68], for submissions to a public hearing on, among others, child marriage and gender-based violence.

[65] 'Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).
[66] https://shehive.co.ls/
[67] 'SAASA - Safe Abortion Alliance of Southern Africa - VCSA Fund' (no date). Available at: https://vcsafund.org/saasa/ (Accessed: 19 November 2024).
[68] Forum, S.P. (no date) Gender Equality, Women Advancement, & Youth Development - SADC Parliamentary Forum. Available at: https://www.sadcpf.org/index.php/en/plenary-assembly/committees/standing-committees/gender-equality-women-advancement-youth-development (Accessed: 19 November 2024).

The young women asked Members of Parliament (MPs) to make sure that:

- Every member state has a progressive ASRHR policy, which enables us to access youth-friendly SRHR information and services such as contraception.
- Every member state engages in community awareness raising to reduce stigma and protect our rights to comprehensive ASRHR.
- We can access safe abortion - preferably by encouraging member states' parliaments to decriminalise abortion completely and by expanding access to good quality, self-managed, medication abortion.

The chairperson of the hearings congratulated them on the submission and said that this work should be "exposed."

Source: VCSAF.[69]

Junior councillors during an SRHR discussion at a Gender Links workshop in Zimbabwe. Photo: Tapiwa Zvaraya

[69] 'Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).

Next steps

Improving adolescent sexual and reproductive health and rights in Southern Africa requires a multifaceted approach that addresses the unique challenges faced by young people in the region. Here are some key recommendations that need to be implemented.

Strengthen comprehensive sexuality education programmes

- Member states must ensure that CSE is integrated into school curricula across all SADC countries, making it accessible to all adolescents. This includes providing age-appropriate, scientifically accurate, and culturally relevant information.
- Member states must engage parents, religious leaders, and community members in developing and implementing CSE programmes to ensure cultural sensitivity and community buy-in.
- Member states must invest in training educators to deliver CSE effectively, equipping them with the necessary skills and resources to address sensitive topics confidently.

Enhance health services for adolescents

- Member states must incorporate adolescent-friendly health services into primary healthcare systems, ensuring that young people have access to comprehensive sexual and reproductive health care, including contraception, HIV testing, and mental health support.
- Health ministries must identify and mitigate barriers that prevent adolescents from accessing health services, such as stigma, discrimination, and lack of confidentiality.
- Governments and civil society organisations are encouraged to launch targeted awareness campaigns to inform adolescents about available health services and encourage them to seek care when needed.
- To prevent adolescent pregnancy, stakeholders need to work to reduce socioeconomic inequalities, GBV and alcohol abuse, and improve adolescents' health care and educational status. Issues such as child marriage, unsafe abortions, poor healthcare infrastructure and non-adolescent-friendly health facilities need to be addressed.

Policy development and implementation

- There is a need to encourage countries without specific ASRHR policies to develop and implement stand-alone policies that address the unique needs of adolescents.
- There is a need for continued advocacy for the harmonisation of the age-of-consent laws with access to contraceptives and SRHR services to reduce barriers for adolescents.
- Given the high rates of early pregnancies in the region, legislators must urgently lower the age of consent for contraception to address this challenge.
- Member states must review and strengthen existing policies to ensure they are comprehensive and effectively address the challenges faced by adolescents in the region.
- There is a need to foster political will and commitment to ASRHR by engaging policy-makers and advocating for increased funding and resources.

Build resilient health systems

- Member states must ensure adequate allocation of resources to health systems to support the delivery of ASRHR services, even during crises such as the COVID-19 pandemic and to be prepared for emergencies such as future pandemics. Some strategies that can be employed include developing tech solutions.
- Member states must invest in recruiting and training healthcare workers to improve the quality and availability of adolescent-friendly health services.
- Member states must strengthen supply chain systems to supply essential medical supplies and contraceptives consistently.

Monitor and evaluate progress

- Member states must implement robust monitoring and evaluation systems to track ASRHR initiatives' progress and identify areas for improvement.
- There is a need to facilitate sharing of best practices and successful strategies among SADC countries to promote learning and collaboration.
- Member states must ensure regular reporting on ASRHR indicators to maintain accountability and transparency.

By taking these steps, SADC can make significant strides in improving the sexual and reproductive health and rights of adolescents, ensuring that they are educated, healthy, and empowered to contribute to the region's future development in line with the objectives of the Strategy for Sexual Reproductive Health and Rights in the SADC Region (2019 - 2030).

Education, health and empowerment in SADC is the future.
Photo: Colleen Lowe Morna

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Safe Abortion

4

Showing support for the right to choose in Namibia. Photo: Gender Links

Key points

- Africa has the highest rates of abortion-related deaths of any region in the world. While Africa accounts for about one quarter of unsafe abortions globally, it accounts for about two thirds of abortion-related deaths.[1]
- Unmet need for contraception and maternal mortality ratio are both unacceptably high.
- The global and continental movement to decriminalise abortion is being countered by the resurgence of the anti-abortion movement.
- 11 SADC Member States have legislation that at least aligns to the Maputo Protocol, the first treaty in the world recognising abortion as a right.
- Many factors can hinder access to legally allowed safe abortion, including poverty; deep stigma and poor social support; insufficient information about the law among women, girls, health professionals and local level law enforcement bodies; lack of health sector guidance; and inadequate equipment or materials.
- Several international bodies, including associations of obstetricians and gynaecologists, are supporting innovative approaches to expanding access to safe abortion care.
- Women are exercising their agency in finding ways to access safe, or at least safer, abortion, including access to medication abortion.
- Grantees of the Voice and Choice Southern Africa Fund have initiated the Safe Abortion Alliance of Southern Africa (SAASA) to spearhead regional collaboration to advocate for legal review and expanded access to safe abortion.

[1] Population Reference Bureau (2021) Abortion facts and figures, Washington, DC. https://www.prb.org/wp-content/uploads/2021/03/2021-safe-engage-abortion-facts-and-figures-media-guide.pdf, accessed 18 August 2024

Introduction

Unsafe abortion is rife and is a major contributor to maternal mortality in SADC

Women from all walks of life, in every country in the world, seek abortions at some point in their lives. Africa was the first continent to adopt a protocol (the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol) recognising abortion, in some circumstances, as a human right. Yet, strong social stigma against abortion persists, driven by deeply held gender norms and fuelled by well-funded, international conservative groups. Many women in Africa and globally still struggle to access safe abortion, also referred to as termination of pregnancy.

Nine tenths of women in Africa live in countries that ban abortion completely, or only allow it to save the life of a woman, to preserve her mental or physical health, or in cases of rape, incest or fetal abnormality. Inability to access legal abortion does not reduce the number of abortions. Rather, it forces women and girls to seek any abortion measure available - most often unsafe. In contexts restricting access only about one quarter of abortions are safe, while in countries allowing abortion on request 90% are safe.

Thus, unsafe abortion is rife and is a major contributor to maternal ill health and mortality in SADC. It is estimated that eight million abortions occur in Africa every year, of which three quarters are not safe - with about a quarter unsafe and half least safe.[2] Unsafe refers to abortions carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. Least safe refers to abortions carried out by an untrained person using dangerous or invasive methods.[3]

Africa has the highest rates of abortion-related deaths of any region in the world. While Africa accounts for about one quarter of unsafe abortions in the world, it accounts for about two thirds of abortion-related deaths. The average death rate from unsafe abortion globally is 103 per 100 000 unsafe abortions. In developed countries it is 30 per 100 000 unsafe abortions, while in Africa it is 220 deaths per 100 000 unsafe abortions.[4] The toll of unsafe abortion is very high. For women and their families, complications and deaths from unsafe abortions can significantly affect psychosocial, physical and economic well-being. For health systems, there are financial costs of providing post abortion care (which is more expensive than providing safe abortion), as well as lost productivity.

This chapter highlights that despite global and continental movements for decriminalisation, there has been very little progress in SADC regarding reviewing and advancing abortion legislation. However, there has been action and progress towards ensuring women and girls are able to access abortion as allowed under national laws, as well as ensure this is good quality care. Across the region, there are examples of programmatic work seeking to change deeply entrenched perceptions of abortion; raise awareness about legal provisions and how these can be accessed; support development of guidelines for comprehensive abortion care; and share information about how to access services. These initiatives are critical to tackle barriers preventing women and girls from accessing safe abortions and seeking quality care that should be available according to legislation.

[2] Population Reference Bureau (2021) Abortion facts and figures, Washington, DC https://www.prb.org/wp-content/uploads/2021/03/2021-safe-engage-abortion-facts-and-figures-media-guide.pdf, accessed 18 August 2024
[3] WHO (2024) Abortion Fact Sheet https://www.who.int/news-room/fact-sheets/detail/abortion, accessed 19 October 2024.
[4] Population Reference Bureau (2021) Op Cit

Despite persisting barriers, women and girls are exercising their agency in finding ways to access safe, or at least safer, abortion. This includes traveling from all corners of SADC to access abortion in South Africa, which has one of the most liberal abortion laws in Africa. It also includes finding ways to access medication abortion.

There is continuing coordination and partnership between different actors working to broaden access to safe abortion. One such example is the collaboration initiated by grantees of the Voice and Choice Southern Africa Fund (VCSAF), highlighted in the following case study.

Safe Abortion Alliance of Southern Africa (SAASA)

VCSAF grantees initiated the Safe Abortion Alliance of Southern Africa (SAASA) at the Learning and Sharing Summit in November 2023. SAASA officially launched in a webinar on Safe Abortion and Gender-Based Violence (GBV) during 16 Days of Activism Against GBV on 6 December, 2023.

SAASA members met again in Harare on the occasion of the SADC Heads of State Summit where they made presentations to the SADC Gender Day meeting on 15 August 2024, as well as drafted an action plan and agreed to broaden their membership to all 16 countries in SADC.

In its short existence, SAASA has already achieved some milestones.

International Safe Abortion Day Dialogue
On International Safe Abortion Day, marked annually on 28 September, SAASA members hosted a dialogue on what needs to be done to improve women's access to safe abortion as prescribed by laws in SADC countries.

Lynette Mudekunye, author of the Safe Abortion chapter of the Voice and Choice SADC Barometer, noted that, "In every country in the world, women of all ages and socio-economic means, for many different reasons, take a decision they are not able to carry a pregnancy to term. Once a woman decides to have an abortion, she will find a way to do it."

Panellists from five countries with different abortion laws and interpretations described the persisting obstacles for women seeking access to safe abortion provided for under national laws.

In **Malawi**, Zaithwa Katherine Milanzi of the Young Women's Consortium on SRHR explained, one of the biggest challenges for women to access any SRH services is lack of resources - from the national health budget shortcomings to women's own resources. Milanzi highlighted climate disasters as a particular challenge in a country vulnerable to cyclones and drought. In disasters, SRHR competes for available resources amidst shortages of many essential goods and services. She lamented that the newly enacted Disaster Management Act 2023 does not specifically mention access to SRHR in disaster management.

According to Refiloe Harris of She-Hive Association, in **Lesotho**, stigma, stereotypes and religious, cultural and social norms are the biggest barriers for women and girls to access safe abortion. Applying existing laws, She-Hive Association successfully secured a court order for a 16-year-old to obtain a termination of a pregnancy that resulted from abuse (see case study found later in this chapter).

Hilda Dadu, from the Coalition for Women Human Rights Defenders, shared that in **Tanzania**, termination of pregnancy is prohibited, except to save a woman's life. Women and girls who become pregnant from sexual assault, rape or incest are forced to either keep the pregnancy or seek unsafe abortions. Both options can result in life-long physical and mental trauma. It is estimated that one million women have unintended pregnancies in Tanzania every year, of which 39% end in abortion.

South Africa is one of only two countries in SADC where abortion is legally available on request. However, women continue to die from unsafe abortions. Judiac Ranape, an abortion provider in the Western Cape, explained that the interplay between morals, ethics and legal duties for healthcare providers creates barriers for women to access safe abortion. She says, "The dearth of abortion providers undermines the availability of safe, legal abortion, making it easier for unscrupulous abortion providers to thrive."

The dialogue underscored the urgent need for a multi-sectoral and multi-pronged approach involving local partners, families, men and policymakers to advocate for decriminalising abortion and protecting women's right to access safe abortion services.

Presentation to the SADC Parliamentary Forum

Three young members of SAASA - Refiloe Harris (She-HIVE Association, Lesotho), Veronika Haimbili (Women of the South Speak Out (WOSSO) Fellow, Namibia) and Vimbai Nyika (Women's Action Group and WOSSO Fellow, Zimbabwe) - made a presentation to the SADC Parliamentary Forum on 23 October, calling for every member state to:

- Adopt progressive adolescent SRHR policies and ensure youth-friendly SRHR information and services like contraception.
- Promote community awareness to reduce stigma and protect adolescent SRHR rights.
- Ensure access to safe abortion by urging decriminalisation by parliaments and expanding quality, self-managed medication abortion options.

Movement building: growing SAASA

Since August 2024, SAASA has grown from 27 members to 43 members from eight SADC countries (DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania and Zimbabwe), with the intention to recruit members from all 16 SADC countries. In collaboration with the Sexual and Reproductive Justice Coalition (SRJC), SAASA is planning a strategy convening in Johannesburg at the end of November 2024 to develop a collective vision for the alliance and strategies to advance safe and legal abortion access across Southern Africa.

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	Maputo Protocol gazetted 2018	Constitution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code Act 2012	Penal Code 2019	Abortion and Sterilisation act 1975	Termination of Pregnancy Act 1994	Choice of Termination of pregnancy Act (92/1996) amended in 2008	Penal Code	Termination of Pregnancy Act 2005 and Penal Code 2014	Termination of Pregnancy Act 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
Compliance with Maputo Protocol	Yes	Yes	Partial	Yes	Yes	Yes	No	Partial	Yes	More than	Yes	More than	More than	Partial	More than	Partial
Unmet need for modern method of contraception																
% of unmarried women 15 - 49 with unmet need	16.9	8.3	6.2	21.7	10.2	5.5	12.2	10.1	4.6	14.9	9		10.2	12.8	11.7	4.4
% of married or in union women 15 - 49 with unmet need	39.0	12.1	36.8	39.7	18.1	16.5	21.6	16.7	36.9	26.8	18.2		14.9	26.9	22.4	11.6
Maternal mortality ratio (MMR)																
MMR 2020	222	186	217	547	240	566	392	381	84	127	215	3	127	238	135	357
Rate of reduction 2010 to 2020 %	40	-19	31	9	64	46	21	26	-53	61	55	63	42	51	50	42
Expected MMR at same rate reduction	134	222	149	498	86	308	309	283	128	50	96	1	74	117	68	206
Maternal mortality attributable to maternal abortion and miscarriage %	9.3	4.0%	11.9	10.1	7.7	No data	7.2	12.6	No data	13.8	8.8	No data	7.4	13.8	14.1	8.5
Guidelines																
Abortion care guidelines				Yes				Yes		Yes			Yes		Yes	Yes
Post-abortion care guidelines		Yes		Yes				Yes		Yes	Yes		Yes	Yes	Yes	Yes

Key for all tables Very good Medium Low Very low Insufficient data

Sources: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019. WHO, Global Abortion Policies Database: https://abortion-policies.srhr.org/, accessed 15 April 2020. https://www.un.org/development/desa/pd/data/family-planning-indicators, accessed 17 September 2024 Trends in Maternal Mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (2023), World Health Organization, Geneva https://data.worldbank.org/indicator/SH.STA.MMRT, accessed 17 September 2024

Matshalaga, N and N. Mehlo, Safe abortion policy provisions in the SADC region: Country responses, key barriers, main recommendations", (2022) South Africa Journal of Health;5(3):68-76. https://doi.org/10.7196/SHS.2022.v5.i3.133, accessed 26 August 2024.

WHO Africa, Country Abortion Health Profiles as of 2019 https://staging.afro.who.int/pt/node/13767, accessed 17 July 2024

Table 4.1 shows that:

- Policy barriers in most SADC countries prevent women from seeking safe abortions when they make this decision as a personal choice. 11 of 16 Member States in SADC have legislation that at least aligns to the Maputo Protocol (abortion authorised in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the physical or mental health of the woman or the life of the woman or fetus).
- Unmet need for contraception ranges from a low of 11.6% in Zimbabwe to a high of 39.3% in the DRC. Several countries have a high unmet need, indicating access to SRH services is not ideal. Rates of unintended pregnancies are likely to be higher in these countries.
- Most of SADC is far from achieving the global sustainable development goal (SDG) target of a maternal mortality ratio (MMR) of 70 per 100 000 live births. Currently only Seychelles has an MMR lower than 70. All other countries

range between 84 and 547. Unsafe abortion leads to high levels of ill health and mortality, which increases overall maternal mortality. The contribution of abortion and miscarriage to the MMR varies between 4% in Botswana and 14.1% in Zambia (though there are differing estimates, some higher).

My Body, My Choice march in Johannesburg, South Africa, on International Day for Safe Abortion held annually on 28 September. Photo: Shamiso Chigorimbo

Abortion in Seychelles

According to the National Bureau of Statistics in the **Seychelles**, the number of legal abortions has remained fairly consistently 400 to 500 per year from 2008 to 2023, while the number of live births has also been quite consistent with about 1500 per year in the same period.

The following table shows the number of abortions per different age groups in 2021 and 2023.

Table 4.2: Abortion by age groups in Seychelles 2021 and 2023

Age group	Number of abortions 2021	Number of abortions 2023	Percentage of all abortions 2023
10 - 14	5	5	1%
15 - 19	49	53	13%
20 - 39	233	317	78%
40 - 49		30	7%

Source: Gender Links with data from Uzice, A, July 2024 and 'Youth voice out concerns'[5]

[5] Uzice, A. 2024. Abortions in Seychelles: Majority recorded among 20-39-year-olds - citing financial issues, failed relationships. http://www.seychellesnewsagency.com/articles/20488/Abortions+in+Seychelles+Majority+recorded+among-+year-olds-+citingfinancial+issues%2C+failed+relationships and Youth voice out concerns on laws, regulations on reproductive health September 2022. https://www.nation.sc/articles/14869/youth-voice-out-concerns-on-laws-regulations-on-reproductive-health accessed 19 July 2024.

Speaking to the media, a specialist consultant of gynaecology and obstetrics at the Seychelles Hospital expressed that Seychelles must invest more in SRHR education, especially about the availability of free contraceptives to prevent unwanted pregnancies. It is believed that there are many unsafe and unrecorded abortions taking place in Seychelles.[6] The Ministry of Youth and civil society organisations are concerned about the rate of teenage pregnancy, illustrated in Table 4.3.

Table 4.3: Adolescent pregnancy and abortion in Seychelles 2014 to 2021

Year	Adolescent girls (12 - 19) population	Reported adolescent pregnancy	Adolescent pregnancy rate per 1000 girls	% of reported abortion among adolescent pregnancy
2014	4555	188	41.3	58.5%
2015	4497	194	43.1	36.1%
2016	4150	211	50.8	37.0%
2017	3595	204	56.7	45.6%
2018	3800	217	57.1	36.4%
2019	4110	237	57.7	29.5%
2020	4203	193	45.9	39.9%
2021	5936	212	35.7	25.5%

Source: 'Youth voice out concerns on laws, regulations on reproductive health'[7]

Normative frameworks

Maputo Protocol 14.1: State 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 fetus.

SADC SRHR Strategy 2018-2030: Rates of unplanned pregnancies and unsafe abortion are reduced. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6).
Barriers - including policy, cultural, social and economic - that serve as an impediment to the realisation of SRHR in the region removed (SDGs 5.1 and 5c).

SADC Protocol on Gender and Development: Article 26: State Parties shall, in line with the SADC Protocol on Health 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: (a) eliminate maternal mortality.

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.[8]

6 Uzice, A. Op Cit.
7 'Youth voice out concerns on laws, regulations on reproductive health', Seychelles Nation, 1 September 2022, https://www.nation.sc/articles/14869/youth-voice-out-concerns-on-laws-regulations-on-reproductive-health accessed 19 July 2024
8 UNECA African Regional Conference on Women Beijing+25 Political Declaration and key messages and priority actions on the implementation of the Beijing Declaration and Platform for Action https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf, accessed 27 May 2020

Nairobi Statement on ICPD25: Accelerating the Promise[9]

2. Zero unmet needs for family planning information and services, and universal availability of quality, accessible, affordable, and safe modern contraceptives.
3. Zero preventable 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.[10]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) was adopted by the African Union in 2003. It was the very first treaty anywhere in the world to recognise abortion, under certain conditions, as women's human right which they should enjoy without restriction or fear of being prosecuted. The SADC SRHR Strategy 2019 – 2030 calls for reduced rates of unsafe abortion. Other normative frameworks focus on the need for improved access to contraception to reduce the rate of unintended pregnancy which underlies most decisions to have an abortion. They also call for reduction in and even elimination of maternal mortality. Given the significant contribution of unsafe abortion to maternal mortality, it is clear that access to safe abortion is critical to achieve maternal mortality targets.

The Maputo Protocol turns 20

The status in SADC of signing and ratifying the Maputo Protocol, which turned 20 in 2023, is shown in the following table.

Table 4.4: Status of signing and ratification of the Maputo Protocol in SADC

Country	Signed	Ratified	Deposited
Angola	22/01/2007	30/08/2007	09/11/2007
Botswana	✗	✗	✗
Comoros	26/02/2004	18/03/2004	16/04/2004
Democratic Republic of Congo	05/12/2003	09/06/2008	09/02/2009
Eswatini	07/12/2004	05/10/2012	06/11/2012
Lesotho	27/02/2004	26/10/2004	05/11/2004
Madagascar	28/02/2004	No	
Malawi	19/12/2003	20/05/2005	29/06/2005
Mauritius	29/01/2005	16/ 06/2017	23/06/2017
Mozambique	15/12/2003	09/12/2005	30/12/2005
Namibia	09/12/2003	11/08/2004	26/08/2004
Seychelles	09/03/2006	08/03/2012	08/03/2012
South Africa	16/03/2004	17/12/2004	14/01/2005
Tanzania	05/11/2003	03/03/2007	05/09/2008
Zambia	03/08/2005	02/05/2006	07/06/2006
Zimbabwe	18/11/2003	14/04/2008	05/09/2008

Source: Gender Links with data from the Centre for Human Rights, University of Pretoria[11]

[9] https://www.nairobisummiticpd.org/content/icpd25-commitments, accessed 27 May 2020
[10] 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 31 May 2020
[11] Centre for Human Rights, University of Pretoria. Country Status. https://www.maputoprotocol.up.ac.za/countries/countries-table, accessed 15 August 2024.

When a state signs a protocol, it intends to adopt all the articles of the protocol and when it ratifies it has adopted all articles. To deposit a protocol means that a country formally submits its instrument of ratification or accession to the African Union's Secretary-General.

In SADC:

- 14 states are amongst the 44 that have ratified the Maputo Protocol.
- Madagascar is one of eight states in Africa that have signed but not ratified the Maputo Protocol.
- Botswana is one of three states in Africa have neither signed nor ratified the Maputo Protocol.

The following table provides an overview of legislation on abortion in SADC, categorised by whether legal provisions are more than, equal to, or less than required by the Maputo Protocol.

Table 4.5: Legal provisions regarding abortion in SADC[12]

Key:	Acronym		Acronym	
	ES	For economic or social reasons	WH	To preserve a woman's health
	FI	In cases of fetal impairment	Wmh	To preserve a woman's mental health
	In	In cases of incest	Wph	To preserve a woman's physical health
	WD	In cases of intellectual/cognitive disability of the woman	WL	To save a woman's life
	Ra	In case of rape	O	Other

Country	Law	Conditions under which an abortion may be granted										Gestational limits	Consent	Provided by	Penalties for an illegal abortion
		ES	FI	In	WD	Ra	WH	Wmh	Wph	WL	O				
Available on demand - Provisions are more than required by the Maputo Protocol															
South Africa	Choice of Termination of pregnancy Act (92/1996) amended in 2008[13]	Available on demand.										On demand to 13 weeks; under specific conditions, 13 to 20 weeks if her or fetus' life in danger or fetal anomalies, 20 weeks.	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 2019	Available on demand.										On demand to 12 weeks; in the case of incest, 16 weeks; in the case of fetal anomalies, 24 weeks.	Parental consent for minors; a health unit committee determines legal grounds.[14]	A certified practitioner at designated facilities.[15]	Yes, for the woman, provider, and person who helps a woman obtain abortion.
Available on socio-economic grounds - more than required by the Maputo Protocol															
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	✗	✗	✗	✗	✗		✗	✗	✗			If three medical practitioners agree in good faith, termination can be done at Victoria Hospital, Mahe		Imprisonment up to 14 years.
Zambia	Termination of Pregnancy Act, 1972, amended in 2005 and Penal Code	✗	✗				✗					Not specified.	Once three medical practitioners have agreed.		Seven years for person who administers; seven years for woman who administers own abortion.

[12] 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. Further refined with input from Centre for Reproductive Rights, The World's Abortion Laws. https://reproductiverights.org/maps/worlds-abortion-laws/ accessed 29 August 2024, and Centre for Reproductive Rights, Maputo Protocol at 20. https://reproductiverights.org/maputo-protocol-at-20/#:~:text=Twenty%20years%20ago%2C%20the%20African,rape%20and%20incest%3B%20when%20the accessed 29 August 2024. Also
[13] https://www.afro.who.int/publications/who-african-regions-countries-abortion-health-profiles accessed 17 July 2024.
[14] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[15] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique

Country	Law	Conditions under which an abortion may be granted										Gestational limits	Consent	Provided by	Penalties for an illegal abortion
		ES	FI	In	WD	Ra	WH	Wmh	Wph	WL	O				
Abortion available in specific circumstances - in compliance with the Maputo Protocol															
Angola	Penal Code 2019		✗					✗	✗	✗	✗	16 weeks to preserve health, fetal impairment no limit.	Parental consent for minors.	Licensed facility and one doctor.	Four to ten years in prison.
Botswana	Penal Code (Amendment) Act, 1991 - Section 160		✗	✗		✗		✗	✗	✗	✗	Termination must be performed before 16 weeks.[16]	Consent of parent or next of kin for minors; two doctors.	Licensed facility	Three years for procurement; seven years for aiding.
DRC	Act of Access to Maputo Protocol, 2018			✗		✗		✗	✗	✗	✗	Up to 14 weeks.	Parental consent for minors.		Yes, for the woman, provider, and person who helps a woman obtain abortion.
Eswatini	The Constitution, 2005		✗	✗		✗		✗	✗	✗	✗	Up to 14 weeks.	Two doctors.		Life imprisonment.
Lesotho	The Penal Code (2012)[17]		✗	✗		✗	✗					Up to 14 weeks.	By a registered medical professional, with written opinion of another registered medical professional.		A fine of M5000-M10 000 or imprisonment of up to three years.
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[18]		✗			✗		✗	✗	✗	✗	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 Sterilisation Act 2 of 1975		✗	✗	✗	✗		✗	✗	✗			Two medical practitioners must approve that the pregnancy is a risk.	Licensed facility.	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both.
Partial compliance with the Maputo Protocol															
Comoros	Comoros-Penal-Code-1995	Very serious medical reasons.										Not specified.	Certified in writing by at least two doctors	One doctor.	Imprisonment six months to two years & a fine of 15 000 to 100 000 francs.
Malawi	Penal Code	Only to save a woman's life.													14 years for having an abortion; three years for supplying instruments to conduct an abortion.
Tanzania	Penal Code 1981[19]	Only to save a woman's life.													Seven years for procurement; three years for suppliers.
Zimbabwe	Termination of Pregnancy Act 1977, Chapter 15:10[20]		✗	✗		✗			✗	✗	✗		A magistrate must grant permission.		Five years in prison and/or fine not exceeding $5000.
Not compliant with Maputo Protocol															
Madagascar	Reproductive Health and Family Planning Law 2017	Abortion is prohibited.													Not explicit, but death, forced labour or life are most severe punishments.

[16] http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions, https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm
[17] http://www.wipo.int/wipolex/en/text.jsp?file_id=238601
[18] https://lesotholii.org/ls/legislation/num-act/6
[19] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[20] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
Termination of Pregnancy Act, http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html

Table 4.5 summarises legislation regarding abortions across SADC and compliance with the Maputo Protocol. It shows that there is a range of compliance in SADC countries.

- *Beyond compliance:* South Africa and Mozambique (abortion on demand in the first trimester) and Seychelles and Zambia (abortion on socio-economic grounds) are among 12 states which have ratified the Maputo Protocol and permit abortion beyond the circumstances listed in the Protocol's abortion provisions.
- *Fully compliant:* Angola, DRC, Eswatini, Mauritius, Lesotho and Namibia are among 11 states which have ratified the Maputo Protocol and permit abortion in all cases listed in the Protocol's abortion provisions. (Botswana is also compliant but has not ratified the protocol).
- *Partially compliant:* Comoros, Malawi, Tanzania and Zimbabwe (which only allows abortion if a woman's physical health is in danger and does not mention mental health) are among 16 states which have ratified the Maputo Protocol and that permit abortion in some but not all of the cases listed in the Protocol's abortion provisions.
- *Non-compliant:* Four states which have ratified the Maputo Protocol directly contravene the protocol by prohibiting abortion under all circumstances. (Madagascar is one of 22 countries in the world which prohibits abortions under all circumstances. It has not ratified the protocol).

The impact of access to legal abortion on selected SRH indicators

It is sometimes suggested that making safe abortion more easily available will result in abortions being used as a form of family planning. Rhodes University and the United Nations Population Fund (UNFPA) reviewed data, as well as peer reviewed articles regarding impact on SRH indicators of broadening grounds under which abortion is legal, for 27 countries globally (including Eswatini, Lesotho, Mauritius and Mozambique in SADC) that enacted change to their abortion legislation between 2000 and 2021.[21]

Table 4.6 summarises their findings.

Table 4.6: Selected SRH indicators for countries that broadened conditions under which abortion is legal since 2000

Key:	Acronym	
	MMR	Maternal Mortality Ratio, per 100 000 live births
	CPR	Contraception Prevalence Rate %
	ASFR	Adolescent Specific Fertility Rates per 1000 girls aged 15 - 19
	CBR	Crude Birth Rate - live births per 1000 population.

Country	MMR 2000	MMR 2015	Relative change in MMR (%)	CPR 2000	CPR 2019	Relative change in CPR (%)	ASFR 2000-2005	ASFR 2015-2020	Ratio ASFR (2015-2020/ 2000-2005)	Ratio CBR (2015-2020/ 2000-2005) compared to ratio ASFR
Australia	7	6	14	59	58	**-1**	16.9	11.7	0.69	1.01 (0.69)
Benin	520	421	19	20	16	**-20**	115.7	86.1	0.74	0.88 (0.74
Bhutan	423	203	52	20	38	93	69.2	20.2	0.29	0.71 (0.29)
Central African Republic	1280	912	29	19	22	19	148.0	129.1	0.87	0.84 (0.87)
Chad	606	550	9	4	6	56	209.7	161.1	0.77	0.84 (0.77)
Chile	31	14	55	43	62	45	57.0	41.1	0.72	0.81 (0.72)
Colombia	94	53.8	43	53	63	20	95.5	66.7	0.70	0.72 (0.70)
Eritrea	1280	518	60	6	8	51	82.4	52.6	0.64	0.88 (0.64)
Eswatini	580	435	25	29	53	87	104.7	76.7	0.73	0.84 (0.73)
Ethiopia	1030	446	57	5	27	407	106.0	66.7	0.63	0.79 (0.63)
Iran	48	17	65	49	58	20	32.8	40.6	1.24	0.70 (1.24)
Kenya	708	353	50	29	46	57	106.0	66.7	0.63	0.74 (0.63)
Lesotho	614	574	7	27	52	89	87.9	92.7	1.05	0.87 (1.05)
Luxembourg	10	5	50	No data	No data	No data	11.7	4.7	0.40	0.86 (0.40)
Mali	836	620	26	8	16	96	186.3	169.1	0.91	0.86 (0.91)
Mauritius	59	73	**-24**	46	42	**-8**	36.5	25.7	0.70	0.77 (0.70)
Mozambique	798	318	60	14	24	69	181.2	148.6	0.82	0.85 (0.82)
Nepal	553	236	58	28	42	50	104.9	65.1	0.62	0.70 (0.62)
Niger	813	555	31	9	15	80	215.5	186.5	0.87	0.88 (0.87)
Portugal	10	9	10	59	61	3	20.2	8.4	0.42	0.72 (0.42)
Saint Lucia	86	115	**-34**	39	48	23	54.6	40.5	0.74	0.76 (0.74)
Somalia	1210	855	29	7	15	108	127.4	100.1	0.79	0.88 (0.79)
Spain	5	4	20	57	60	6	10.2	7.7	0.75	0.84 (0.75)
Switzerland	7	5	29	72	72	0	5.3	2.8	0.53	1.02 (0.53)
Thailand	43	38	12	52	56	7	41.9	44.9	1.07	0.77 (1.07)
Togo	489	398	19	19	23	21	93.6	89.1	0.95	0.84 (0.95)
Uruguay	26	18	31	51	57	11	64.7	58.7	0.91	0.88 (0.91)

Source: Gender Links adapted from Macleod, C.I., Speciale, A., & Delate, R. (2021)[22]

The findings support the thesis that expanding access to safe abortion generally leads to reduction in maternal mortality and is associated with increased contraception prevalence, meaning that abortion is not being used as a means of family planning. Further, there was greater reduction in adolescent fertility than in fertility of all women.

Specifically:

- There was reduction in the maternal mortality ratio (MMR) between 2000 and 2015 in 25 of the 27 countries, of between 0 and 25% in eight countries; between 25 and 50% in nine; and of over 50% in eight (including Mozambique which had reduction of 60%).

[22] Macleod, C.I., Speciale, A., & Delate, R. Op Cit whose data is from Center for Reproductive Rights; MMR source: WHO Global Health Observatory and United Nations

- The contraception prevalence rate (CPR) increased in 23 of the 27 countries, 10 saw an increase of between 0 and 25%; two increased between 25 and 50%; while 11 were over 50%. The CPR in Eswatini increased from 29% to 53%.
- Adolescent specific fertility rates (ASFR) reduced between the period 2000-2005 and the period 2015-2020 in 24 of the 27 countries. Further the Crude Birth Rate also decreased in most of the countries. The decrease in ASFR was more than that of the CBR in 20 of 27 countries, indicating that fertility decreased more in adolescents than in all women of reproductive age in these countries.

A movement for the total decriminalisation of abortion

In June 2022, the United States Supreme Court, in the Dobbs v. Jackson Women's Health Organisation decision, overturned the Roe v. Wade ruling, which had legalised abortion in the United States in 1973. The global environment post the Dobbs decision has been very unfriendly to any efforts to liberalise abortion legislation. This decision has emboldened anti-abortion groups like Family Watch International, which has a focus on Africa, to increase their attacks on possible legal change.[23]

Nonetheless, there is still a global call for complete decriminalisation of abortion founded in notions of gender equality and human dignity, and challenging legal restrictions to women's bodily autonomy. Legal campaigns for decriminalising abortion embrace criminal, health, constitutional and international law.[24]

The World Health Organisation (WHO) 2022 Abortion Care Guidelines calls for "the full decriminalisation of abortion."[25] 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.[26]

FIGO (the International Federation of Gynaecology and Obstetrics) 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 well-being of women and girls placed at the centre of their care."[27]

The African Union Special Rapporteur on the Rights of Women, Honourable Commissioner Maria Teresa Manuela, has called on States to *decriminalise abortion*[28] and empower women and girls to make their own choices about their reproductive health."[29]

[23] Roe fallout: Religious conservatives rally to curb abortion in Africa, Rédaction Africanews, 3 July 2023. https://www.africanews.com/2023/07/03/post-roe-fallout-religious-conservatives-rally-to-curb-abortion-in-africa/, accessed 30 June 2024.
[24] 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 30 June 2022.
[25] WHO (2022) Abortion care guidelines, Geneva, World Health Organization https://apps.who.int/iris/handle/10665/349316, accessed 21 June 2022
[26] Ibid
[27] nternational Federation of Gynecology and Obstetrics (2022) FIGO Calls for the Total Decriminalisation of Safe Abortion. Available from: www.figo.org/resources/figo statements/figo calls total-decriminalisation safe abortion
[28] Emphasis Gender Links.
[29] "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", African Commission on Human and Peoples' Rights, 28 September 2021 https://www.achpr.org/pressrelease/detail?id=602, accessed 6 July 2022.

Lobbying and advocacy in SADC for improved access to safe abortion

In June 2024, the chairperson of **Zimbabwe**'s Parliamentary Portfolio Committee on Health and Child Care, Hwange Central legislator Daniel Molokele, called for repealing the country's Termination of Pregnancy Act, saying the Termination of Pregnancy Act of 1977 is outdated, violates the current Constitution's promotion of gender equality and places women in dangerous situations.[30]

The Justice, Legal and Parliamentary Affairs Minister, Ziyambi Ziyambi, acknowledged the need for reforming the Termination of Pregnancy Act which only permits abortion in three specific scenarios:

- Continuation of the pregnancy endangers the woman's life or poses a serious threat of permanent impairment to her physical or mental health.
- Child may be born with serious physical or mental defects.
- Fetus was conceived as a result of rape or incest.

Molokele contends that safe abortion is available in Zimbabwe to those that can pay for it, but that poverty deprives many women of what should be a right. He further believes that if a revised Act is aligned to the Zimbabwe 2013 constitution, which has a robust Bill of Rights, it will be very different. He believes that each generation should move the process towards decriminalisation.[31]

Civil society organisations working on safe abortion in Zimbabwe, including VCSAF grantee Women's Action Group (WAG), have formed the Safe Abortion Coalition to coordinate advocacy. They are negotiating with the Minister of Health and Child Care, Dr. Douglas Mombeshora, regarding expanding the circumstances under which safe abortion can be accessed; complete review of the Termination of Pregnancy Act (1977); access to comprehensive quality SRHR services and increased budget allocation to the Ministry of Health and Childcare.[32]

There is ongoing advocacy for legal reform in **Malawi**. The case study below highlights work to mobilise communities to demand safe abortion.

Traditional leaders as champions for safe abortion in Malawi

In a bold step toward advancing reproductive health rights, VCSAF grantee the Malawi Human Rights Resource Centre (MHRRC), in collaboration with other civil society organisations (CSOs), conducted an impactful campaign in Kasungu, in Malawi's Central Region, on International Safe Abortion Day. This event, aired on national television, sparked critical discussions about the urgent need to enact the Termination of Pregnancy (ToP) Bill, which is crucial to address unsafe abortions and safeguard the reproductive rights of women and girls.

A panel discussion brought together influential stakeholders, traditional leaders, Members of Parliament, young people, service providers and members of CSOs. The discussion focussed on how the ToP Bill could address the widespread challenges faced by women and girls in accessing safe abortion services, which is essential for reducing maternal deaths and ensuring reproductive rights.

During the discussion, Traditional Authorities Lukwa and Njombwa passionately advocated

[30] Moyo, S. 'Lawmaker pushes for easier access to safe abortion", June 2024 https://www.chronicle.co.zw/lawmaker-pushes-for-easier-access-to-safe-abortion/#google_vignette
[31] Personal Communication, 7 August 2024.
[32] Masiyiwa, E. Presentation to the SADC Gender Day, 15 August 2024

for the passage of the ToP Bill. As respected leaders in their communities, they emphasised the critical need for Parliament to take immediate action. Both leaders highlighted how unsafe abortions continue to claim the lives of women, especially those from impoverished backgrounds who are forced to resort to unsafe methods due to lack of access to safe medical procedures.

Senior Chief Lukwa pointed out the glaring disparity in abortion access, noting, "The issue is that those with financial means can access safe abortion services because they can afford them, while those without money are forced into dangerous backstreet procedures, risking their lives."

Senior Chief Lukwa speaking on the panel discussion in Kusungu, Malawi on International Safe Abortion Day. Credit: Lyness Soko, MHRRC

Senior Chief Njombwa reinforced the urgent need for Parliament to act, stating that continuing to deny women access to safe abortion only deepens their vulnerability. He called for lawmakers to enact the ToP Bill, which could save the lives of many women and girls.

The panel included young people and women from the community. Many lamented the fact that women and girls continue to die from unsafe abortions, yet society, religious leaders and the law seem indifferent. One young woman shared her concerns, "We are dying, and it feels like no one cares. People hide behind religion and the law, but women and girls are raped every day, and some are forced to carry the pregnancies of their rapists. How is that justice?"


Honourable Dr. Ngwale, Chairperson of the Parliamentary Health Committee, speaking during the International Safe Abortion Day in Kasungu, Malawi. Credit: Lyness Soko, MHRRC

These powerful testimonies highlighted the real-life struggles faced by women and girls, who endure not only sexual violence but also the burden of carrying unwanted pregnancies resulting from rape. For them, the ToP Bill represents more than just a legal reform - it is a lifeline that could restore their dignity and protect their health.

Young people called for an end to the silence around sexual violence and unsafe abortions, urging Members of Parliament to listen to the lived experiences of survivors and take action to prevent more deaths.

Matthew Ngwale, Chairman of the Parliamentary Health Committee, attended the event. Ngwale committed to bringing the stalled Termination of Pregnancy Bill back to parliament and said he plans to initiate community consultations about the Bill.

Coverage in the national print media and on television sparked a national conversation on reproductive rights, amplifying the voices of women, young people, and traditional leaders who support enacting the ToP Bill. It reinforced the role of traditional leaders, Members of Parliament, and community stakeholders in the fight for reproductive justice. The collective call for the ToP Bill sends a strong message to lawmakers that the lives and rights of women and girls must be prioritised, ensuring that no one is left behind due to outdated laws and harmful social norms.

Source: MHRRC report

Chitete, S. "Chiefs demystify safe abortion," The Nation, Blantyre Malawi. 21 October 2024

Accessing abortion services available in the law

In all Member States many circumstances keep women from realising safe abortion rights that should be made possible in law. This includes in South Africa and Mozambique, which have the most liberal legislation. Some of these circumstances are:

- Limited knowledge or understanding of what is legally allowed and poor access to information among women, girls, their partners, health providers and legal practitioners.
- Lack of guidelines for the health sector to ensure they do provide what should be available. Many health facilities do not have the correct medicines or equipment, especially so in rural areas.
- Many laws have unreasonable requirements e.g. approval by two doctors in countries where doctors are few and far between, and especially not available in rural and other underserved areas.
- Delays, for instance in determining that a pregnancy was the result of rape or incest, which pushes pregnancies beyond the time limit which is allowed for an abortion.
- Stigma, rooted in moralistic religious, cultural and traditional gender norms.
- Attitudes of health professionals, and conscientious objection by health professionals.
- Poor social support for a woman to seek an abortion.
- Poverty and insufficient money to pay to access a safe abortion. This may include money for transport to get to a facility that provides abortions and, quite often, to go back to that facility if a woman or girl cannot receive the service when they initially go.

The following section of the chapter presents information from different countries of barriers for accessing safe abortion services that should be available under national laws, as well as action being taken and innovations introduced to ensure women and girls are able to access these services.

Operationalising legislation to improve access to abortion care in the DRC

Until 2018, the **DRC** had one of the most draconian laws against abortion of any nation while also curtailing access to contraceptives. Low levels of contraceptive prevalence and high levels of sexual violence in the ongoing conflict are two factors that contributed to high levels of unsafe abortions in the DRC. In 2017, Médecins Sans Frontières (MSF) reported that 13% of all abortion related complications they treated in the 75 countries where they work were in the DRC (2,800 cases).[33]

Although the DRC ratified the Maputo Protocol in 2008, it only nationalised the protocol's provisions in 2018 with publication in the *Journal officiel edition spécial du 5 Juin 2018* (National Gazette), enabling it to become the law of the land. Abortion is now legally allowed in the DRC through 14 weeks in cases of sexual assault, rape, incest, fetal abnormalities, and when continuing the pregnancy endangers the mental or physical health or life of the pregnant woman.

Independently of the process to have the Maputo Protocol gazetted, another process resulted in the passage of a Public Health Law also in 2018. This law allowed access to contraception for all persons of reproductive age and provided for legal abortion to preserve the life of the mother and in cases of fetal malformations. The provisions of the Public Health Law and Maputo Protocol were not the same, but DRC law provides that the provisions of international protocols take precedence over national law.[34]

In 2020, the Ministry of Health (MOH) developed standards and guidelines for woman-centred abortion care aligned to the WHO standards. The standards determine who may perform abortions, where they can be performed, what

[33] Glover, A L., JC Mulunda, P Akilimali, D Kayembe & JT Bertrand (2023) Expanding access to safe abortion in DRC: charting the path from decriminalisation to accessible care, Sexual and Reproductive Health Matters, 31:1, 2273893, DOI: 10.1080/26410397.2023.2273893 Accessed 20 July 2024
[34] Ibid

methods can be used and to whom abortion can be offered.

Though the gazetting of the Maputo Protocol should have provided an avenue for increased access to abortion care, a study in 2021 found that 19% of women in Kinshasa were unaware of the legal conditions for abortion.[35] Health providers are also unsure of the legal provisions and often lack skills in providing abortion care, as well as the necessary equipment or medication.

Misoprostol was on the essential medicine list and should have been available in hospitals to treat postpartum haemorrhage and manage post-abortion complications. However, a Service Provision Assessment (SPA) conducted in 2017 found that only 13.4% of DRC health facilities had misoprostol on hand.[36] The MOH has since authorised mifepristone-misoprostol medication abortions and added mifepristone to the essential medication list. Further, the MOH has authorised providers to give prescriptions for Mifepak (the combination package of mifepristone 200 mg and misoprostol 200 mcg tablets) that women can access in pharmacies. Medication abortion has significant potential to expand safe abortion care. NGOs, healthcare providers and some community agents can provide access to medication abortion through community facilities.

The 2017 SPA found that only one third of health facilities in the DRC were ready to provide safe abortion care and that readiness varied considerably between provinces. Since then, training curricula and tools such as guide sheets and wall posters for providers have been developed and disseminated. Clinical training in safe abortion care has been added to nursing and medical schools' curricula.

High levels of stigma, ostracisation and rejection towards both women who procure an abortion as well as those that provide abortions are still prevalent throughout the DRC.[37] It is difficult for women to access accurate information. The study in Kinshasa found that women valued confidentiality and therefore prioritised seeking information from a very small circle of trusted female relatives or friends. They sometimes entrusted their partners, who were able to seek information more widely, and rarely directly approached health care providers. Some partners shared information with the affected women, allowing them to make their own decisions. Others used the information to make decisions on behalf of their partners, thereby denying them the agency to make their own decisions. Women still often resort to unsafe abortions, which are more confidential, to avoid stigma.

Some of the recommendations to improve access to safe abortion care in the DRC are:

- Wide awareness campaigns for women, men, local authorities, religious authorities, traditional leaders and health providers on the current provisions of the law. The campaigns should include:
  - Risks of unsafe abortions.
  - Availability of post-abortion care and need to access this to save women's lives, without stigma.
  - Availability of legal reproductive health services, including abortion care, to reduce the risks.
  - Address stigmatisation of abortion.
  - Any minor's pregnancy is automatically eligible for safe abortion if the minor wishes it as sexual intercourse before the age of 18 is rape.
- Advocacy for further change of legal policies for abortion and sexuality based on a human rights perspective.
- Consider task shifting in the provision of legal abortion care, especially training pharmacists who are popular contact points for women.
- Improve service provision in health centres through:
  - Replacing use of sharp curettage with manual and electric vacuum aspirators.
  - Training health providers in provisions of the law, as well as safer medical abortion.
  - Improve collection of national statistics on provision of abortion care.

[35] Ngondo D, Karp C, Kayembe D, Basile KS, Moreau C, Akilimali P, et al. (2024) Abortion information-seeking experiences among women who obtained abortions in Kinshasa, DRC: Results from a qualitative study. PLOS Glob Public Health 4(2): e0002383. https://doi.org/10.1371/journal.pgph.0002383, accessed 20 July 2024.
[36] Glover at al. Op Cit.
[37] See for instance, Collective of Youth Organizations for Solidarity in the Democratic Republic of Congo (COJESKI-DRC), (5 April 2024). Public Debate on Reducing Abortion stigma in Goma. https://www.safeabortionwomensright.org/news/democratic-republic-of-congo-very-first-public-debate-on-reducing-abortion-stigma-in-goma/ accessed 20 July 2024.
Also Ngondo et al Op Cit.

Social change in Mozambique needed for legal changes to make a difference

At a national level, **Mozambique** has been a leader in reviewing legislation to make abortion care more available to girls and women. Review of the abortion law in 2014 was followed by revision of the outdated Penal Code in 2019. Legal abortions are allowed on demand in the first trimester (up to 12 weeks gestation). In cases of rape or incest abortions are legal to 16 weeks and until 24 weeks in cases of fetal anomaly. The law stipulates that abortions must be performed at designated facilities by qualified practitioners.[38] The Ministry of Health developed clinical guidelines on abortion and post-abortion care in 2017.

At local level, however, entrenched gender norms lead to deep stigma regarding abortions. This often deters women, and particularly unmarried, younger women, in rural areas where services are not as easily accessible and who have less accurate information, from accessing safe abortions. Thus, the number of unsafe abortions, with accompanying complications and mortality, is still high.

A study to assess adolescents', young women's, informal abortion providers', and other adult community members' knowledge, attitudes, practices, and preferences related to abortion, with a focus on gender values and norms found four major themes:[39]

1. *Gender norms and expectations put girls at increased risk of unintended pregnancy*. These norms are rooted in beliefs that a woman's primary role is procreation. Such norms promote child marriage and adolescent pregnancy within these marriages. They also limit girls' agency in negotiating safe sex with male partners and their agency to discuss access to contraception with their parents. Poor socio-economic situations may push girls into transactional sex, at times encouraged by their parents or caregivers, with limited protection from pregnancy or sexually transmitted infections.
2. *Gender norms and stigma around adolescent pregnancy affect pregnancy decisions.* Even while girls' role in procreation is valued, it is only valued in the context of marriage. There is enormous stigma against sexual activity and pregnancy outside of marriage. Some girls who become pregnant are afraid of disappointing their parents, or that their parents will insist they must marry the man. Others fear they will be rejected by family, not allowed to continue school, or be cut off from their faith community.
3. *Gender norms contribute to abortion stigma and influence choice of provider.* There is still considerable stigma associated with having an abortion. A general perception is that girls and young women that have abortions are "loose," with many partners, such that they do not know who the father of the child is. Health providers often exhibit stigmatising attitudes, and may publicly chastise young woman seeking an abortion for engaging in sex while young and unmarried. Fears of stigma encourage girls to seek abortions which will be secret, which often means an unsafe abortion, outside a health facility. For these girls social safety is more critical than medical safety.
4. *Men, family members, and others have a strong influence on pregnancy and abortion decision-making.* Some young women discuss the pregnancy with male partners. Many partners express that they are not able to care for a child or are already married and strongly encourage the girl to have an abortion, with some contributing the costs. Some girls also consult their parents or other female relatives, who may be supportive, especially when they are still studying, and assist them to access abortions.

[38] IPAS. March 26 2020. In recent penal code review Mozambique recognizes legal right to abortion. https://www.ipas.org/news/in-recent-penal-code-review-mozambique-recognizes-legal-right-to-abortion/ accessed 20 July 2024.
[39] Griffin, S.; Melo, M.d.; Picardo, J.J.; Sheehy, G.; Madsen, E.; Matine, J.; Dijkerman, S. The Role of Gender Norms in Shaping Adolescent Girls' and Young Women's Experiences of Pregnancy and Abortion in Mozambique. Adolescents 2023, 3, 343-365. https://doi.org/10.3390/adolescents3020024 accessed 20 July 2024.

The study concluded that legal change alone was not sufficient to ensure women access to safe abortion, social change is also needed. Accurate information, supportive healthcare providers and peer or family support are all critical enabling factors for the necessary social change. Further, programmes need to mobilise communities, including men, parents and community leaders, as well as health providers, to challenge current gender norms.

Supporting expanded access to abortion in Mozambique:

Several organisations, including IPAS, Pathfinder and MSF are supporting the Government of Mozambique to expand access to safe abortion. For instance, MSF runs clinics in Beira, in central Mozambique, focusing on the most marginalised women - adolescents and sex workers. Most of the abortions are medication abortions using a combination of misoprostol and mifepristone. Women take one pill at the clinic and the others at home. Women who access abortions from these clinics comment on the confidentiality and support from staff.[40]

As previously discussed in this chapter, abortions are legal in **South Africa** on request in the first trimester. The following case study illustrates how technology can be a powerful force to provide information around abortion services which are legally available, yet often socially difficult for marginalised women such as sex workers.

Harnessing technology to provide information to sex workers

GRIT (Gender Rights in Tech), formerly known as Kwanele - Bringing Women Justice, is a VCSAF grantee based in South Africa. The GRIT Mobile App was initially developed to assist women reporting violence, guiding women through the process of collecting essential evidence and throughout the reporting process, as well as court appearances. This app is now being refined for wider use, including related to abortion service information. In addition to the app, GRIT is developing an AI-assisted chatbot named Zuzi, designed with the persona of a friendly African Aunt.

One of the key workshops during Zuzi's development was run with sex workers to test, refine, and co-create the technology. This particular session focused on access to abortion services, as many sex workers expressed a need for reliable information and access to safe abortion options. Participants shared concerns about visiting formal providers due to anxiety over the procedure, fear of judgment related to their occupation, as well as of stigma and discrimination. These concerns often led to delays in seeking care, until they were beyond the safe period for accessing abortion services.

Through a participatory discussion, the GRIT team explored how the Zuzi chatbot could offer relevant advice and support, including options for self-managed abortions. While the response to at-home abortion was mixed, most participants agreed that Zuzi could make abortion services more accessible. They noted that being able to discuss their fears and receive unbiased information from Zuzi would make them more comfortable seeking safe, legal services.

Since the initial workshop, dataset collection has expanded, with further input from sex worker teams across three provinces. This data was critical in refining the chatbot and enhancing its functionality. It is crucial to conduct dataset collection with sex workers in South Africa to ensure that technology solutions, like the Zuzi chatbot, are informed by their unique experiences and needs. This makes the solutions more effective in addressing issues such as stigma, discrimination and access to safe services. The

[40] Rajaonary, M. (2023). Stories of safe abortion care in Mozambique Women share their diverse experiences with safe abortion care in the nation with one of the most liberal abortion laws in Africa. MSF. Mozambique. https://www.doctorswithoutborders.org/latest/stories-safe-abortion-care-mozambique accessed 21 July 2024.

ChatGBV is a chatbot simplifying access to information, resources, and assistance for GBV survivors navigating the justice system. Credit: GRIT

chatbot is currently in beta mode for additional testing and growth, with full deployment planned for the middle of 2025.

The GRIT app, however, is fully deployed and now has over 10,000 users, including sex workers from all of South Africa's nine provinces. Moving forward, GRIT plans to expand its training with sex workers nationwide, leveraging insights from the chatbot's development and the app's success to make the technology more inclusive. This initiative will also explore ways to enhance the reporting of incidents, including those involving police misconduct, to provide a more comprehensive and supportive platform for sex workers.

Source: GRIT (Kwanele) VCSAF Report, July 2024 with additional information

Review of the comprehensive abortion care guidelines

The Ministry of Health and Child Care with support from WHO, UNFPA, the Making Abortion Safe (MAS) programme, and other partners, finalised an expanded and updated third edition of the National Guidelines for Comprehensive Abortion Care (CAC) in **Zimbabwe**. These updated guidelines include the provisions of the current Termination of Pregnancy (ToP) Act and cover procedures to follow to provide abortion allowable under the Act (instances of unlawful sexual intercourse, specifically rape and incest; severe fetal abnormality; or danger to the mother's life). They also include updated information on post-abortion care.[41]

> Communities need to be aware of abortion services that can be offered at local health centres

Edinah Masiyiwa, director of WAG, a VCSAF grantee in Zimbabwe, said of the CAC guidelines, "Popularisation of the CAC guidelines by the Ministry of Health and Child Care and non-governmental organisations to communities must occur so that they are aware of the abortion services that can be offered at health centres. Awareness raising should also include the provisions of the current Termination of Pregnancy Act and highlight the gaps. There should be continuous information dissemination in communities to allow those who need abortion services to receive it. This way we will be able to fight the stigma associated with abortion."[42]

The MAS programme was supported by the Royal College of Obstetricians & Gynaecologists (RCOG) as a multi-country programme, of which only Zimbabwe was in SADC. In addition to supporting the guidelines, the programme supported research and sensitisation of health care providers and others, such as magistrates, on the provisions of the ToP Act.[43]

[41] Ministry of Health and Child Care (2022) National Guidelines for Comprehensive Abortion Care in Zimbabwe, Harare. MOHCC
[42] Masiyiwa, E. Hope on the horizon for Zimbabwe as health Ministry signs Comprehensive Abortion Guidelines, 10 January 2024, Health times. https://healthtimes.co.zw/2024/01/10/hope-on-the-horizon-for-zimbabwe-as-health-ministry-signs-comprehensive-abortion-care-guidelines/
[43] De Vries, I et al. 2024. RCOG Making Abortion Safe Project - final evaluation. Amsterdam, KIT Royal Tropical Institute.

The following case study is of an organisation in **Tanzania** that is engaging in public interest litigation on issues of abortion as one way to raise the issue nationally.

New commitment for SRHR public interest litigation

Sophia Sushi is the Executive Director and one of the founders of Teens Corridor, an organisation promoting adolescent sexual reproductive health and rights (SRHR), as well as a member of the Coalition of Women Human Rights Defenders (CWHRD). Sushi has a new perspective on advocacy for SRHR. Sushi is from the remote Mwanza region in the northern part of Tanzania, about 1000 kilometres from the capital city, Dar es Salaam.

Sophia Sushi. Credit: CWHRD

She says, "I now understand that there are challenges of service availability, accessibility, affordability, acceptability and quality. A large part of the government budget on SRHR comes from development partners, we need to create even larger movements from the grassroots level to advocate for SRHR issues including budget allocation and legal transformation."

Sushi is one of the WHRDs in Tanzania who have been engaged in the "Building vibrant repro rights movement in Tanzania" project, implemented by the Coalition for Women Human Rights Defenders with support from Gender Links, with funding from Amplify Change. The project aims to reduce discrimination, stigma and legal barriers for safe abortion and post-abortion services in Tanzania. It is working to building a joint sense of ownership over a common agenda that is inclusive and mutually understood, enhancing cross-generational feminist solidarity and knowledge transfer around selected SRHR issues in order to keep movements strong, active and alive.

Sushi participated in a training on public interest litigation, where she learned about using public interest litigation as an advocacy tool to address SRHR challenges facing women and girls in Tanzania. "I have been following public interest litigation cases, but I did not understand the whole process, such as the stages to follow in developing cases, and how to file cases in court," she said. "I have also been transformed in terms of existing myths and perception around SRHR"

She said that through participating in various activities, she now has a positive attitude towards advocacy on SRHR as a fundamental human rights issue. She committed to using the knowledge and skills to enhance advocacy on SRHR in her organisation, as well as sensitise her staff who have negative myths and perceptions about SRHR issues, particularly sensitive issues such as safe abortion. Sushi believes, "It is essential for Women Human Rights Defenders to start movements on SRHR at the grassroots level to advocate for legal transformation."

Source: Coalition for Women Human Rights Defenders report to Gender Links, October 2024

Unintended pregnancy, access to contraception and abortion: assessments in Botswana, Eswatini, Lesotho and Namibia

WHO and the UNFPA supported the Ministries of Health in Botswana, Eswatini, Lesotho and Namibia to engage in strategic assessments on unintended pregnancies, contraception, abortion, sexual and gender-based violence and HIV through the 2gether 4SRHR programme. Comparative analysis of the background papers developed in the four countries showed:[44]

- All have high abortion-related contribution to the MMR.
- All have good but not optimal contraceptive prevalence.
- All have restricted access to abortion, but it is available in certain circumstances (in compliance with the Maputo Protocol) and is not completely banned.
- Women, in general, as well as other key stakeholders, including men, have poor knowledge of contraception that is available, including emergency contraception, as well as the provisions of the abortion laws.
- Only Botswana has post-abortion care guidelines, and none have guidelines for the abortions allowed in the law.

The study in **Eswatini** examined unintended pregnancy as well as abortions.[45] The Ministry recognised that progress to address maternal mortality was not on track to achieve the SDG target. The study found that a key driver of unintended pregnancy was poor provision of SRHR programmes for certain populations. This includes people with disability; in and out of school adolescents, where the adolescent unmet need for contraception is double that of the general population; and men, whose knowledge of contraception methods, availability and use was very poor.

A key driver of unintended pregnancy was poor provision of SRHR programmes

This was coupled with sub-optimal awareness about contraceptive availability in general. It was also exacerbated by lengthy stock outs of contraceptives at public facilities, as well as poor use of opportunities to engage with women in post-natal or post abortion care about contraception. Other drivers were poverty which drove women into transactional or commercial sex, without adequate protection, and rampant gender-based violence.

The study noted that the constitution of Eswatini allows abortion under certain constrained circumstances, including to preserve the life, physical and mental health of the woman; when the pregnancy is the result of incest or rape; and in cases of fetal abnormalities. However, neither the general public nor health professionals are aware of these provisions. Further, the constitution requires two doctors to agree and to be present for the termination. These conditions are difficult to provide, and many determinations of rape take so long that the pregnancy has advanced beyond the allowed gestational period for a legal abortion. Furthermore, many women and girls seek abortions for other reasons, particularly poverty and the inability to care for a child; when the paternity of the child is in doubt or a father denies responsibility for the pregnancy; or to be able to continue with her education. As a result, many women still seek clandestine abortions, many of which are unsafe. Methods used include misoprostol, which is widely available on the black market, inserting a foreign object into the vagina, various traditional concoctions and going to South Africa where abortion is legal.

The study reported that women of all ages accessed abortions, but few came to health facilities for post-abortion care as they believed that they would be reported to the police and face imprisonment. It is believed that those that do access health care have serious complications, and they report spontaneous miscarriage. Health care workers decried the lack of post-abortion care guidelines.

[44] Macleod, C. I., Reuvers, M., Reynolds, J. H., Lavelanet, A., & Delate, R. (2023). Comparative situational analysis of comprehensive abortion care in four Southern African countries. Global Public Health, 18(1). https://doi.org/10.1080/17441692.2023.2217442 https://www.tandfonline.com/doi/full/10.1080/17441692.2023.2217442#d1e1999 Accessed 8 September 2024.

[45] Ministry of Health (2023). Strategic Assessment on Unintended Pregnancies, Contraception and Post Abortion Care 2023. Mbabane, Eswatini. Ministry of Health.

The **Botswana** assessment of unintended pregnancy, access to contraception and unsafe abortion was conducted in 2020[46] and has been followed by discussion and deliberation throughout the country. Similar to Eswatini, there is sub-optimal uptake of contraception, with an emphasis on long-acting reversible contraceptives (LARCs) which are implants or intrauterine devices. Comprehensive sexuality education (CSE) is not taught as well as it could be. There is poor community awareness of contraception which is available and of the legislation on abortion (with the general perception being that all abortion is banned).

There is suboptimal awareness and uptake of available contraception

Health workers need guidance and training on safe abortion as well as on insertion of contraceptive implants and intrauterine devices. GBV is rife and there is need for community dialogue to address this scourge, as well as support for survivors. There are extremely high levels of stigma in relation to sexuality, contraception and abortion.

The most common methods of clandestine abortion are: cytotec (misoprostol) which is readily available on the black market; insertion of objects (feathers, pen cartridges, straws, etc), traditional medicine taken orally or placed in the vagina.

The recommendations are to:

- Expand access to contraception by improving supply and information to girls, women, men and the general population.
- Increase uptake of services through broad awareness and discussion about contraception and abortion to address the low levels of awareness and the stigma.
- Have wide discussions and community dialogue to reduce GBV.

Though legislation allows for abortion in certain circumstances, specific situations must often be argued in the courts and within twelve weeks of the first trimester. The following case study is of a situation in Lesotho that was successfully argued in court.

Test court case to access abortion care available within the law in Lesotho

She-Hive Association, a VCSAF grantee in Lesotho, persisted until a court order was granted by the Children's Court in 2024 allowing the termination of a sixteen-year-old girl's pregnancy. Lesotho's Penal Code of 2010 allows abortion in compliance with the provisions of the Maputo Protocol, including to prevent significant harm to the health of the pregnant person. In most cases this refers to physical health. However, in this instance it was a mental health issue, which is not easy to prove due to the subjective and intangible nature of mental health conditions. Though physical health conditions often have obvious signs, mental health struggles typically require more nuanced evidence and evaluations. Eventually, the court order was issued just before the end of the first trimester, which was in time to conduct the legal termination. The girl was first referred to She-Hive by her aunt in March 2024. The aunt was concerned that the girl was being abused by her paternal grandfather with whom she lived, as the aunt was abused by her own father and had a child by him. She came to She-Hive because she said she did not want her niece to go through the same nightmare. The girl's mother passed on when she was only three months old, and her father is working in South Africa. She-Hive's investigations found that she was being abused and arranged for her to be removed and placed

[46] Rakareng, T. et al. Assessment of unintended pregnancies, contraception, and abortion in Botswana. Int J Gynecol Obstet. 2024;164(Suppl. 1):51-60. DOI: 10.1002/ijgo.15336

in the Department of Gender's emergency shelter, to receive psychosocial support (PSS) while the grandfather was prosecuted. While at the centre, she was impregnated by a security guard. As the girl said that sex with the guard was consensual, the Child and Gender Protection Unit denied the initial She-Hive request for the pregnancy to be terminated.

She-Hive's psychosocial team assessed that the sex was in the context of a trauma bond (when a deep attachment develops from a cycle of physical and/or emotional abuse. Trauma bonds most commonly develop in romantic relationships, and leaving these relationships can be very hard). They therefore pursued the case and took it up in court. This resulted in the issuance of the court order for termination.

She-Hive approached the Department of Social Development seeking a social grant for the young girl. The Ministry of Home Affairs needed family members to write a letter asking for their assistance to issue the girl with a birth certificate or granting She-Hive permission to apply on her behalf. Most family members were afraid to sign the letter, because they did not want to appear to be siding with the young girl against the prosecuted grandfather. The children's welfare section of the Department of Social Development is now seeking a court order granting issuance of the birth registration documents. She-Hive and Social Development are also trying to find a long-term shelter where the girl will live. The family is so afraid of the grandfather that none of them wants to be associated with the girl.

Source: She-Hive Association presentation to SADC Gender Day, 15 August 2024, with updates.

Situation in Namibia regarding legislation and practice

There has been on-going debate and discussion about review of the **Namibia**n legislation on abortion since 1996 when the first minister of Health and Social Services introduced a bill to oppose the Abortion and Sterilization Act of 1975, inherited from apartheid-era South Africa.[47] The intention in 1996 was to make abortion available on demand within a specified time period. This bill was opposed and did not pass. Recently there has been further debate and discussion following the tabling in 2020 of a petition with 63 000 signatures calling for review. However, there is no timetable for when parliament will resume debate on the issue.

In the meantime, there are continuing media stories of unwanted babies being "dumped" with the police acknowledging 234 of these between 2016 and 2022. There is media coverage of back street abortions, most of which are unsafe. There are also now stories of women who fly, when they can afford it, or take a long bus trip to neighbouring South Africa to access safe abortions.[48]

Supporting abortion providers in South Africa

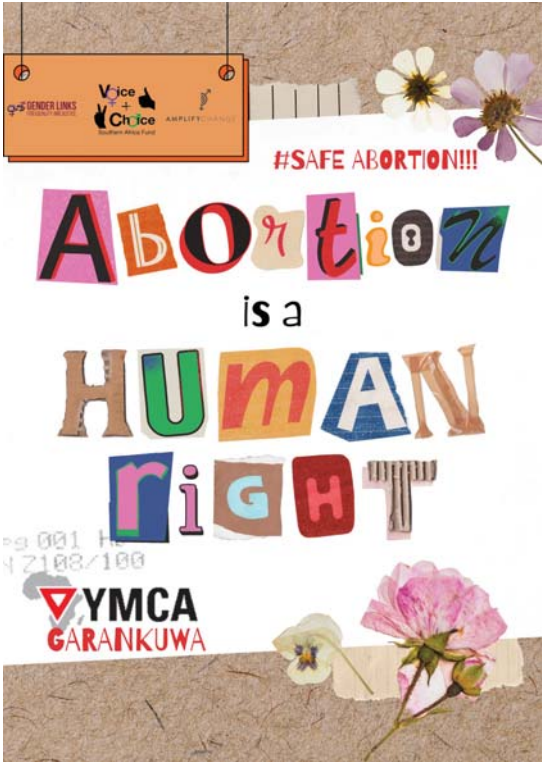
Research conducted by the SRJC, a VCSAF grantee in **South Africa**, found that abortion providers in South Africa experienced low levels of support from the Department of Health at district, provincial or national level. This includes poor supervision, provision of necessary equipment and medication, continuing training or recognition. Abortion providers also receive low levels of collegial support and mentorship. At the same time, abortion providers experience

[47] Rauna Namukwambi, R, L. Sheehama, Justice EK. Sheehama, H N. Nakambale. 2023, Exploring Women's Perspectives on Abortion Legalization in Namibia: Insights from Residents of Gereres, Keetmanshoop. medRxiv preprint doi: https://doi.org/10.1101/2023.07.20.23292972 accessed 22 July 2024
[48] 'Women are risking their lives': Abortion reform debate splits Namibian opinion, News 24, 29 May 2023 https://www.news24.com/news24/africa/news/women-are-risking-their-lives-abortion-reform-debate-splits-namibian-opinion-20230529, accessed 24 July, 2024

high levels of societal stigma and facility-based discrimination. This situation leads to isolation and burn out with poor levels of service provision. However, the providers see themselves as champions for women's reproductive rights. When the official services are struggling, illegal backstreet operators mushroom and flourish.

The research recommended that government should:

- Enhance public sector SRH services and invest more in services and staff development.
- Improve alignment of legislation and policy to ensure that requisite materials and support is available.
- Foster collaboration and development of support networks to combat stigma and make accurate information about the law as well as services available.[49]



Poster advocating for Safe Abortion by VCSAF grantee, YMCA Garankuwa, near Pretoria, South Africa. Credit: YMCA Garankuwa

Exercising agency to access safer options

Women are exercising agency, within the means available to them, to find safer abortion options. This includes traveling to South Africa where abortion is legal, which is discussed in the case study below. It also includes accessing medication abortion, which may be legal and safe or is also available on the black market with variable levels of safety.

Women are finding ways to make abortion safer - travelling to South Africa or accessing medication abortion

Abortion services provided in South Africa to clients from other SADC countries

The Sexual and Reproductive Justice Coalition (SRJC), a VCSAF grantee, is collaborating with Gender Links and SAASA to survey abortion providers in South Africa. The goal is to collect information and collaborate with and support providers to improve services. Consolidated data from this survey is being used to advocate for greater access to safe choice of termination of pregnancy, including through this Barometer. The SRJC conducted a rapid survey amongst a network of abortion providers that the SRJC works with in South Africa.

[49] Rucell, J. Presentation to the SADC Gender Day meeting, 15 August 2024

The survey had 30 responses within the first month. The respondents were from:
- Limpopo (11.37%)
- Gauteng (8.27%)
- Western Cape (5.17%)
- KwaZulu Natal (3.10%)
- Mpumalanga (3.10%)

The abortion providers were:
- Midwife (17)
- Registered Nurse (10)
- Medical Doctor (2)
- Other - Online information service provider (1)

Preliminary findings show that 60% of surveyed providers are based at a public clinic or hospital and 37% at a private facility, while one respondent is providing information. In terms of abortion services, 26 provide first-trimester surgical abortions; 25 first-trimester medication abortions; six second-trimester surgical abortions; and five support self-managed abortions. All providers also offer contraception counselling and various SRHR services - 25 provide treatment for STIs and 24 counselling, testing for HIV and referral for ARV access.

The research shows that women from most SADC countries, and beyond, seek abortion services in South Africa, one of only two countries in SADC where abortion is legal on demand.

Abortions were provided to people from:

Country from which clients come	Number of providers that see clients from this country
South Africa (my province)	28
South Africa (another province)	14
Zimbabwe	11
Lesotho	9
Mozambique	8
Malawi	7
Eswatini	7
Botswana	5
Others	4
Nigeria	4
Namibia	4
DRC	3
Zambia	1
Angola	1

Providers based in Gauteng reported seeing 480 clients from other countries in the last quarter, Limpopo 104 clients, Western Cape 60 clients, Mpumalanga 15 and KwaZulu Natal three. A total 528 clients from other countries were seen in public facilities while 104 were in private facilities.

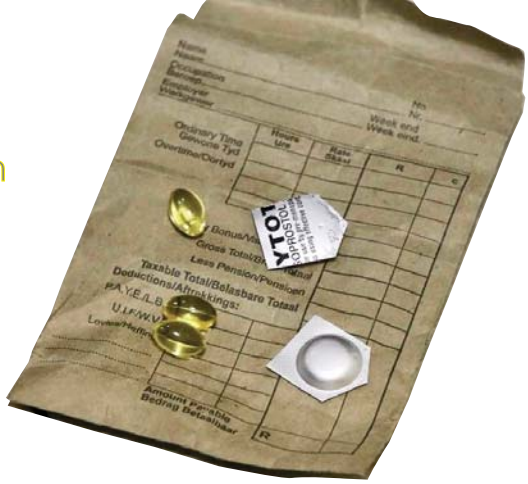
These results underscore that women who have decided to have an abortion will find a way to do so. Women who can afford it, will travel to South Africa from neighbouring countries, and even farther afield, to access safe abortion. This raises the question of why such services are not available to them and to the many other women who cannot afford to travel, within their own countries.

Source: SRJC presentation to SADC Gender Day, 15 August 2024

Increased access to medication abortion

Use of misoprostol for abortions 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.

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 referral services if they need or desire it.



Abortion Pills, the common name medical abortion using mifepristone and misoprostol to end a pregnancy. Credit: Keletso Serowe

Support from national associations of obstetricians and gynaecologists

The Livingstone Safe Abortion Care Charter was drafted at a learning and sharing meeting of national associations of obstetricians and gynaecologists, convened by FIGO. The charter was signed by the Presidents of 12 National Associations of Obstetricians and Gynaecologists,[50] including Malawi, Mozambique and Zambia in SADC, in January 2023.[51]

The Charter reaffirms the commitment of obstetric and gynaecological societies to strengthen access to safe abortion care for women and girls, including self-managed abortion care. This includes creating enabling environments within which health systems function and health care professionals are empowered to meet the needs and entitlements of women and girls. The signatories pledged to leverage clinical expertise and resources to address the scale of unsafe abortion in Africa through advocacy and addressing stigma. They also pledged to advocate for decriminalising abortion care and urging their governments to regulate it like any other health care provision.

The Self-Management of Abortion (SMA) project (2023 to 2024) was a collaboration between FIGO and the **Zambia** Association of Gynaecologists & Obstetricians (ZAGO).[52] The project aimed to identify and remove barriers to self-managed abortion in the country. It worked with 30 healthcare facilities in ten districts of three provinces.

The project developed training curricula, a reference manual for self-managed medical abortion (SMA), protocols and job aids to support health care professionals. These are available for use in other health facilities and districts. It raised awareness of and created demand for SRH including SMA through radio programmes and working with youth advocates and community health volunteers.

The project promoted a culture of openness and acceptance to create an enabling environment for women and girls to seek safe abortion care without fear. It raised awareness about the legal framework on abortion in Zambia as many people did not know that abortion is legal in the country, and that self-managed abortion is an option.

Though the pilot project has ended, the health-care facilities are continuing to provide SMA and ZAGO is working with the Ministry of Health to

[50] Benin, Burkina Faso, Cameroon, Cote d'Ivoire Kenya Mali, Mozambique, Rwanda, Uganda, Zambia. Ethiopia, Malawi.
[51] FIGO, Livingstone Safe Abortion Care Charte https://www.figo.org/resources/figo-statements/livingstone-safe-abortion-care-charter
[52] Removing barriers to access Safe Abortion through Self-Management Zambia https://www.figo.org/news/removing-barriers-access-safe-abortion-through-self-management-zambia accessed 22 July 2024. and
The Long Lasting Impact of the Self-Management Abortion Project https://www.figo.org/news/long-lasting-impact-self-management-abortion-project accessed 23 September 2024

integrate SMA within existing repro-ductive health services. This involves training more healthcare providers, raising awareness about safe abortion and strengthening monitoring and evaluation.

The WHO multi-country survey on abortion (MCS-A) studied post abortion care provided to 15 671 women at 210 facilities in 11 sub-Saharan African countries (including DRC, Malawi and Mozambique in SADC) in 2017 - 18.[53] The study found that the most common complications were different forms of bleeding or haemorrhage which suggested that more women may be accessing medication abortion. There were: 2.6% severe maternal outcomes, 7% potentially life-threatening complications, 58.2% with moderate complications and 32.4% with mild complications. Women with lower educational achievement (no education or primary) were more likely to experience potentially life-threatening complications. Factors associated with severe abortion-related complications were being single, having a prior pregnancy and late gestational age (over 13 weeks).

Only 20% of the women who participated in an exit interview admitted to inducing an abortion. The most common methods reported were misoprostol (54.3%), other medicines either orally or vaginally (40.5%) and procedures that cleared out contents from the uterus (38.7%). However, 18.7% reported using herbs, anti-malarial drugs, bleach, gasoline or detergents and 14.3% reported using traditional abdominal massage. The study concluded that more women seem to be accessing safer medical abortion. However, they may not have full information about expected complications and when they need to seek medical intervention.

About one tenth of the women reported accessing information on social media or the internet, indicating potential to utilise social media to share information to more women and thus reduce the burden on both the women and the health care system. The high percentage still using unsafe approaches, with tragic results, is indicative of a continuing gap in access to safer methods.

There is need for correct information about dosages and timing of medication abortion

Availability of misoprostol: A qualitative study conducted in Dar es Salaam, in a context of severely constrained legal avenues for safe abortion,[54] found that misoprostol was widely available through formal and informal pharmacies and could quite easily be purchased without a prescription. The WHO issued guidelines for the use of misoprostol alone for abortion in 2012. "Miso," as the drug is commonly known in Dar es Salaam, is heat stable, cheaper and a more available drug than mifepristone. With good quality drugs and correct usage, it is 85-90% effective. The WHO stresses the need for post abortion care in instances such as incomplete abortion. Other methods known to have been used for unsafe abortions include concentrated teas, washing detergents, wood ashes, anti-microbial drugs in high doses and uterine insertion of sharp objects. Medical practitioners have also made surgical abortions available.

The study identified three main themes:

- "Miso is common" - known, widely accessible and in demand.
- "It's your secret" - using misoprostol for an abortion from a pharmacy is more private, simple and safe, which was valued by women.
- "It's a business" - respondents viewed many suppliers to be opportunistic, who provided poor information and resulted in incomplete abortions. There were real concerns about the quality of the misoprostol that is available and the poor advice about dosage and when to take the pills. The study found that even many health care professionals did not have accurate information about dosage. Thus, many girls and women purchase and take fewer tablets than is recommended or at incorrect time intervals.

[53] Qureshi Z, Mehrtash H, Kouanda S, et al. Understanding abortion-related complications in health facilities: results from WHO multicountry survey on abortion (MCS-A) across 11 sub-Saharan African countries. BMJ Global Health 2021;6:e003702. doi:10.1136/bmjgh-2020-003702. Accessed 8 Sept 2024. The 11 countries included in the study are: Benin, Burkina Faso, Chad, DRC, Ghana. Kenya, Malawi, Mozambique, Niger, Nigeria, Uganda

[54] Solheima I.H et al (2020) Beyond the law: Misoprostol and medical abortion in Dar es Salaam, Tanzania. Social Science & Medicine 245 (2020) 112676 https://doi.org/10.1016/j.socscimed.2019.112676

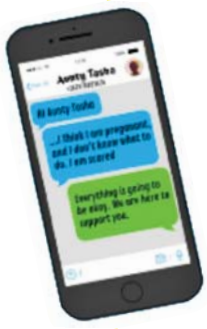
The MAMA (Mobilising Activists around Medical Abortion) Network

MAMA is a feminist network and movement of 67 grassroots member organisations in 21 countries (including DRC, Malawi, South Africa, Tanzania and Zambia in SADC) that promotes the potential of self-managed abortion. MAMA trains activists, disseminates information, facilitates access to abortion pills and creates conditions for women and pregnant people to safely self-manage their abortions.[55] There are three MAMA affiliated hotlines in SADC:[56]

Aunty Sissy Hotline

24 hours a day,
7 days a week in
English and Chichewa
Hotline numbers:
0987 873 001 or
0884 678 303

Aunty Tasha is an e-service platform in Zambia.



Toll free line: 0213 325 325
WhatsApp line: 0955 325 325
Email: info@auntytasha.com
Instagram: @auntytashahotline
Twitter: @Aunty_Tasha
Facebook:
https://www.facebook.com/pages/category/Local-Service/Aunty-Tasha-Hotline-105138391207162/

Tantine Marthe - DRC

The line is open 24 hours a day, 7 days a week.
Numbers: (+243) 89 87 92 002, (+243) 99 66 55 418, (+243) 82 84 02 772
Auntie Marthe is based in Uvira, South Kivu and covers the provinces of South Kivu, North Kivu, Tanganyika and Maniema.

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.

Most countries provide some access to post abortion care

My body, my choice art display in South Africa. Credit: Thato Phakela

[55] The MAMA Network. https://mamanetwork.org/ accessed 19 October 2024
[56] Help lines. https://mamanetwork.org/helplines/ accessed 19 October 2024

Table 4.7: Abortion/post-abortion guidelines and policies for SADC Member States

Country	Abortion/ post-abortion guidelines	Any related policies and/or guidelines
Angola	N	Angola Medical Ethics Code 2000; National List of Essential Medicines, 2021
Botswana	Y	Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines
Comoros	N	Essential Medicines List, 2014
DRC	Y	Comprehensive Abortion Care Guidelines, 2020; Essential Medicines List 2020
Eswatini	N	National Policy on Sexual and Reproductive Health 2005; Standard Treatment Guidelines and Essential Medicines List of Common Medical Conditions
Lesotho	N	Lesotho Essential Medicines List 2005
Madagascar	N	Health Code 2011; Reproductive Health Norms and Procedures 2006; List of Medications 2014; List of Medications 2014; National Family Planning Policy 2008-2012
Malawi	Y	Standards and Guidelines for Comprehensive Abortion Care, 2020; National Reproductive Health Service Delivery Guidelines, 2019; Malawi Standard Treatment Guidelines 2015;
Mauritius	N	Medical Council Act, 1999
Mozambique	Y	Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007
Namibia	N	Namibia Essential Medicines List; Namibia Standard Treatment Guidelines 2011 - First ed
Seychelles	N	Termination of Pregnancy Act; Seychelles List of Basic Essential Medicines Ministry of Health 2010
South Africa	Y	National Guideline for Implementation of Choice on Termination of Pregnancy Act, 2019; South Africa Standard Treatment Guidelines and Essential Medicines List, 2020
Tanzania	Y	Comprehensive Post-Abortion Care Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List, 2017
Zambia	Y	Zambia Standards and Guidelines for Comprehensive Abortion Care 2017; Register of Marketing Authorisations, 2015; Standard Treatment Guidelines, Essential Medicines List and Essential Laboratory Supplies
Zimbabwe	Y	National Guidelines for Comprehensive Abortion Care in Zimbabwe, 2022; Essential Medicines List and Standard Treatment Guidelines for Zimbabwe, 2011; Register for Approved Human Medicines, 2015

Source: Matshalaga, N and N. Mehlo,[57] updated by the Global Abortion Policy Database[58]

The **Zimbabwe** National Comprehensive Abortion Care Guidelines highlight the following challenges with post-abortion care in the country, identified by a study conducted in 2016:[59]

- Many women experiencing complications from unsafe abortion or miscarriage face delays in obtaining post-abortion care. On average, nearly two full days elapse between experiencing complications and receiving completed treatment. Common reasons for delays include lack of money, lack of transportation and distance to a health facility.
- Post-abortion care is not offered at most primary health centres, which are the facilities most accessible to rural women. Nearly half of post-abortion care patients had to seek care at more than one facility to get complete treatment.
- One-fifth of public facilities asked women to pay for post-abortion care prior to treatment, causing delays in treatment, even though these facilities are supposed to provide the service at no cost.
- A substantial proportion of first trimester post-abortion cases were treated using surgical procedures not recommended by WHO or national guidelines for this type of care. These procedures are more expensive and carry greater risk for further complications than medically recommended methods such as manual vacuum aspiration and use of recommended medicines such as misoprostol, mifepristone and letrozole.

[57] Matshalaga, N and N. Mehlo Op Cit
[58] WHO, Global Abortion Policy Database, https://abortion-policies.srhr.org/, accessed 20 September 2024
[59] Ministry of Health and Child Care (2022) Op Cit.

Next steps

Key recommendations include:

- Governments of SADC Member States must stop "hiding behind religion and law," and start caring about the high levels of unsafe abortion and resulting high maternal mortality and act to address these. Assessments done in Botswana, Eswatini, Lesotho and Namibia show that Governments need to act with urgency to address unintended pregnancy, particularly amongst younger women. This can be achieved by adopting progressive ASRHR policies which enable young people to access youth friendly SRHR information and services, including:
  - Increasing investment in high quality comprehensive sexuality education for 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 and address stock outs of contraceptives.
  - Improving protection from sexual violence and work with communities to build safe communities that do not tolerate gender norms which perpetuate such violence.
- SADC Member states must pay attention to calls for decriminalisation of abortion from the AU Special Rapporteur on the Rights of Women, WHO and FIGO and critically consider why they believe it is necessary to keep such laws which are denying girls and women their right to self-determination over their own bodies. Governments and activists should be wary of the activities of well-funded groups that are opposed to abortion.
- Governments and activists should promote access to self-managed medication abortion as a safe method of abortion care. This must be accompanied by accurate information regarding dosage and timing, with access to post abortion care if needed.
- Community leaders and health care professionals need to pay attention to overwhelming levels of stigma that prevent young and other marginalised women from accessing SRH services. There should be community dialogues to engage traditional and religious leaders, men, women and all stakeholders to challenge gender norms that promote stigma.
- To save lives, all SADC Member States should provide post-abortion care to all women with abortion complications and train staff in the safest and most up to date approaches as well as provide the necessary equipment and drugs.
- Activists and political leaders need to work together to share information about the conditions under which abortion can be accessed and ensure that both those that need abortions and those that provide abortions are aware of these circumstances.
- There is an urgent need for much better data to inform decision-making on the issue of abortion. Data needs to include access (or lack of access) to contraception by all who need it (not only women and men in marriage); rate of legal abortions performed; demand for abortion and reason for the demand; rate of illegal abortions performed; and rate of unsafe abortions.

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https://apps.who.int/iris/handle/10665/349316. License: CC BY-NC-SA 3.0 IGO, accessed 21 June 2022.

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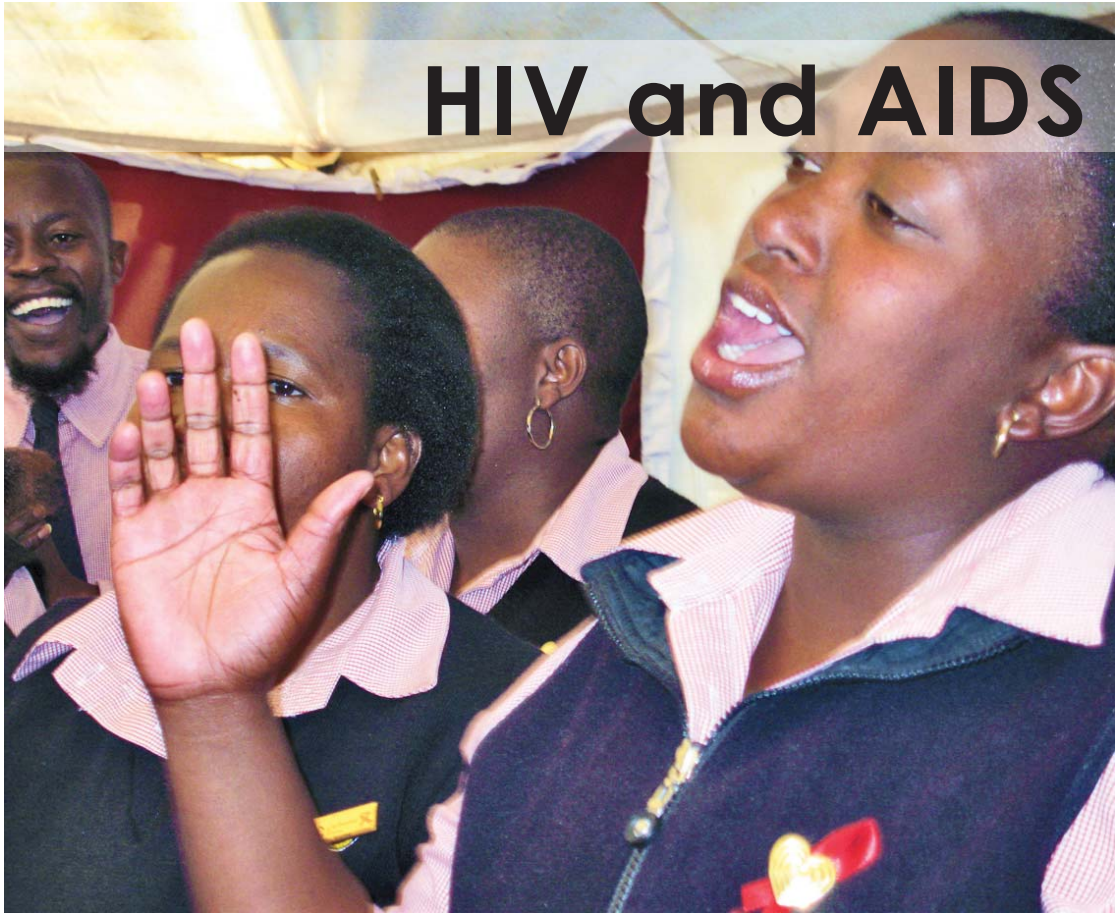
HIV and AIDS

5



Let us Grow, an organisation offering peer education, care and support in Orange Farm, Johannesburg, South Africa. Photo: Colleen Lowe Morna

Key points

- SADC is still the world's most heavily HIV-affected region. While prevalence is slowly declining, six SADC countries are the only in the world still with HIV prevalence rates over 10%.
- Prevalence is higher in women than in men in most SADC countries. Prevalence in women is two times higher in South Africa and Tanzania and 2.2 times higher in Angola. HIV prevalence in young women is about double young men in eight countries.
- The surge of HIV and AIDS in Madagascar calls attention to the necessity of inclusive, people-centred prevention in all countries as HIV can rapidly spread beyond a relatively contained epidemic in key populations. Investment is urgently needed for HIV and AIDS control in Madagascar where only 22% of people living with HIV (PLHIV) know their status and 22% are on antiretrovirals (ARVs)[1].
- SADC must continue crucial steps to eradicate AIDS as a public health threat by 2030. In the absence of an HIV cure or vaccine, SADC must prepare to sustain extensive treatment programmes for many years beyond 2030.
- There is continued emphasis on prevention, especially of vertical transmission to children, for adolescent girls and young women, adolescent boys and young men, and key populations.
- Investment by funders into condoms, critical in HIV prevention, has declined. Thus, highly subsidised condoms are no longer as readily available.
- Botswana and Namibia are the only countries in Africa, and with high HIV prevalence, to achieve the status of being on the path towards elimination of vertical transmission to children (or fewer than 750 new HIV infections per 100 000 births).[2]
- All SADC countries have an HIV and AIDS policy, strategy or plan, most of which are up to date and revised regularly.

[1] UNAIDS, 2023 data, https://aidsinfo.unaids.org/, accessed 25 July 2024
[2] UNAIDS (2024), The Urgency of Now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS.

- Globally, Eswatini, Botswana, Zimbabwe, Zambia and Malawi are amongst the nine countries that have already achieved the 95-95-95 targets. Lesotho and Namibia are amongst the ten countries on track to achieve the targets by 2025. Women are still more likely than men to have been tested, accessed ARV therapy, and achieved viral suppression in most countries (global target is 95% of all people living with HIV know their status, 95% of those diagnosed with HIV access antiretroviral treatment (or 90% of all PLHIV) and 95% of those on ARVs (or 86% of all PLHIV) achieve viral suppression).
- With health systems straining to provide prevention, testing, access to treatment and supporting treatment adherence for large numbers of PLHIV, community organisations are being called on for prevention, treatment and care services.
- Access to treatment continues to lag for children.

Introduction

We cannot partly end a pandemic. Leaders can end AIDS as a public health threat only by overcoming it everywhere, for everyone

In the Foreword to the 2024 Global AIDS Update, "The Urgency of Now: AIDS at a Crossroads," Winnie Byanyima, UNAIDS Executive Director, reminds us that "we cannot partly end a pandemic. Leaders can end AIDS as a public health threat only by overcoming it everywhere, for everyone."[3] She calls on global leaders to invest as required in their responses and reform policies to ensure prevention, testing, treatment and adherence for everyone, especially key populations and those most at risk. SADC has made tremendous progress, with impressive achievements in many countries. The plea highlighted in this chapter from medical researchers and professionals in Madagascar, where HIV and AIDS appear to be surging, is a reminder that no country can afford complacency.

SADC, which accounts for 5% of the world's overall population,[4] has 17.4 million people living with HIV or 43.6% of the world's total. HIV prevalence rates are declining in many countries, with Eswatini now the only country in the world with a national adult prevalence rate over 20% and prevalence in women over 30%. However, progress is uneven. Prevalence rates vary between some districts within countries and remain much higher than national averages among key populations, such as sex workers. Access to treatment continues to lag for children. Declines in prevalence and new infections are the result of substantial investment and wide-ranging prevention and treatment programmes. Until there is a vaccine or a cure for HIV, these programmes must be sustained for many years beyond 2030.

The road to ending HIV and AIDS as a public health threat has many twists and turns. COVID 19 had major negative impacts on HIV services. MPox, which is spreading in the DRC and has been declared a public health emergency of international concern, is more common and has more severe outcomes in people living with HIV (PLHIV). Evidence shows that the impact of climate change - drought and floods which are displacing populations and disrupting livelihoods - also negatively affects access to HIV services and treatment adherence.[5]

The Global AIDS Strategy 2021 - 2026 sets out the following interlinked priorities:

- Strategic Priority 1: maximise 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.

[3] UNAIDS (2024) The Urgency of Now. Op Cit.
[4] https://data.worldbank.org/indicator/SP.POP.TOTL, accessed 15 October 2024
[5] See for instance, Orievulu, K. et al. Economic, social and demographic impacts of drought on treatment adherence among people living with HIV in rural South Africa: A qualitative analysis. Climate Risk Management 36 (2022) 100423. https://doi.org/10.1016/j.crm.2022.100423.

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 optimise 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.
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 synergise 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, urbanisation and human settlements: cities and human settlements as centres for economic growth, education, innovation, positive social change and sustainable development to close programmatic gaps in the HIV response.

The Global AIDS Strategy outlines three specific targets to address inequalities that contribute to HIV vulnerability (referred to as the three tens). These are:

- 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.

The Global AIDS Strategy sets specific targets related to treatment, the 95 - 95 -95 goals:

- 95% of all people living with HIV know their status.
- 95% of those diagnosed with HIV access antiretroviral treatment (which equates to 90% of all people living with HIV).
- 95% of those on ARVs (or 86% of all people living with HIV) achieve viral suppression.

The strategy has other specific targets, some of which are referenced throughout this chapter.

Table 5.1: Key HIV data, 2023

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
HIV prevalence																
Overall prevalence adults aged 15 - 49 (%)	1,5	16,6	<0,1	0,17	25,1	18,5	0,4	6,7	1,5	11,5	9,7		17,1	3,8	9,8	10,5
Women who are HIV positive as a % of total	69	63	50	64	64	62	47	63	37	65	64		65	69	62	63
Women aged 15 to 49 HIV prevalence rate	2,0	21,4	<0,1	0,8	30,3	23,5	0,4	8,4	1,1	14,5	12,7		22,6	5,1	12,6	13
Men aged 15 to 49 HIV prevalence rate	0,9	11,8	<0,1	0,5	19,9	13,4	0,4	4,8	1,8	8,3	6,6		11,5	2,5	6,9	7,9
Prevalence women/prevalence men	2,2	1,8	1	1,6	1,5	1,8	1	1,8	0,6	1,8	1,9		2	2	1,8	1,7
HIV prevalence among young women (15-24)	0,7	5,6	<0,1	0,3	7,5	6,6	0,1	2,4	0,4	6,2	5		8,4	1,4	3,7	4
HIV prevalence among young men (15-24)	0,3	2,7	<0,1	0,2	4,5	3	<0,1	1,5	0,4	2,4	2,2		3,8	0,7	1,5	2,8
Prevalence young women/prevalence young men	2,3	2,1	1	1,5	1,7	2,2	1	1,6	1	2,6	2,3		2,2	2	2,5	1,4
Prevention																
Sex workers																
HIV prevalence (%)			0,5	7,5	60,8			49,9	18,2		29,9		62,3			40,2
% sex workers who received at least 2 HIV prevention interventions (PIs) in past 3 mons	51	90		38	9	31		68		57			34	90		79
Men who have sex with men																
HIV prevalence (%)	3	32	1,8	7,1	27,2	26		12,9			7,8		29,7		22,8	8,1
% of all MSM who received at least 2 HIV PIs in the past 3 months				39	29		28	65		31	33		10	4	5	26
Proportion of people who know their status																
Percent of people living with HIV who know their HIV status	72	97	69	87	>98	95	22	95	24	89	93		95	87	96	95
Condom use at last high-risk sex																
Condom use at last high-risk sex - women	32,1		29,3	22,6	53,9	77,7	4,1	49,9		36,7	65,9		60,0	21,7	34,5	64,7
Condom use at last high-risk sex - men	63,3		62,1	30,7	67,3	81,3	9,1	76,3		46,5	82,2		68,4	43,4	53,5	82,0
Elimination of vertical transmission																
Coverage of pregnant women who receive ARV to prevent vertical transmission (PVT) (%)	89	>98		40	>98	93	27	96	79	90	92		97	>98	93	88
Vertical transmission rate (%)	13,5	1,2		25,5	3,3	5		6,2		9,7	5,3		2,4	8	6,6	7,4
Knowledge																
Comprehensive knowledge of HIV and AIDS	32,3	47,2	20,4	36,8	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	36,4	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	41,5	50,9	30,9	25,5	44,3	30	30,2	51,1		45,6	46,7	40,6	46,6
Treatment - Antiretroviral therapy																
% of those living with HIV who are on ART	50	95	65	86	93	89	22	91	24	86	89		77	82	95	95
Women aged 15 and over receiving ART (%)	56	98	65	90	>98	93	29	94	21	91	92		81	84	97	98
Men aged 15 and over receiving ART (%)	43	90	70	91	82	83	17	89	26	80	87		71	79	94	91
Children aged 0 to 14 receiving ART (%)		66		44	>98	80	7	72	68	67	58		63	66	71	63
Viral suppression																
Percent of people living with HIV who have suppressed viral loads (86% indicates achievement of 95-95-95)	27	94	45	77	92	88		87	18	77	87		71	79	92	91

Source: Gender Links computations and UNAIDS 2023 data, https://aidsinfo.unaids.org, accessed 25 July 2024

Table 5.1, compared with previous Barometer reports, shows:

- HIV prevalence rates in Southern Africa continue to fall slowly, yet remain the highest in the world. Eswatini, Lesotho, Botswana, Mozambique, South Africa and Zimbabwe are the only countries worldwide with prevalence rates above 10%.
- In Southern Africa, HIV is still predominantly a heterosexually driven pandemic. In Comoros, Mauritius and Seychelles transmission is mainly within key populations.
- Prevalence in women is higher than in men; two times higher in South Africa and Tanzania and 2.2 times higher in Angola. This is indicative of an expanding epidemic, as prevalence increases rapidly in women before it begins to increase in men.
- There is a particularly marked difference between young women and young men. Prevalence is more than two times higher in young women than young men in Angola, Botswana, Lesotho, Mozambique, Namibia, South Africa, Tanzania and Zambia.
- People who know their HIV status is over 95% in Botswana, Eswatini, Lesotho, Malawi, South Africa, Zambia and Zimbabwe. It is over 80% in DRC, Mozambique, Namibia and Tanzania, but as low as 22% in Madagascar and only 24% in Mauritius.
- Coverage of adults and children living with HIV receiving antiretroviral therapy (ART) has improved dramatically, but ranges from 22% in Madagascar and 24% in Mauritius to over 90% in Botswana, Eswatini, Malawi, Zambia and Zimbabwe. There is a major disparity between coverage of adults on ART and children on ART, with notable exceptions being Eswatini and Mauritius where a higher percentage of children than adults living with HIV are on ART. This reflects low priority accorded to addressing the challenges of testing and treatment for children.
- Women are generally much more likely than men to be on ART. The exceptions are Comoros, DRC 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 where this data exists, there is good progress. Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe all have suppression rates over 86%.
- Coverage of ART for elimination of vertical (mother-to-child) transmission is improving rapidly. Where coverage is over 95% the vertical transmission rate is falling - South Africa's achievement of 2.4% transmission is notable given the size of the South African epidemic. However, vertical transmission rates remain unacceptably high in Angola (14%) and DRC (26%) - pointing to the need for continued vigorous efforts.

HIV prevalence

As stated in the introduction, HIV prevalence in SADC continues to decline, but still has the highest prevalence rates in the world (the only countries with prevalence over 10%).

Umguza Rural District Council HIV and STI IEC material, Harare, Zimbabwe.
Photo: Tapiwa Zvaraya

Figure 5.1: HIV prevalence in SADC, 2023

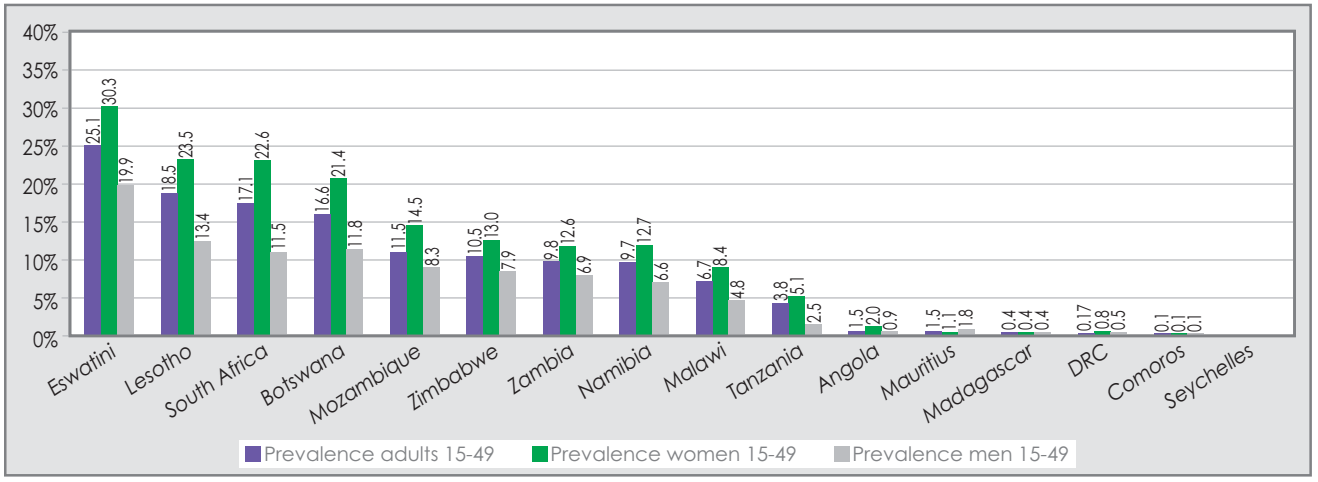


Table 5.2: HIV prevalence in SADC, 2023

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	25,1	30,3	19,9	7,5	4,5	1,67
Lesotho	18,5	23,5	13,4	6,6	3	2,20
South Africa	17,1	22,6	11,5	8,4	3,8	2,21
Botswana	16,6	21,4	11,8	5,6	2,7	2,07
Mozambique	11,5	14,5	8,3	6,2	2,4	2,58
Zimbabwe	10,5	13	7,9	4	2,8	1,43
Zambia	9,8	12,6	6,9	3,7	1,5	2,47
Namibia	9,7	12,7	6,6	5	2,2	2,27
Malawi	6,7	8,4	4,8	2,4	1,5	1,60
Tanzania	3,8	5,1	2,5	1,4	0,7	2,00
Angola	1,5	2	0,9	0,7	0,3	2,33
Mauritius	1,5	1,1	1,8	0,4	0,4	1,00
Madagascar	0,4	0,4	0,4	0,1	0,1	1,00
DRC	0,17	0,8	0,5	0,3	0,2	1,50
Comoros	0,1	0,1	0,1	0,1	0,1	1,00
Seychelles						

Key for all tables Very good Medium Low Very low Insufficient data

Source: Gender Links compiled from UNAIDS 2023 Data [6]

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

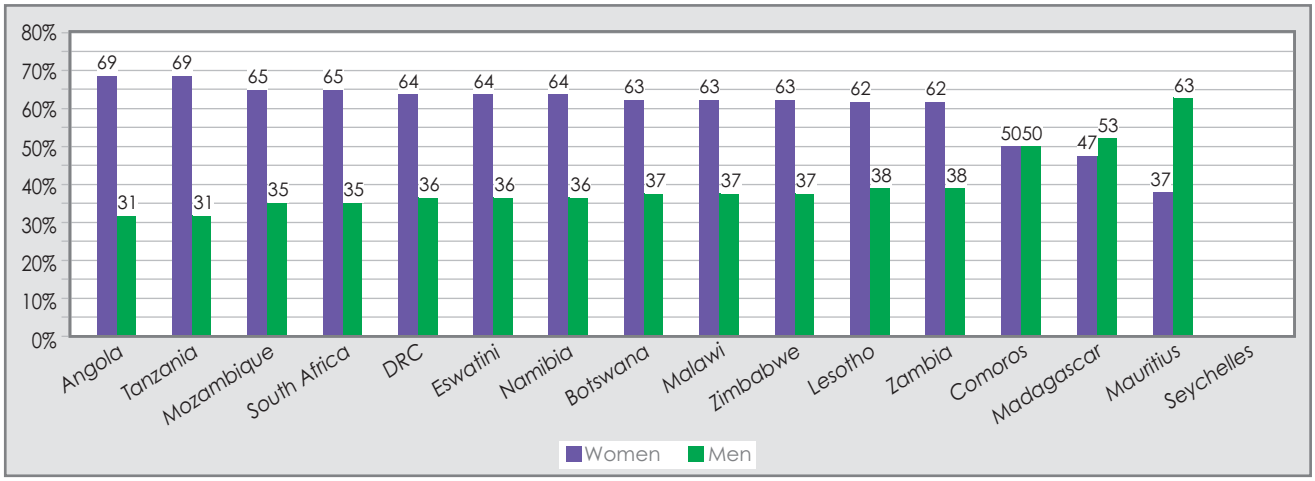
- Adult prevalence rates range from 0.1% in Comoros to 25.1% in Eswatini.
- Eswatini is the only country, in SADC and globally, with over 20% prevalence rate and prevalence in women over 30% (shaded in orange in the table). Lesotho, South Africa, Botswana, Mozambique and Zimbabwe have adult prevalence rates between 10 and 20% (shaded in yellow in the table).
- Most of SADC has a generalised, heterosexual pandemic with higher prevalence in women than in men. Prevalence rates are particularly higher for young women compared to young men. Though the difference is narrowing, in Mozambique, Zambia, Angola, Namibia, South Africa, Lesotho, Botswana and Tanzania HIV prevalence in young women is more than double that in young men.

[6] UNAIDS 2023 Data https://aidsinfo.unaids.org/, accessed 25 July 2024

- The island nations have epidemics largely present in key populations. The epidemic in Madagascar is becoming generalised and prevalence is now about equal in women and in men, where previously it was higher in men. Prevalence in young women in Mauritius is now equal to young men, though overall prevalence is still higher in men.
- Seychelles, whose population is only about 120 000 and which has a very low prevalence rate, has small total numbers of people living with HIV. Thus, very little data is available, and Seychelles is missing from much of the discussion in this chapter. Comoros and Mauritius have larger populations and more data available.

HIV disproportionality affects women in SADC and globally. Societal factors, such as gender inequalities, social norms, and gender-based violence contribute to women's HIV risk.

Figure 5.2: Proportion of Women and Men Living with HIV %, 2023



Source: Gender Links, derived from UNAIDS 2023 Data

Figure 5.2 shows the proportions of women and men for all people living with HIV across SADC. In most countries, the proportion of women living with HIV is higher. The highest proportions are in Angola and Tanzania. Madagascar and Mauritius are the only member states with more men than women living with HIV.

Only in Madagascar and Mauritius are there more men than women living with HIV

HIV transition metrics

Various indicators have been suggested to track progress of the transition from "high HIV incidence and mortality to low levels of transmission and effectively managed care." Some of these are:

[7] Amon JJ, Eba P, Sprague L, Edwards O, Beyrer C. Defining rights-based indicators for HIV epidemic transition. PLoS Med. 2018 Dec 21;15(12): e1002720. doi: 10.1371/journal.pmed.1002720. PMID: 30576316; PMCID: PMC6303010 accessed 27 September 2024.
[8] AVAC. Metrics for Epidemic Transition: A glossary. https://avac.org/wp-content/uploads/2023/03/AR2019_Metrics-Epidemic-Transition.pdf, accessed 27 September 2024.

Change in incidence of HIV (new infections) compared to a baseline of 2010[8]
HIV incidence is the estimated number of new HIV infections.

Table 5.3: Change in incidence of HIV (new infections per 1000 uninfected adults) 2010 - 2023

Country	2010	2023	Rate of reduction
Zimbabwe	11,07	1,48	87%
Malawi	6,9	0,98	86%
Lesotho	22,34	5,02	78%
Zambia	9,21	2,09	77%
Botswana	13,14	3,15	76%
Eswatini	31,98	7,69	76%
South Africa	13,12	4,55	65%
DRC	0,72	0,25	65%
Mozambique	12,66	4,49	65%
Angola	1,88	0,72	62%
Namibia	9,14	3,75	59%
Tanzania	3,46	1,55	55%
Comoros	0,03	0,02	33%
Mauritius	1,28	1,47	-15%
Madagascar			

Source: Gender Links compiled from UNAIDS 2023 Data

As table 5.3 shows, the change (reduction) in incidence from 2010 to 2023 varies from negative change in Mauritius where incidence has increased to 87% reduction in Zimbabwe. Many SADC countries have made tremendous progress in reducing incidence (new infections) from very high levels. Zimbabwe, Malawi, Lesotho, Zambia, Botswana and Eswatini have made the most significant progress. No data was available for Madagascar.

Change in AIDS-related deaths compared to a baseline of 2010
AIDS-related deaths are deaths caused by the advanced stage of HIV infection, acquired immuno-deficiency syndrome, commonly referred to as AIDS.

Table 5.4: Decrease in AIDS-related deaths compared to 2010

Country	2010	2023	Rate of decrease
DRC	43000	11000	74%
Malawi	37000	11000	70%
South Africa	150000	50000	67%
Zimbabwe	57000	19000	67%
Tanzania	53000	25000	53%
Eswatini	6200	3100	50%
Lesotho	7600	4000	47%
Mozambique	71000	44000	38%
Botswana	6100	3900	36%
Namibia	5500	3700	33%
Zambia	25000	17000	32%
Angola	15000	12000	20%
Comoros	100	100	0%
Mauritius	1000	1000	0%
Madagascar	1200	3100	-158%
SADC Total	**478700**	**207900**	-57%
SADC as % of Global	**27%**	**33%**	
Global Total	**1800000**	**630000**	65%

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.4 shows that the rate of decrease in AIDS-related deaths varies, from a negative figure for Madagascar where the death rate is increasing to 74% in DRC. Malawi, South Africa and Zimbabwe have high rates of decrease as well. Several countries, such as Botswana, had quite steep decreases in AIDS-related deaths between 2000 and 2010.

The incidence to prevalence ratio

This comprises two desirable outcomes: long, healthy lives for people living with HIV and a rapid reduction in new infections. The metric assumes average life expectancy of 30 years after a person acquires HIV infection. The calculations show that the HIV and 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 5.5: Incidence: Prevalence ratio

Country	2000	2010	2020	2023
Botswana	9,64	4,19	1,76	1,15
Zimbabwe	7,76	6,1	1,47	1,19
Malawi	10,22	6,19	1,74	1,23
Zambia	10,15	6,76	3,35	1,69
Lesotho	12,04	6,61	2,31	1,78
Eswatini	15,74	7,66	2,09	1,83
South Africa	14,54	5,85	2,24	1,9
Namibia	13,56	6,18	2,63	2,65
Tanzania	9,29	7,27	4,44	3,13
Mozambique	17,9	10,25	5,43	3,33
DRC	9,04	7,03	4,93	4,02
Comoros	15,09	11,71	5,85	4,79
Angola	14,46	11,18	5,95	4,86
Mauritius	30,48	10,31	8,4	8,64
Madagascar				

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.5 shows that the ratio of incidence to prevalence has continued to improve. Eight countries now have ratios below three and Tanzania and Mozambique are very close.

Overall indices can mask inequalities in access especially for young people and key populations

Overall indices such as the three above can mask inequalities in access to services, especially for young people and key populations. The prevention section of this chapter outlines progress, as well as numerous bottlenecks remaining for expanding services to key populations.

Comprehensive evaluation of progress on transition needs to consider four categories of indicators:

1. Coverage of evidence-based prevention and treatment interventions for all.
2. Incidence / prevalence data as well as AIDS related deaths.
3. Stigma and discrimination.
4. Legal and policy environment.

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 1take 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.

All SADC member states have established agencies to lead coordination and champion efforts to prevent and manage HIV and AIDS.

All SADC countries have HIV strategies or plans and national coordinating agencies

These have different names, such as National AIDS Councils (NACs), National AIDS Coordinating Agency and so on. These agencies work closely with UNAIDS, which brings together the efforts and resources of 11 United Nations system organisations to unite the world against AIDS. The agencies lead the development and review of national policies and strategies, using data to target high impact solutions.

Table 5.6: Most recent HIV and AIDS policy or strategy in SADC countries

Country	Most recent HIV strategy	Year
Angola	National Strategic Plan for HIV/AIDS, Viral Hepatitis and Sexually Transmitted Infections (STIs) (PEN VII 2024-2028)	2024
Eswatini	Eswatini National Multisectoral HIV and AIDS Strategic Framework (NSF) 2024-2028	2024
Botswana	The Botswana HIV Prevention Road Map 2023-2025	2023
South Africa	The National Strategic Plan for HIV, TB and STI's - 2023-2028	2023
Namibia	National Strategic Framework for HIV and AIDS Response in Namibia 2023/24 to 2027/28	2023
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
Seychelles	National Strategic Plan for HIV, AIDS & Viral Hepatitis 2019 - 2023	2019
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
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
Mauritius	Republic of Mauritius. National HIV Action Plan 2023 - 2027	2017
Madagascar	Plan Strategique National de Reponse aux Infections Sexuellement Transmissibles et au SIDA a Madagascar 2013 - 2017	2014
Comoros	National Strategic Plan 2011 - 2015	2011

Source: Gender Links internet search

Table 5.6 shows that all SADC countries have an HIV and AIDS policy, strategy or plan. The majority are up to date and revised regularly, which is indicative of the attention being paid to HIV in SADC.

Prevention: Elimination of vertical (mother-to-child) transmission

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

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

The gap in testing, treatment and viral suppression between children and adults is one of the widest gaps in the HIV response. Launched in July 2022, The Global Alliance to End AIDS in Children (Global Alliance) brings together 12 African countries, of which seven (Angola, DRC, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) are in SADC. The Global Alliance is mobilising leadership, funding and action to end AIDS in children as a public health threat

by 2030. The 12 countries together accounted for 66% of new HIV infections and 64% of AIDS-related deaths among children globally in 2021.[9]

Challenges with HIV testing and treatment for children have resulted in glaring gaps in coverage of care

The many challenges for providing care to young children have contributed to this gap. One challenge is early testing for newborn children. The commonly used adult HIV test shows the presence of antibodies produced in reaction to HIV. As babies are born with antibodies from their mother, such tests at birth detect these maternal antibodies and do not signify if the baby has acquired infection or not. Newborns require more complex PCR (Polymerase Chain Reaction) tests which detect HIV's genetic material, or RNA. PCR tests are now becoming available where newborn babies receive care, enabling tests to be done and results received immediately. Otherwise, babies require subsequent tests, meaning having to wait and potentially return to the health centre several times before valid results are obtainable. Furthermore, as HIV infection in children is very low in rich nations, there is very little economic incentive for pharmaceutical companies to invest in developing paediatric treatment. Paediatric treatment is more complex than adult formulations as it must change as the child grows, and it is more practical in liquid form as children struggle to swallow tablets.

The Global Alliance focuses on four pillars:[10]

1. Accessible testing, optimised treatment and comprehensive care for infants, children and adolescents living with and exposed to HIV.
2. Closing the treatment gap for pregnant and breastfeeding girls and women living with HIV and optimising continuity of treatment.
3. Preventing and detecting new HIV infections among pregnant and breastfeeding adolescent girls and women.
4. Addressing rights, gender equality and the social and structural barriers that hinder access to services.

Pillar one of the strategy centres on testing, treatment and care for infants, children and adolescents living with and exposed to HIV. This section focuses on infants and children below the age of 14, adolescents are addressed in other sections of this chapter.

Table 5.7: New infections in children 0 - 14

Country	1990	2000	2010	2021	2023	Decline 2021 - 2023
Mozambique	4 400	27 000	34 000	16 000	12 000	25%
South Africa	9 300	72 000	28 000	8 300	6 500	22%
DRC	12 000	15 000	10 000	6 600	6 300	5%
Tanzania	22 000	31 000	13 000	7 500	5 700	24%
Zimbabwe	25 000	33 000	17 000	4 700	3 600	23%
Angola	2 200	5 300	7 400	4 100	3 200	22%
Zambia	13 000	20 000	9 900	4 500	3 200	29%
Malawi	16 000	27 000	15 000	2 500	2 100	16%
Eswatini	200	3 100	1 300	500	500	0%
Lesotho	1 000	4 300	1 800	1 000	500	50%
Namibia	1 000	4 000	1 600	500	500	0%
Botswana	1 500	4 800	1 400	200	100	50%
Mauritius	100	100	100	100	100	0%
Comoros						
Madagascar						
Total SADC	**107 700**	**246 600**	**140 500**	**56 500**	**44 300**	**22%**
SADC as % of Global	**38%**	**47%**	**47%**	**40%**	**37%**	
Global	**280 000**	**530 000**	**300 000**	**140 000**	**120 000**	**14%**

Source: Gender Links compiled from UNAIDS 2023 Data

[9] UNAIDS (2024) Transforming Vision into Reality: The 2024 Global Alliance Progress Report on Ending AIDS in Children by 2030. Joint United Nations Programme on HIV/AIDS. Geneva
[10] Ibid

Table 5.7 shows that new infections in children increased in most SADC countries until the early 2000s, numbers then fell quite sharply as access to ARVs to prevent vertical transmission increased. New infections in children across SADC declined 22% between 2021 and 2023. This varied by country, ranging from 0% to 50%, with promising decline in SADC countries that are members of the Global Alliance, except DRC. The decline was 15% across Global Alliance countries[11] and 14% globally.

The Ministry of Health in **Comoros** instituted a prevention of mother-to-child transmission programme. All pregnant women are advised during their first antenatal visit to be tested for HIV. As of 2021, all pregnant women living with HIV have been initiated on ARVs and their babies are tested at one month old. To date, all babies are HIV negative. The programme's success is encouraging other women to be tested. By 2025 Comoros aims to achieve zero new infections in infants born to mothers living with HIV, to have 75% of pregnant women knowing their HIV status, and a 75% reduction in the number of new infections compared with 2020.[12]

Mirroring the Global AIDS strategy, The Global Alliance to End AIDS in Children has set specific targets related to children and treatment. The table below outlines progress against these targets.

- **First:** 95% of children living with HIV know their HIV status
- **Second:** 95% of children who know their HIV status are accessing treatment
- **Third:** 95% of children accessing treatment are virally suppressed

HIV test kit displayed during a Mutare field visit in Zimbabwe.
Photo: Tapiwa Zvaraya

Table 5.8: Progress towards achieving the 95-95-95 targets in children, 2015 - 2023

Country	2015			2021			2023		
	First 95	Second 95	Third 95	First 95	Second 95	Third 95	First 95	Second 95	Third 95
Angola	11	>98		20	>98		27	>98	
Botswana	73	92		91	77		80	83	
Comoros					91			89	67
DRC	20	90		55	88	82	52	85	82
Eswatini	81	89		>98	88	94	>98	85	95
Lesotho	61	88		83	89	93	95	84	96
Madagascar	<1	83		8	93		8	87	
Malawi	41	88	66	80	86	75	88	83	84
Mauritius	36	>98		88	>98	48	72	94	56
Mozambique	43	91			88	64	77	88	76
Namibia		86			78	89		75	95
South Africa	71	73	68	86	72	73	87	73	75
Tanzania	47	88		70	86	91	78	86	92
Zambia	74	91		78	87	91	82	88	94
Zimbabwe	44	>98		62	>98	79	63	>98	89
Global	**47**	**84**	**67**	**62**	**87**	**80**	**66**	**86**	**84**

Source: Gender Links compiled from UNAIDS 2023 Data[13]

[11] UNAIDS (2024) Transforming Vision into Reality. Op Cit
[12] WHO Africa. Comoros on the path to ending mother-to-child HIV transmission, 1 December 2022. https://www.afro.who.int/countries/comoros/news/comoros-path-ending-mother-child-hiv-transmission#:~:text=By%202025%20Comoros%20aims%20to,new%20infections%20compared%20with%202020, accessed 30 September 2024.
[13] UNAIDS 2024 Data https://aidsinfo.unaids.org/, accessed 25 July 2024

Table 5.9: HIV exposed children who receive Early Infant Diagnosis (EID)

Country	% of children who receive virological test within 2 months (EID)	No of infants who received EID	Percentage of global
Namibia	95	10500	1%
South Africa	90	245000	33%
Botswana	86	7200	1%
Malawi	85	29000	4%
Zimbabwe	84	41200	6%
Zambia	77	36800	5%
Mozambique	75	93700	13%
Tanzania	71	50700	7%
Lesotho	66	4400	1%
Mauritius	50	70	
Eswatini	41	2900	0%
Angola	13	3200	0%
DRC	12	3000	0%
Total SADC		**527670**	**71%**
Global		**747000**	

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.9 shows the percentage of HIV exposed children in SADC who received early infant diagnosis (EID), which is a virological HIV test, within two months of birth. Over 90% of children born to mothers living with HIV in Namibia and South Africa received EID, while over 80% of such children received EID in Botswana, Malawi and Zimbabwe. In 2023 SADC accounted for 71% of all children globally who received EID.

A major challenge for countries is sustainably tracking infants after their mothers have been enrolled for lifelong ART during pregnancy. This is important as infants can contract HIV during breast feeding.

South Africa is instituting universal testing for all infants at 18 months.[14]

With support from the US Presidents Emergency Fund for AIDS Relief (PEPFAR), **Tanzania** is linking registration of HIV-exposed infants with their first immunisation visit and actively tracking these children. This has increased the proportion of infants who receive early testing.[15] Integrating HIV services into routine maternal and child health services is critical for sustainability.

The death of any child from AIDS-related causes is not only a tragedy, but also an outrage

Poor access to testing and treatment results in higher rates of AIDS-related deaths in children than in adults. In the foreword to the 2024 Global Alliance report, Winnie Byanyima, executive director of UNAIDS says, "The death of any child from AIDS-related causes is not only a tragedy, but also an outrage. Where I come from, all children are our children. We must be the generation that ends AIDS in children."[16]

Mobile assistance from the Matabeleland Aids Council in Zimbabwe, Southern Africa. Photo: Gender Links

[14] UNAIDS (2024) Transforming Vision into Reality. Op Cit.
[15] Ibid
[16] Ibid

Table 5.10: AIDS-related deaths children 0-14

Country	1990	2000	2010	2021	2023	Decline 2021 - 2023
Mozambique	2 000	15 000	20 000	9 500	7 800	18%
Tanzania	11 000	21 000	12 000	4 400	3 800	14%
DRC	6 100	10 000	8 300	3 800	3 200	16%
Angola	1 200	3 200	5 100	3 700	2 900	22%
Zambia	6 300	14 000	6 800	3 100	2 300	26%
Zimbabwe	13 000	25 000	12 000	3 000	2 300	23%
South Africa	4 100	44 000	18 000	1 900	1 500	21%
Malawi	7 700	18 000	12 000	1 800	1 400	22%
Madagascar	100	100	500	1 000	1 000	0%
Lesotho	500	2 800	1 500	500	500	0%
Botswana	1 000	3 000	1 000	200	100	50%
Mauritius	100	100	100	100	100	0%
Comoros						
Namibia						
Total SADC	**53 100**	**156 200**	**97 300**	**33000**	**26900**	**18%**
SADC as % of Global	**38%**	**45%**	**42%**	**37%**	**35%**	
Global	**140 000**	**350 000**	**230 000**	**89 000**	**76 000**	**15%**

Source: Gender Links compiled from UNAIDS 2023 Data

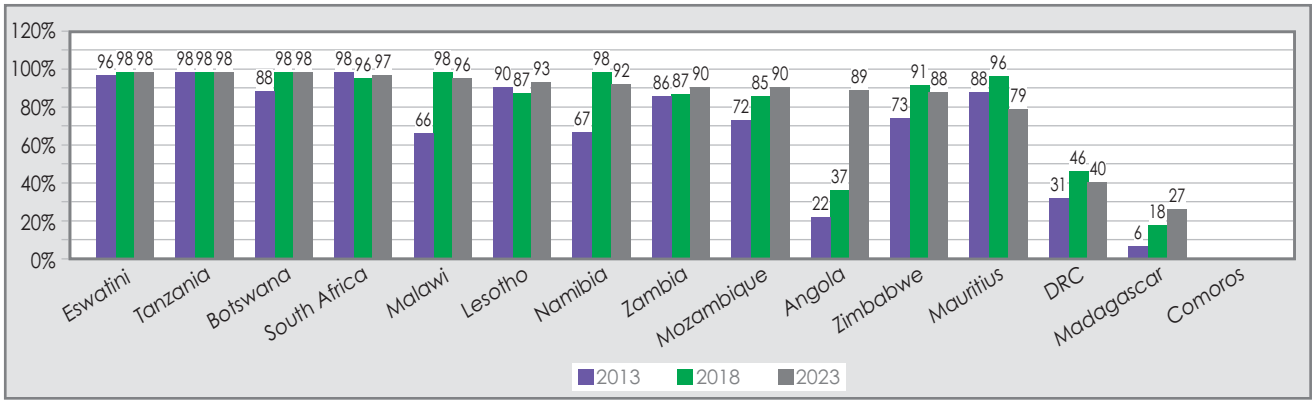
Table 5.10 illustrates changes in numbers of AIDS-related deaths in children between 1990 and 2023. AIDS-related deaths in children increased very quickly from 1990 to 2000, then began to decline - decreasing 18% between 2021 and 2023. A number of countries had rates of decline higher than the average. Even with the decline, children still account for about one-eighth of all AIDS-related deaths.

Continuing research and developing new treatment formulations helps drive decreases in AIDS-related deaths in children. For instance, the WHO recommended Dolutegravir (DTG) in 2018. DTG is shown to be highly effective and safe for children in non-research situations in Botswana, Eswatini, Lesotho, Malawi, Tanzania and Uganda.[17]

Mozambique is implementing multi-month dispensing of a DTG-based regimen for children older than two years. Viral suppression has improved in children moved to the new regimen and Mozambique has expanded coverage to 1780 sites nationally.[18]

Pillar two seeks to close the treatment gap for pregnant and breastfeeding girls and women.

Figure 5.3: ART Coverage (%) for pregnant women living with HIV 2013, 2018 and 2023



Source: Gender Links compiled from UNAIDS 2023 data

[17] Bacha JM, et al. Realizing the Promise of Dolutegravir in Effectively Treating Children and Adolescents Living with HIV in Real-world Settings in 6 Countries in Eastern and Southern Africa. Pediatr Infect Dis J. 2023 Jul 1;42(7):576-581. doi: 10.1097/INF.0000000000003878. Epub 2023 Feb 14. PMID: 36795586; PMCID: PMC10259212. Accessed 28 September 2024.
[18] UNAIDS (2024) Transforming Vision into Reality. Op Cit.

Figure 5.3 reflects tremendous progress in ART access for pregnant women living with HIV between 2013 and 2023. Five member states have achieved at least 95% coverage. Angola has made marked progress from 2018 to 2023, increasing from 37% to 89% coverage. Increased effort is needed in DRC and Madagascar. The Global Alliance target is for 100% of all pregnant women living with HIV to receive lifelong antiretroviral therapy. Coverage in countries fluctuates, showing the difficulties of maintaining high coverage rates.

Table 5.11: Pregnant women on ART 2013 - 2018 - 2023 and vertical transmission

Country	No of pregnant women receiving ART for prevention of vertical transmission			Vertical transmission rate %		
	2013	2018	2023	2013	2018	2023
South Africa	360 163	300 826	264 889	4	3	2
Mozambique	83 766	109 464	112 645	19	14	10
Tanzania	74 206	76 465	70 002	12	10	8
Zambia	45 271	48 409	43 474	16	14	7
Zimbabwe	54 842	59 621	43 281	13	8	7
Malawi	33 969	44 526	32 469	18	7	6
Angola	5 668	9 633	21 117	29	25	13
DRC	7 802	11 376	9 894	33	29	26
Namibia	9 412	12 531	9 766	13	5	5
Botswana	12 290	12 497	8 392	5	2	1
Eswatini	10 332	11 269	6 924	9	4	3
Lesotho	10 126	8 122	6 305	10	8	5
Madagascar	62	279	635			
Mauritius	95	109	109	10	8	11
Comoros	1	7	11			
Total SADC	**708 005**	**705 134**	**629 913**			
SADC as % of global	**64%**	**64%**	**64%**			
Global	**1 100 000**	**1 100 000**	**980 000**			

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.11 shows how numbers of pregnant women on ART is changing in different countries. For a number of countries with more mature epidemics, the number has peaked and is now beginning to decline. However, the number is still increasing in Mozambique, Angola, Madagascar and Mauritius. It is noteworthy that even with continued increase in total numbers, vertical transmission rates are still declining. SADC accounts for a more or less constant 64% of pregnant women on ART globally.

Eliminating vertical transmission requires that the vertical transmission rate falls below 5%. Even while transmission rates are falling, only five countries (South Africa, Namibia, Botswana, Eswatini and Lesotho) have been able to maintain a transmission rate of 5% or lower. Another four countries have rates between 6% and 10%, while DRC is 26%.

It is hoped that long-acting injectable treatment formulations will improve adherence by avoiding the need to take medication every day. Research is showing that injectable formulations can be effective with adolescents. Further research is needed to be confident these are effective and safe during pregnancy and breast feeding.[19]

Pillar three focuses on prevention of new infections in pregnant and lactating women.

This includes a target to reduce new HIV infections in adolescent girls and young women to less than 50 000 by 2025, which is covered in more detail in another section of this chapter.

The PEPFAR funded DREAMS programme provides broad educational, livelihood and social support to adolescent girls and young women

[19] UNAIDS (2024) Transforming Vision into Reality. Op Cit.

in selected districts of 16 African countries, including Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC. The results suggest that this approach is effectively reducing new infections.[20]

Prevention and re-testing need to be integrated into routine post-natal care services.

Pillar four focuses on addressing rights, gender equality and the social and structural factors for accessing services. This includes efforts to achieve the 2025 global AIDS target of fewer than 10% of women, key populations and people living with HIV experience gender-based inequalities and violence. For example, ensuring that women and girls have equal access with boys and young men to education.

The World Health Organization has validated only 18 nations globally for elimination of vertical transmission of HIV (or fewer than 50 new HIV infections in children per 100 000 births). Most are countries in Europe and the Caribbean with very low adult prevalence rates. Botswana and Namibia are the only African, and high HIV prevalence countries, to achieve the status of being on the path towards elimination (or fewer than 750 new HIV infections per 100 000 births).[21]

Prevention of other new infections

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, prioritised, 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 pre-exposure prophylaxis (PrEP) for people at substantial risk of HIV and post-exposure prophylaxis for people recently exposed to HIV.
- 95% of people within humanitarian settings at risk of HIV use appropriate, prioritised, people-centred and effective combination prevention options.[22]

Twenty-eight countries joined the Global Prevention Coalition (GPC) in 2017 and 2018, including 12 in SADC (Angola, Botswana, DRC, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe). These countries accounted for 76% of all new infections in 2016. With focused attention to HIV prevention, they reduced their share of new infections to 67% by 2022. Twelve more countries (including Madagascar in SADC) joined the GPC in 2022. The forty members of the GPC accounted for 76% of all new infections in 2022 or just over one million new infections.[23]

GPC issued the HIV Prevention 2025 Road Map in mid-2022, updating guidance for national HIV

[20] USAID. DREAMS: Partnership to Reduce HIV/AIDS in Adolescent Girls and Young Women. https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/dreams, accessed 30 September 2024.
[21] UNAIDS (2024) The urgency of now: AIDS at a crossroads. Geneva: Joint United Nations Programme on HIV/AIDS.
[22] UNAIDS (2021) Global AIDS Update. 2021. Op Cit.
[23] UNAIDS (2024) HIV Prevention - From Crisis to Opportunity. Joint United Nations Programme on HIV/AIDS. Geneva:

responses to achieve the 2025 targets. The overall goal remains to reduce the number of new infections to fewer than 370 000 per year by 2025, with 95% of people at risk of HIV having equitable access to and using appropriate prioritised, person-centred and effective combination prevention options.

The roadmap refined the five pillars to guide HIV responses to reflect the evolving nature of the HIV epidemic. The pillars now emphasise people-centred approaches, addressing persistent inequalities, promoting integrated service delivery, and speeding up introduction of new technologies.

The five pillars are:

1. Key Populations: prevention for and with sex workers, gay men and men who have sex with men, people who inject drugs, transgender people and prisoners.
2. Adolescent Girls and Young Women: prevention in settings with high HIV incidence.
3. Adolescent Boys and Men: prevention in settings with high HIV incidence (including voluntary medical male circumcision (VMMC) and testing and treatment).
4. Condom Programming: Promotion and distribution of male and female condoms, and lubricants.
5. ARV-based Prevention: Pre-exposure prophylaxis, post-exposure prophylaxis, treatment as prevention including for elimination of vertical transmission.

Table 5.12: Number of new infections (all ages) 2010, 2016 and 2023

Country	2010	2016	2023	Reduction 2010 - 2023	Reduction 2016 - 2023
Zimbabwe	79000	42000	15000	81%	64%
Malawi	58000	34000	12000	79%	65%
Lesotho	19000	12000	4800	75%	60%
Eswatini	15000	9200	4200	72%	54%
Botswana	14000	10000	4100	71%	59%
Zambia	64000	69000	23000	64%	67%
South Africa	340000	230000	150000	56%	35%
Namibia	13000	8900	6000	54%	33%
Mozambique	160000	140000	81000	49%	42%
DRC	37000	27000	21000	43%	22%
Angola	28000	23000	16000	43%	30%
Tanzania	87000	100000	53000	39%	47%
Comoros	100	100	100	0%	0%
Mauritius	1000	1000	1100	-10%	-10%
Madagascar					
SADC Total	**915100**	**706200**	**391300**	**57%**	**45%**
SADC as % of global	**44%**	**39%**	**30%**		
Global	**2 100 000**	**1 800 000**	**1 300 000**	**38%**	**28%**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.12 shows changes in the numbers of new infections among all ages in SADC since 2010. There have been impressive rates of decline in new infections - with Zimbabwe, Malawi, Lesotho, Eswatini and Botswana all recording more than 70% reductions between 2010 and 2023. These countries may achieve the goal of 88% reduction by 2025. Other countries have declined more slowly, notably South Africa (56%), Mozambique (49%) and Tanzania (39%).

Key populations

Pillar 1 focuses on prevention with and for key populations, such as sex workers (SW), gay men and men who have sex with men (MSM), people who inject drugs(PWID), transgender (TG) people and prisoners.

Table 5.13: HIV prevention coverage among key populations in SADC GPC countries

Indicator	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
Condom use of sex workers with most recent client, % (reported by SW)	id	76	48	50	62	id	65	id	42	id	72	id	95
Condom use at last anal sex among men who have sex with men (MSM) (%)	id	78	57	80	46	id	79	id	55	72	id	58	69
Condom use transgender people (%)	id	id	52	id	id	id	50	id	id	77	id	id	82
Condom use at last paid sex act, % (reported by men)	71	id	34	id	90	13	75	31	67	83	id	56	90
% of PLHIV on ART - sex workers*	42	88	id	id	id	id	90	id	id	70	id	86	83
% of PLHIV on ART - MSM*	id	74	id	id	id	id	93	id	id	44	id	id	83
% of PLHIV on ART - PWID*	id	id	id	id	id	id	id	id	id	id	id	id	id
Population size estimate for female sex workers in 1000s **	id	id	526	7	8	191	39	224	9	146	id	126	id
% of all SW who received at least 2 HIV PIs in the past 3 months	51	90	38	9	31	93	68	57	id	34	90	id	79
Pop size estimate MSM 1000s**	id	id	195	4	6	17	50	64	2	310	id	20	23
% of all MSM who received at least 2 HIV PIs in the past 3 months	3	32	39	29	26	28	65	31	33	10	4	5	26
Pop size estimate PWID 1000s**	id	id	168	<1	id	2	8	14	id	83	36	12	id
% of all PWID who received at least 2 HIV PIs in the past 3 months	id	id	23	37	id	100	id	40	id	17	11	3	id
Pop size estimate TG people 1000s**	id	id	57	id	id	Id	5	id	id	179	id	4	id
% of all TG people who received at least 2 HIV PIs in the past 3 months	id	id	12	id	id	id	id	id	id	2	id	6	28

Source: Gender Links derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.13 is an overview of service provision to key populations in the SADC countries which are GPC partners. The paucity of data, indicated by the number of boxes which are grey and id (insufficient data), is indicative of the low priority accorded to providing services to key populations.

Table 5.14: Policy and structural factors affecting services to key populations

Country	Key populations												
	National strategy includes key elements of recommended package					% who avoided health care due to stigma & discrimination				Criminalisation of key populations			
	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people	Prisoners	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people	Sex workers	Gay men & other MSM	People who inject drugs	Transgender people
Angola	> Half	> Half	None	< Half	< Half	id	id	id	id	N	N	id	Y
Botswana	> Half	< Half	None	< Half	< Half	id	id	id	id	Y	N	Y	N
DRC	All	> Half	Some	< Half	< Half	id	17.8	14	18	Y	N	N	N
Eswatini	> Half	> Half	None	< Half	> Half	34	id	id	id	Y	Y	Y	N
Lesotho	> Half	> Half	None	id	id	8	id	id	id	Y	N	Y	N
Malawi	< Half	< Half	None	> Half	< Half	49	12.9	id	id	Y	Y	Y	Y
Mozambique	> Half	> Half	< Half	id	id	id	id	id	id	N	N	Y	N
Namibia	> Half	> Half	None	id	None	id	id	id	id	Y	Y	Y	N
South Africa	> Half	> Half	> Half	> Half	> Half	id	id	id	id	Y	N	Y	N
Tanzania	> Half	> Half	> Half	< Half	> Half	id	id	id	id	Y	Y	Y	N
Zambia	> Half	> Half	> Half	> Half	> Half	id	id	id	id	Y	Y	Y	Y
Zimbabwe	> Half	> Half	None	> Half	> Half	39.3	8.3	id	10.8	Y	Y	Y	N

Source: Gender Links derived from UNAIDS, 2024. HIV Prevention - From Crisis to Opportunity

Table 5.14 shows how many countries criminalise different key populations - Chapter 8, Sexual Orientation and Gender Diversity, has more in depth information on the criminalisation of LGBTQI people. Evidence from around the world shows that criminalisation contributes to driving HIV in key populations, as people are reluctant to come forward to receive services. As noted at the beginning of this chapter, it is not possible to address a pandemic for some people and not for others. Only Angola and Mozambique do not criminalise sex work. Very few national strategies pay enough attention to services for key population groups. Further, the scant data available about stigma and discrimination suggests that stigma is rife, which reduces access to services.

As long as members of key population groups are not accessing at least 2 prevention interventions there will be continued spread of HIV, both within these groups and beyond. The number of red boxes showing poor prevention services to different key populations is reason for great concern. The target is for 95% of people at risk of HIV infection, within all epidemiologically relevant groups, age groups and geographic settings, to access and use appropriate, prioritised, person-centred and effective combination prevention options.

The case study below is an example of a people-centred programme designed to address accessibility of HIV services for key populations.

Moonlight services: Reaching key populations with comprehensive SRH services

The Matabeleland AIDS Council (MAC), a Voice and Choice SAF grantee in southwestern Zimbabwe, realised that certain groups such as artisanal miners, long distance truck drivers and sex workers were not accessing sexual and reproductive health (SRH) and HIV services. The normal health facility operating hours, along with stigma and discrimination they encountered, deterred these groups from accessing health services.

MAC therefore expanded their mobile integrated SRH and HIV services to provide suitable services to these groups in all six districts of Matabeleland South and Midlands Provinces where they work. The mobile services visit a convenient location, once per month on an appointed day, often in the evening.

Nighttime services are provided at strategic hotspot locations, such as business centres and where people converge for entertainment and to socialise. MAC either uses nearby rooms or sets up a tent to create a safe, private, confidential space. Services are all offered at the same place, enabling clients to have a "one-stop shop" for integrated SRH and HIV services. MAC health providers are experienced and sensitive to their clients' unique needs, reducing the stigma associated with seeking health services.

Staff offering moonlight services in Zimbabwe. Photo: Matabeleland Aids Council

In addition, through a peer outreach model, peers from the different target groups give health talks and distribute coupons for free access to follow up services at any Matabeleland AIDS Council outreach site. Through the mobile services and peer outreach, MAC reaches large numbers of people with an array of services, including providing condoms and lubricants, family planning services, HIV self-testing and PrEP. Most clients welcomed the programme as they are very mobile due to the nature of their jobs.

MAC provides services to approximately 240 clients through the once-a-month moonlight services at six service points. Female sex workers comprise about 65% of clients served.

The Moonlight health services model is an innovative approach to providing SRH and HIV services to key populations. It provides a safe space to access services, resulting in increased service uptake for key populations and diverse groups, contributing to improved health outcomes.

Many clients of the Moonlight programme return regularly for health services, at the same or other service points. MAC has noted good uptake of condoms and lubricants. Clients express, through various feedback mechanisms, that they prefer the moonlight service option to regular service provision.

Source: Matabeleland AIDS Council, report to Gender Links. October 2024

Adolescent girls and young women

Pillar 2 focuses on prevention in high incidence settings with and for adolescent girls and young women.

Table 5.15: Selected prevention service outcome indicators among adolescent girls and young women (15-24 years) in SADC GPC focus countries, 2022

Country	Condom use non-regular partners (young women, 15-24 yrs, %)	Condom use non-regular partners (young men, 15-24 years, %)	% of priority districts with full progs for young women & male partners	% of AGYW in high HIV incidence communities reached with PIs	Proportion of women who experienced IPV (15-49)	Laws requiring parental consent for adolescents to access HIV testing services, age of consent	Girls who completed lower secondary education
Angola	31	46	id	id	id	Yes, <12	32
Botswana	id	id	56	4	id	Yes, <16	92
DRC	25	33	id	id	id	Yes, <18	52
Eswatini	55	74	80	100	id	Yes, <12	54
Lesotho	84	83	90	34	id	Yes, <12	55
Malawi	53	73	id	21	id	Yes, <14	21
Mozambique	51	48	33	46	id	Yes, <12	11
Namibia	68	84	42	19	id	Yes, <14	62
South Africa	61	73	50	6	30.3	Yes, <12	91
Tanzania	id	id	id	61	id	Yes, <14	27
Zambia	34	49	28	37	25.3	Yes, <16	50
Zimbabwe	54	81	89		19	Yes, <16	53

Source: Gender Links, derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.15 summarises selected prevention indicators for adolescent girls and young women in the SADC countries which are members of the GPC. The proportions of young women and young men using condoms with a non-regular partner is only high in Lesotho. Eswatini, Lesotho and Zimbabwe have good coverage of programmes for young women, while Mozambique, Namibia, South Africa and Zambia have poor coverage.

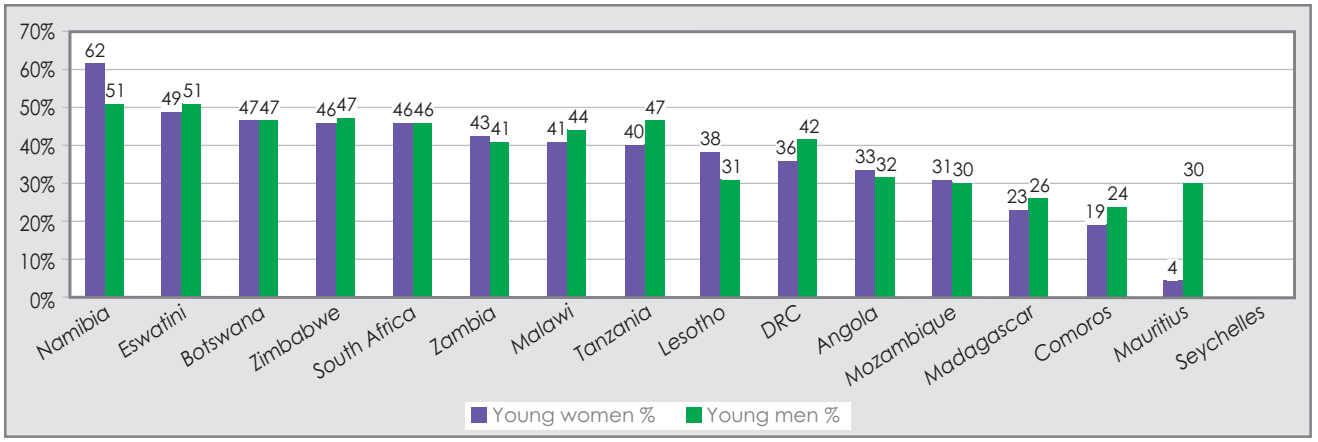
Programmes have focused on districts with high incidence while those with more moderate incidence levels have poorer coverage, but still account for high absolute numbers of new infections. Even where programmes exist, the percent of women reached is widely variable, ranging from 6% in South Africa to 100% in Eswatini.

Botswana and South Africa have good secondary education completion for girls, while Mozambique, Malawi, Tanzania and Angola have low completion rates. Access to secondary education is shown to be a protective factor for child marriage, early sexual activity and contracting HIV.

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 5.4: Knowledge on HIV prevention among young people



Source: Gender Links, compiled from UNAIDS 2023 data

Figure 5.4 shows that levels of comprehensive HIV knowledge, defined as specific, accurate knowledge about prevention and transmission, are still well below the goal of 90%. All countries in the region have policies to provide skills-based HIV and sexuality education, but this is often not prioritised. Knowledge levels are much higher in young women than men in Namibia, very similar between young women and men in other countries and higher in men than women in Tanzania, DRC, Comoros and Mauritius.

Mossel Bay Mobile HIV Outreach in Western Cape, South Africa, conduct HIV testing in the community. Photo courtesy of David Marcus

Pillar 3 focuses on prevention in high incidence settings with and for adolescent boys and men (including VMMC services).

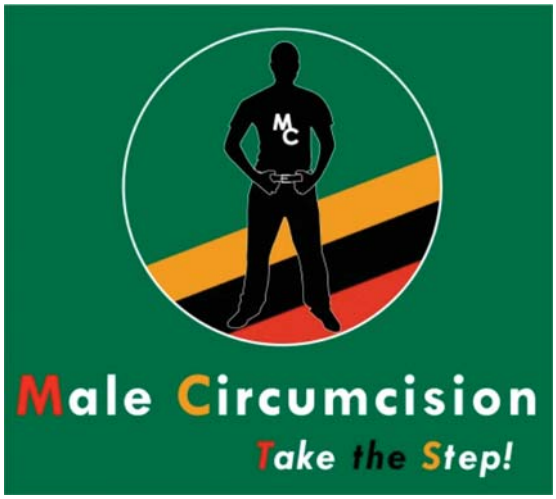
Table 5.16: HIV prevention among adolescent boys and men

Indicator	Botswana	Eswatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
National male circumcision prevalence (15-24 years) (%)	23	5	70	29	66	22	60	82	37	19
National male circumcision prevalence (15-49 years) (%)	26	29	69	28	47	26	id	80	32	14
Condom use with non-regular partners (men 15-49 years) (%)	id	83	81	73	47	82	68	35	54	82
% of PLHIV on ART (men 15+ yrs)	88	92	81	86	78	87	68	92	90	93
% of PLHIV virally suppressed (men 15+ years)	87	90	79	81	70	81	62	90	87	88
% performance towards 2025 targets (15-34 years)	5	13	100	11	27	20	58	100	90	25
VMMC coverage (15-34 years) (%)	51	47	54	44	76	65	51	94	78	34

Source: Gender Links derived from UNAIDS (2024) HIV Prevention: From Crisis to Opportunity

Table 5.16 shows selected indicators of prevention programming for boys and men, especially voluntary medical male circumcision (VMMC). VMMC programming is concentrated in 15 priority countries, including Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe in SADC.

Fewer than 40% of young men aged 15 - 24 have accessed VMMC in six countries. The best coverage is 82% in Tanzania, with Lesotho, Mozambique and South Africa being between 60 and 70%. Research suggests that poorer and rural populations are least likely to be accessing VMMC programmes.



Zambia's voluntary male circumcision initiative poster.

Table 5.17: Numbers of voluntary medical male circumcisions (VMMCs) conducted in SADC

Country	2015	2018	2023
Tanzania	435 302	885 599	586 860
Zambia	222 481	482 183	521 195
South Africa	485 552	572 442	215 716
Mozambique	198 340	311 891	162 993
Zimbabwe	188 732	326 012	155 617
Malawi	108 672	199 399	119 161
Namibia	18 549	34 942	21 654
Lesotho	25 966	26 448	12 807
Botswana	15 722	24 207	9570
Eswatini	12 952	14 316	4747
SADC Total	**1 712 268**	**2 877 439**	**1 810 320**
SADC as % of Global	**65%**	**70%**	**70%**
Global Total	**2 623 788**	**4 135 786**	**2 594 873**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.17 shows that annual numbers of VMMCs increased from 2015 to 2018 then were severely impacted by the COVID pandemic. Only Malawi, Tanzania and Zambia have achieved their targets in 2023. Countries in SADC provide 70% of the global total of VMMCs conducted, with Tanzania accounting for 23% of global total and Zambia 20%.

Countries in SADC conduct 70% of global VMMCs

Table 5.18: Number of new infections (young people 15 - 24) 2010, 2016 and 2023

Country	2010	2016	2023	Reduction 2010 - 2023	Reduction 2016 - 2023
Zimbabwe	27 000	14 000	4 400	84%	69%
Eswatini	6 400	3 600	1 500	77%	58%
Malawi	17 000	11 000	4 000	76%	64%
Lesotho	6 700	4 500	1 700	75%	62%
Botswana	5 100	3 700	1 400	73%	62%
South Africa	150 000	96 000	55 000	63%	43%
Zambia	22 000	23 000	8 200	63%	64%
DRC	9 200	7 300	5 000	46%	32%
Mozambique	55 000	53 000	31 000	44%	42%
Namibia	3 500	3 100	2 100	40%	32%
Angola	8 100	6 000	4 900	40%	18%
Tanzania	21 000	8 500	19 000	10%	-124%
Comoros	100	100	100	0%	0%
Mauritius	200	200	200	0%	0%
Madagascar					
Total SADC	**331 300**	**234 000**	**138 500**		
SADC as % of Global	**49%**	**47%**	**38%**		
Global	**680 000**	**500 000**	**360 000**		

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.18 shows the decline in new infections in young people aged 15 - 24 (both female and male) between 2010, 2016 and 2023. Rates of decline are highest in Zimbabwe, Eswatini, Malawi, Lesotho and Botswana. SADC's share of the global new infections in young people has decreased from 49% in 2010 to 38% in 2023.

Adolescence is a phase of development during which young people exert their independence, but still need support and constructive guidance from their parents and guardians. Open discussion about sexuality and other issues in their lives is very critical. The case study below highlights a programme which fosters such communication.

Intergenerational Dialogue Mupangayi Secondary School, Shurugwi District

Women in Communities (WICO) Zimbabwe, a Voice and Choice SAF grantee, worked with selected schools in Shurugwi district of southwestern Zimbabwe to improve access to integrated SRH and HIV services for adolescent boys and girls. The "I Am My Daughter's/Son's Keeper" programme included health clubs, prefects trained as peer educators and supporting teachers to develop stigma-free school environments.

An important component of the programme was intergenerational dialogues between parents or guardians and their children, mediated through the schools. One school which hosted such dialogues was Mupangayi Secondary School.

The intergenerational dialogue at Mupangayi Secondary School was an opportunity to address issues creating tension and misunderstanding between adolescents and their parents/ guardians. It allowed parents to express their fears and concerns regarding their children and

Intergenerational dialogues in action in Zimbabwe. Photo: Women in Communities

children to express their feelings of being misunderstood. The session began with an open discussion for parents/guardians and their children to voice some of the issues and tensions occurring.

Examples of concerns raised included:
Tendai Nyoni[24] is a Form 4 girl living with both her parents. Her parents really try to provide the school resources she needs, and she has above average grades. Recently she asked for a cell phone to help with research for her studies. Though reluctant, Tendai's parents succumbed to her persistence and bought her the phone. They later noticed she spent more and more time on the phone and became very secretive about it. This worried the parents and created friction between them and Tendai.

Brian Zimuto, a boy in Form 4, lives with his uncle as both his parents work in South Africa. They are very supportive of their son and buy him trendy clothes and gadgets. After school Brian visits the very busy township, hanging around with older out of school boys who seem to have a negative influence on his behaviour. His grades were dropping, and his behaviour suggested he is abusing alcohol and other substances.

Chipo Chizana, a Form 3 girl, lives with her maternal grandmother. She did not complete her O' level (school leaving examination) the first time because she fell pregnant and eloped with her young boyfriend. The relationship did not work out and she soon returned to her grandmother. She re-entered school as a Form 3 student. She is keen to work harder and better but faces ridicule and stigma from other learners who do not seem to understand her situation.

It used to be taboo for a father to discuss menstrual hygiene with his daughter.

Boys copied their fathers' drinking habits.

One-on-one family discussions followed the open dialogue. Learners began to appreciate that parents are keen to know what is happening with their child at all times, more for their protection than to blame them. Parents also listened to their children's perspectives. This led to better understanding and appreciation of each either's viewpoints. The general consensus was that it is important to have open dialogue at all times between children and their parents/guardians for better SRHR and HIV outcomes. The dialogue improved communication and relationships, increasing trust between the adolescents and their parents. Some comments from parents and adolescents were:
"Today we learnt a lot about bridging the gap between parents and children. We realised that we need to communicate better with our children by being more open with them all the time. This helps prevent them from seeking help elsewhere which may be misleading. The use of phones was discussed at length, and we agreed that learners should focus on making the best use of the technology and not abuse it," said one mother.

"I am a learner at Mupangayi secondary school in Ward 11 of Shurugwi district. Today we had a visit from WICO Zimbabwe who took us through ways of improving communication between us and our parents. This may be academic problems or social problems like abuse and negative peer pressure. We need to accept guidance from our parents and guardians as they have our best interests at heart. We are very grateful for the opportunity for dialogue with our parents."

Adolescents and young people are more likely to make healthy choices if they have good and correct information about sexuality in line with their needs, and not imposed on them. An open and stigma-free environment at home and school, where they can ask questions, encourages young people to translate the information into attitudes and behaviours to make healthy decisions in their lives. They need access to contraception and HIV prevention to prevent unwanted pregnancies and sexually transmitted infections, including HIV.

Source: WICO Zimbabwe, Report to Gender Links. October 2024

[24] All names in the case have been changed to protect the child's identity.

Condoms

Pillar 4 recognises that condoms are a key component of HIV prevention strategies and indicates condoms have had a significant impact on reducing new HIV infections.

Table 5.19: Condoms distributed across SADC, 2019 to 2023

Country	2019	2020	2022	2023
South Africa	635 981 213	558 190 486	403 740 579	548 365 152
Malawi	154 442 236	81 219 283	120 240 675	130 991 775
Zimbabwe	94 849 706	82 720 989	119 595 390	115 494 666
Mozambique	95 715 852	84 273 291		108 672 876
Tanzania	32 664 445	26 828 131	133 615 400	94 487 900
Angola	19 782 000			23 236 848
Zambia	19 392 644	17 252 787	17 442 392	21 479 580
DRC		36 169 500	2 500 150	18 007 773
Eswatini	12 144 576	14 809 730	9 900 949	13 368 228
Lesotho	4 018 032		1 480 676	8 969 580
Namibia		34 000 000	11 414 992	2 925 648
Madagascar	17 682 860	11 469 917		1 259 982
Seychelles	452 772	223 447	343 422	261 677
Comoros	930 007	650 064		233 811
Botswana	41 148 720	26 932 500	38 987 700	
Mauritius	975 119			
SADC total	**1 130 180 182**	**974 740 125**	**859 262 325**	**1 087 755 496**
SADC as % of global	**41%**	**39%**	**29%**	**38%**
Global total	**2 753 451 961**	**2 509 145 066**	**2 982 666 039**	**2 890 411 803**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.19 shows huge fluctuations in condom availability in different national HIV programmes. SADC's share of global condom distribution has varied between 29% and 41%. In 2021, South Africa accounted for 19% of all condoms distributed worldwide. Investment by PEPFAR and the Global Fund (the two largest funders of condom programmes) into condoms has declined. Thus, highly subsidised condoms that have been available for many decades are not so readily available any longer.[25]

Table 5.20: Condom use, selected determinants of use, distribution

Country	Condom use with non-regular partners (%)		Knows condom as prevention method (%)		Woman justified to insist on condom use if husband has STI (men 15-49 years) (%)	# of condoms distributed/ sold per couple-year* (age range 15-64 years - 2021)	% of condom distribution need met (2021)
	Women 15-49 years	Men 15-49 years	Women 15-49 years	Men 15-49 years			
Angola	27	46	66	78	59	1	3
Botswana	id	id	id	id	id	54	id
DRC	24	33	56	73	68	0	1
Eswatini	66	83	91	87	94	28	79
Lesotho	78	81	92	88	92	2	6
Malawi	49	73	75	75	82	22	100
Mozambique	42	47	55	65	61	id	id
Namibia	66	82	88	90	93	15	46
South Africa	60	68	id	id	id	20	63
Tanzania	28	35	id	id	id	8	42
Zambia	35	54	83	87	73	3	16
Zimbabwe	65	82	84	88	87	30	100

Source: Gender Links derived from UNAIDS, 2024. HIV Prevention - From Crisis to Opportunity

[25] UNAIDS (2024) The urgency of now Op Cit.

According to Table 5.20, Eswatini, Malawi and Zimbabwe have reasonable to good condom distribution, meeting most or all of the need. Condom use with non-regular partners is poor in many countries, even though knowledge of condoms as a prevention strategy is high.

ARV-based Prevention

Pillar 5, ARV-based prevention includes:

- PrEP (pre-exposure prophylaxis) which involves taking an ARV before sex by anyone at high risk of contracting HIV;
- PEP (post-exposure prophylaxis) which involves taking ARVs after high-risk sex (usually rape) to prevent HIV; and
- Viral suppression in as many people living with HIV as possible to ensure they do not transmit HIV.

Table 5.21: Antiretroviral-based prevention scorecard for SADC countries in the GPC

Indicator	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
% of all PLHIV diagnosed	58	97	83	97	94	id	94	86	95	94	95	93	95
% of all PLHIV on ART	46	93	82	95	86	18	93	81	91	75	94	90	94
% of all PLHIV virally supressed	id	93	id	93	85	id	87	71	86	69	92	87	89
% of all PLHIV virally supressed (women 15+)	id	97	id	95	88	id	93	74	90	74	96	89	93
% of all PLHIV virally supressed (men 15+)	id	87	78	90	79	id	81	70	81	62	90	87	88
% of estimated PrEP need met (%)	id	48	12	id	id	0	53	id	id	61	75	id	id
Composite PrEP score (0-10 points based on regulatory, guidelines and coverage)	id	6	3	id	10	0	5	id	10	6	10	8	8

Source: Gender Links, derived from UNAIDS. 2024. HIV Prevention - from Crisis to Opportunity

Table 5.21 shows that many SADC countries have made impressive gains towards the three 95% goals, with higher levels of viral suppression in women than in men. This means that more men are still able to transmit HIV which continues to drive new infections in younger women. PrEP roll out is still quite slow.

Table 5.22: Number of people using PrEP at least once in the year

Country	2018	2019	2020	2021	2022	2023
South Africa	8184		106 401	346 667	406 170	803 171
Zambia	3823		110 714	147 397	162 695	184 256
Malawi		459		10 971	23 104	72 335
Tanzania				41 335	162 477	59 332
Namibia					29 826	49 904
Lesotho	7279	35 478		15 749	28 128	30 993
Zimbabwe	4982	8351	48 583	7061	79 602	30 396
Eswatini			9125			27 961
DRC			553		8650	23 349
Botswana	38	1954	2259	5149	13 380	14 537
Madagascar					459	678
Seychelles	4	26	3	1	5	4
Mauritius	3			19	102	
Mozambique	1934		18 513	57 717		
Total SADC	**26 247**	**46 268**	**296 151**	**632 066**	**914 598**	**1 296 916**
SADC as % of Global	**33%**	**36%**	**56%**	**69%**	**36%**	**37%**
Global total	**79 881**	**129 910**	**524 877**	**911 825**	**2 569 923**	**3 529 845**

Source: Gender Links compiled from UNAIDS 2023 Data

Table 5.22 shows the expansion of PrEP in different countries from 2018 to 2023. Expansion has been patchy, except in South Africa, which accounted for 23% of global PrEP in 2023. The global coverage of PrEP reached 3.5 million in 2023, which is still well below the target of ten million by 2025.

There is considerable on-going research to develop new forms of PrEP, including long-acting (LA) injectable PrEP. With long-acting PrEP, a person at risk receives one injection twice a year. The advantage is in not needing to take a daily pill. The research is extremely promising.

Large-scale roll-out of PrEP requires regulatory approval, development of guidelines and production of generic and more affordable PrEP medications. Those at high risk of contracting HIV should be aware of PrEP, including possible side effects and long-term impacts and have the choice to use this game changing bio-medical advancement.

People need to be able to choose prevention methods that work for them

Rolling out cheap and high-quality PrEP production may take several years. LA Cabotegravir has been registered in 17 countries (including Botswana, Malawi, Mozambique, South Africa, Tanzania, Zambia, Zimbabwe in SADC) and by the European Medicines Agency, and has been submitted for registration in Namibia.[26] Gilead Sciences announced on 2 October 2024, that it had signed royalty-free, non-exclusive licensing agreements with six generic manufacturers to increase access to injectable lenacapavir (which is also a long acting medication) to be made available in 120 high-incidence, resource-limited countries. The International AIDS Society applauded the move and called for further expansion as the agreement does not cover several high incidence countries.[27]

Another option, which has been approved in Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe in SADC, is the dapivirine vaginal ring. A woman inserts this flexible silicone ring into her vagina, near the cervix, and leaves in place for a month. The ring releases ARVs slowly to counteract any HIV. A version effective for three months, which should less expensive, is expected to be available in 2025 or 2026.[28] It is important that people are able to choose prevention methods that work best for them.

Treatment

Article 27.3

b) Ensure universal access to HIV and AIDS treatment for infected women, men, girls and boys

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.

As discussed previously in this chapter, the Global AIDS Strategy includes targets for: 95% of all people living with HIV know their status; 95% diagnosed with HIV accessing antiretroviral treatment; 95% on ARVs achieve viral suppression.

[26] Worldwide registration: cabotegravir PrEP. London: ViiV Healthcare; 2024 https://viivhealthcare.com/content/dam/cf-viiv/viivhealthcare/en_GB/pdf/cab-prep-wwrs-03-may-2024.pdf accessed 28 September, 2024.
[27] IAS statement: IAS calls for global access as Gilead announces lenacapavir licensing. https://www.iasociety.org/ias-statement/ias-calls-global-access-gilead-announces-lenacapavir-licensing accessed 4 October 2024.
[28] UNAIDS (2024) The urgency of Now. Op Cit.

Table 5.23: Progress to achieving the 95-95-95 goals in SADC, 2015 and 2023

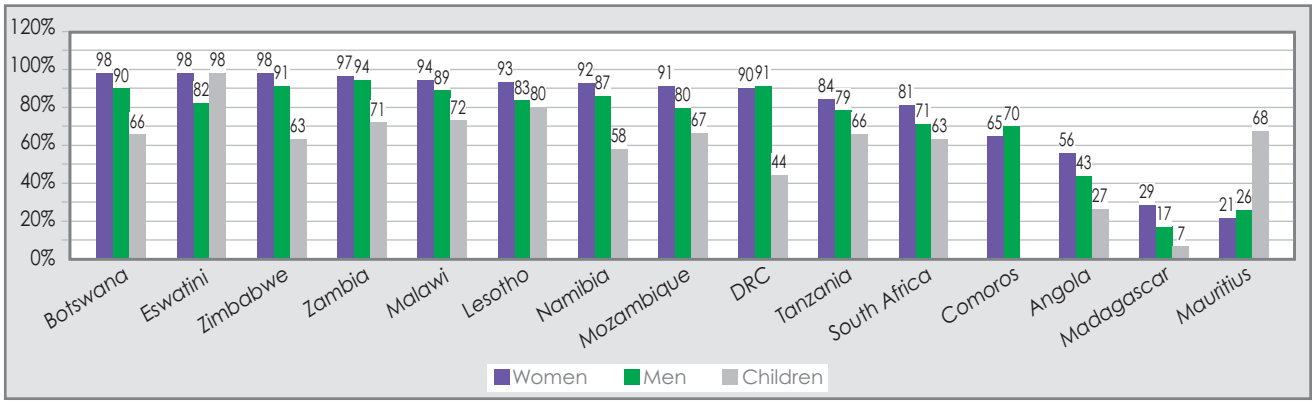
Country	Progress to achieving 95-95-95 in women over 15		Progress to achieving 95-95-95 in men over 15	
	2015	2023	2015	2023
Eswatini	95, 75 ---	>98, >98, >98	90, 59,---	95, 86, >98
Botswana	85, 90--	>98, >98, >98	81, 83,---	96, 94, >98
Zimbabwe	89, 75--	>98, >98, 96	78, 73,---	95, 95, 95
Zambia	84, 78--	97, >98, 98	76, 87,---	96, >98, 97
Malawi	89, 78, 90	97, 97, 96	78, 66, 87	94, 95, 95
Lesotho	95, 58--	96, 97, >98	87, 54,---	93, 90, >98
South Africa	90, 64, 85	96, 84, 92	83, 57, 83	94, 75, 91
Namibia	88, 66--	95, 96, >98	79, 71,---	91, 95, >98
Mozambique	71, 66--	92, >98, 90	56, 55,---	85, 95, 90
DRC	41, 73--	91, >98, 90	35, 55,---	91, >98, 89
Tanzania	72, 69--	88, 95, 97	63, 56,---	86, 93, 97
Angola	60, 48--	80, 70, ---	50, 40,---	72, 60, --
Comoros	39, 93--	72, 91, ----	31, 98,---	71, >98, 62
Madagascar	5, 79--	29, >98, ---	3, 93,---	18, >98, --
Mauritius	15, >98--	21, >98, 72	27, >98,---	26, >98, 75
Global	**78, 68--**	**91, 91, 94**	**66, 64, 84**	**83, 86, 94**

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.23 shows progress towards achieving the 95-95-95 targets by 2025, disaggregated by women over 15 and men over 15. The table shows there has been great progress between 2016 and 2023 for both women and men. However, women are still more likely to have been tested, to have accessed ARV therapy and to have achieved viral suppression than men in most countries.

Men are more likely to have been tested, accessed ARVs and achieved viral suppression in Mauritius. There is more attention to men living with HIV in Mauritius as the country's epidemic is largely among key populations. As with other HIV indicators, the island nations have much lower testing rates than SADC mainland nations. Five SADC nations (Eswatini, Botswana, Zimbabwe, Zambia and Malawi) are amongst the nine countries globally that have already achieved the 95-95-95 targets. Lesotho and Namibia are amongst the ten countries on track globally to achieve the targets by 2025.[29]

Figure 5.5: ART coverage for those living with HIV (%)



Source: Gender Links, compiled from UNAIDS 2023 data

[29] UNAIDS (2024) The urgency of Now. Op Cit.

Figure 5.5 shows great progress in access to ARVs across SADC, with smaller proportions of men living with HIV accessing ARVs than women in most countries except Mauritius, DRC and Comoros, and the smallest proportion being children, except in Mauritius and Eswatini where children are the highest proportion.

Table 5.24: Number of people on Antiretroviral Therapy

Country	2010	2015	2023	Increase 2010 - 2023 %
Madagascar	266	1234	16 790	6212%
DRC	43 790	121 762	444 592	915%
Mozambique	218 991	802 659	2 088 982	854%
Angola	22 036	71 541	160 392	628%
Tanzania	244 225	620 057	1 389 882	469%
Mauritius	654	2521	3080	371%
South Africa	1 407 392	3 682 691	5 936 501	322%
Zambia	349 076	758 646	1 273 804	265%
Malawi	250 953	595 634	896 805	257%
Eswatini	60 757	147 587	213 416	251%
Zimbabwe	363 261	835 472	1 233 934	240%
Namibia	77 453	130 272	202 604	162%
Lesotho	94 287	153 459	241 462	156%
Botswana	159 350	255 119	339 716	113%
Total SADC	**3 292 491**	**8 178 654**	**14 441 960**	
SADC as a % of Global	**43%**	**48%**	**47%**	
Global	**7 700 000**	**16 900 000**	**30 700 000**	

Source: Gender Links compiled from UNAIDS 2023 data

Table 5.24 shows how the number of people on antiretroviral therapy has expanded dramatically since 2010. The global target is for 34 million people to be on ART by 2025. There are now 14 441 960 people living with HIV, 83% of all those living with HIV, who are on ART in SADC. South Africa alone accounts for 19% of the global total of people living with HIV who are on ART. The rate of increase of people on ART has been highest in Madagascar.

A group of medical academicians and practitioners from **Madagascar** wrote an impassioned plea for support and resources to enable Madagascar to curb an enormous increase in the numbers of people that are being infected with HIV.[30] Even with limited capacity for testing across the country, the group quoted several indicators as evidence the country needs an urgent and substantial investment in generalised testing and access to ARVs: a surge in STIs; increased HIV positivity rates in sex workers and pregnant women in some areas; and AIDS defining conditions and late stage AIDS illnesses. While HIV has largely been concentrated within key populations in Madagascar, the group raised serious concerns regarding surging new infections and AIDS-related deaths in key populations and possibilities of a more generalised epidemic expanding, pleading for increased funding to implement the national HIV strategy.

This is a stark reminder that all countries must be very vigilant about HIV and reinforces the pressing priority of inclusive strategies that reach key populations.

The case study below illustrates one programme's efforts to re-enrol people who have dropped out of treatment.

HIV and AIDS screening in Madagascar. Photo: Zoto Razanadratefa

[30] Andrianarimanana-Köcher D, Rakotoarivelo RA, Randria MJdD, et al. Call for action: addressing the alarming surge of HIV in Madagascar. BMJ Glob Health 2024;9:e015484. doi:10.1136/bmjgh-2024-015484 https://gh.bmj.com/content/9/4/e015484.full accessed 21 July 2025

Strong in Jozi: Focus on Men's Health


Matthew Mathable.
Photo: Let us Grow

Matthew Mathabe is a young man in his early 40s living with HIV in Orange Farm, an informal settlement south of Johannesburg, South Africa. Like most young men who from Orange Farm, Mathabe has had many challenges in his life.

Growing up in a community and family marked by poverty and unemployment, Mathabe began abusing various substances at a very young age. One day Mathabe went home after using substances and got into a heated argument with his mother. His mother was admitted to Baragwanath Hospital after the argument and, after a few days, she passed away.

After his mother's passing, life became very difficult for Mathabe. Most of his family members and the community blamed Mathabe for his mother's passing. His brother and sister left him in the house and moved on with their lives. Mathabe yearned to be independent, but each day he faced bitterness from people in the community who did not want him anywhere near them or their children, they believed Mathabe to be a bad influence on their children.

Mathabe contended with rejection and hatred each day of his life. During this time, he found out he had contracted HIV, which became another struggle in his life. He went to a local clinic to start his ART (HIV treatment) but that was also not easy for him. Most of the clinic knew him and his background and were very judgemental. This led to Matthew stopping his treatment.

In May 2024 Mathabe was at home when he saw a group of young men wearing white T-shirts with the slogan," Strong in Jozi." Strong in Jozi is an awareness campaign led by ANOVA Health Institute, working in partnership with local organisations such as Let us Grow, running in Orange Farm since the beginning of 2024. (Jozi is a slang name for Johannesburg). Strong in Jozi targets men in and across Johannesburg, encouraging access to health services educating men about their health especially HIV, AIDS and prostate cancer, as well as GBV. The door-to-door awareness programmes educate men in the community and offer clinic referrals. Mathabe learnt about the programme through outreach to men in his community.


Strong in Jozi team from Orange Farm, South Africa.
Photo: Let us Grow

These young men told Mathabe about proper condom use, ARV'S, PEP and other health information. This was good news to Mathabe as he was longing to go back on treatment, but he did not know how to. He also needed a health facility (clinic) that could assist with his other health issues, such as TB. The group of young men told him that they were from Let us Grow organisation and gave him directions to go to the office.

A few days later, Mathabe visited Let us Grow offices where a loving team of young people received him, some living with HIV just like him. Mathabe explained his challenges to one of the field workers. saying that he would like to get back on treatment at another health facility. The field worker and co-ordinator arranged a referral for Matthew to a clinic in another extension (area) where people do not know him. The Let us Grow co-ordinator also offered to take Mathabe to the clinic to give him moral support and show him love and acceptance.

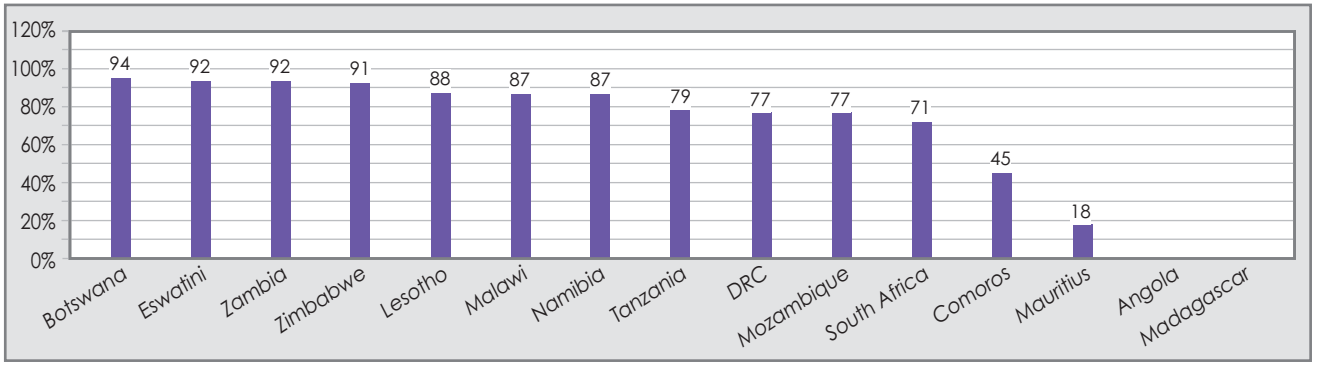
Mathabe is now back on treatment and has joined the group of field workers. Every day he encourages young men to test for HIV and to take their treatment. He feels so loved by his team members and nobody is judging him, regardless of what they know about him. Through the Voice and Choice Fund Let us Grow is able to make change and reach out to people in the community, one person at a time.

Source: Let us Grow report to Gender Links, October 2024

Viral suppression

UNAIDS TARGET 3: 95% of all people receiving antiretroviral therapy will have viral suppression.

Figure 5.6: Percent of people living with HIV who have suppressed viral loads



Source: Gender Links compiled from UNAIDS 2023 data

Figure 5.6 shows tremendous progress towards viral suppression with seven countries already over 86% which is the target for 2025 (note that 86% of all people living with HIV is equivalent to 95% of 95 % of 95%). Data on suppression is not available from Angola or Madagascar. Mauritius still has a low rate of suppression.

Health systems across SADC strain to fulfil the need to continue HIV prevention, testing, access to treatment for new patients and support to patients to adhere to treatment for life. There are reports of patients who feel better stopping their treatment or failing to take it regularly as is required. Poor adherence can lead to AIDS illness, death, antiretroviral resistance, and viral transmission. Adherence Clubs are a common initiative to support stable patients to adhere to their treatment. These Clubs may be based at a health facility or in the community. Group members meet once every two to three months and are issued with their pre-packaged ARVs, as well as medication for any other co-morbidities. In some areas they are also issued with prophylaxis for Tuberculosis (TB). The Adherence Club facilitator checks on all members and refers any that have problems to the health facility for further support. All members have their blood drawn to check their viral load and have other routine medical checks once or twice a year. Those who default on these visits should be followed up by home visits.

A study conducted in Ekurhuleni (an area with one of the highest prevalence rates in South Africa) with 730 members of Adherence Clubs meeting in health facilities, ranging in age from 20 to 69 with a median age of 39, identified factors associated with poor adherence[31] as:

- presence of co-morbidities which may be a result of the number of different medications patients are taking every day;
- changing from several ART tablets to a 1 pill a day formulation, which may result in patients feeling better and thinking they do not need the one pill any longer;
- longer duration of club membership, which may be resulting in treatment fatigue; and
- age - members who are older than 30 were more adherent than younger members, which may be a result of their feeling more welcome in the health facility.

It is important for health systems to be aware of factors that promote adherence and factors associated with poor adherence to be able to address these issues in the club meetings. Factors may be different in different settings.

[31] Ndoro T, Ndlovu N, Nyasulu P (2022) Factors associated with ART adherence among HIV-positive adherence club members in Ekurhuleni Metropolitan Municipality, South Africa: A cross-sectional study. PLoS ONE 17(11): e0277039. https://doi.org/10.1371/journal.pone.0277039 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0277039 Accessed 30 September, 2024.

Costs of HIV programmes

The cost of large HIV treatment programmes places a heavy strain on fragile health systems in SADC

The cost of HIV programmes takes a heavy toll on fragile economies in SADC. Figures reported for South Africa, for instance, show domestic annual expenditure of $1.42 billion and international contributions of $443 million.[32] Comparable figures for Seychelles, with a relatively small HIV burden, are $3.3 million from domestic public resources, $47 000 from domestic private sources and $45 000 from international sources.[33]

The Government of Zimbabwe established the **Zimbabwe AIDS Levy** through legislation in 1999. The AIDS Levy is funded by a 3% levy on individual income and corporate taxes, which is collected in the National AIDS Levy Trust and administered by the National AIDS Council (NACA). In 2023 this amounted to about $30 million, which gave the NACA flexibility to identify local priorities, cover gaps in donor funding, and power to convene donors and key actors to improve coordination of effort. Budgets are provided as follows: 50% for antiretroviral therapy programme, 10% prevention, 6% M&E and coordination, 5% enabling environment and 23% and 4% for programme logistics support and assets respectively. The Ministry of Health and Child Welfare monitors expenditure and results, including allocations to civil society, and the fund is audited annually. Zimbabwe is able to make strategic long-term investments in aspects of the HIV programme such as condoms where donor funding is fluctuating.[34]

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 a leading cause of death among people living with HIV.

Table 5.25: TB-related deaths in people living with HIV

Country	2000	2010	2022	Rate of decrease 2010 to 2022
Tanzania	54 000	41 000	5 100	88%
Malawi	13 000	18 000	3 600	80%
Zambia	19 000	14 000	2 800	80%
Mozambique	20 000	21 000	4 300	80%
DRC	25 000	19 000	5 100	73%
Eswatini	2 400	2 400	650	73%
South Africa	121 000	88 000	31 000	65%
Angola	1 900	9 100	3 300	64%
Lesotho	4 200	4 700	2 400	49%
Botswana	3 900	2 100	1 100	48%
Namibia	4 600	2 100	1 100	48%
Zimbabwe	14 000	8 100	6 000	26%
Madagascar	37	55	370	-573%
Mauritius	7	2	15	-650%
Comoros	0	0	1	
Seychelles	0	0	0	
Total SADC	**283 044**	**229 557**	**66 836**	**71%**
SADC as % of Global	**39%**	**42%**	**39%**	
Global	**720 000**	**550 000**	**170 000**	**70%**

Source: Gender Links compiled from UNAIDS 2023 data

[32] UNAIDS (2024) Country Factsheet South Africa 2023. https://aidsinfo.unaids.org/ Accessed 24 July 2024.
[33] UNAIDS (2024) Country Factsheet Seychelles 2023. https://aidsinfo.unaids.org/ Accessed 24 July 2024
[34] HIV Multisector Leadership Forum. 2024. Zimbabwe AIDS levy: Investing locally for HIV prevention A case study. https://hivpreventioncoalition.unaids.org/sites/default/files/attachments/the_zimbabwe_aids_levy_investing_locally_for_prevention.pdf

Table 5.25 compares the number of TB related deaths in people living with HIV in 2000, 2010, and 2022. The global target is to reduce the rate of deaths due to TB in people living with HIV by 80% compared to a 2010 baseline by 2025. The global rate of decline by 2022 was 70%. SADC's decline was not very different at 71%. Tanzania, Malawi, Zambia and Mozambique have achieved the target already and DRC and Eswatini had rates of decline that were higher than the global average. These are commendable results in view of the serious disruption to TB programmes caused by COVID-19. SADC accounts for about 40% of all TB related deaths in people living with HIV.

MPox

MPox, previously known as Monkey Pox, is a viral disease that produces a fever, pains and skin lesions. While the infection is often mild, it is more severe in people with compromised immune systems, children and pregnant women. MPox has been found for some time in the DRC and the tropical forests in West Africa. The latest MPox outbreak, whose epicentre is in the DRC, was declared a Public Health Emergency of Continental Security by the Africa Centres for Disease Control and Prevention (Africa CDC) on August 13 2024. The WHO declared it a Public Health Emergency of International Concern (PHEIC) on August 14.

A recent update from the Africa CDC is that MPox has spread to 16 countries in all five regions of Africa, with South Africa being the only other SADC country to experience cases so far.[35] MPox has affected more men than women and leads to severe illness in children. Over 40% of those that have contracted MPox around the world are people that are living with HIV. One of the routes of MPox transmission is through sex. Condoms reduce sexual transmission.

The Africa CDC is working to secure vaccines for MPox. By mid-September 2024, it had 4.3 million doses out of a target of 10 million and was anticipating further pledges, including from the United States President, Joe Biden. The Coalition for Epidemic Preparedness Innovations is contributing $72 million for vaccine development and $145 million for manufacturing of the vaccine in Rwanda.[36]

Care work

Article 27.3

c) 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 caregivers as well as promote the involvement of men in the care and support of people living with HIV and AIDS.

SDG 5.4

Recognise and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

[35] Africa CDC. 2024. Outbreak Report, 13 September 2024: Mpox Situation in Africa. https://africacdc.org/download/outbreak-report-13-september-2024-mpox-situation-in-africa/ accessed 11 October 2024

[36] Africa CDC. Communique of 3rd Meeting of the Committee of Heads of State and Government of the Africa CDC, 23 September 2024. https://africacdc.org/news-item/communique-of-3rd-meeting-of-the-committee-of-heads-of-state-and-governement-of-the-africa-centres-for-disease-control-and-prevention-africa-cdc/ accessed 11 October 2024.

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 emphasising shared responsibilities between women and men, girls and boys.

The HIV response is very deeply community rooted. In the early 2000s, hundreds of poorly resourced and poorly supported community home-based care groups provided essential care to many millions of people living with HIV and people desperately ill with AIDS. They often also cared for the ill people's children, who too often became orphans when one or both of their parents died. With the advent of ARVs the need for home care lessened and many groups disbanded. However, as the epidemic persists, health systems are strained to continue prevention, testing, access to treatment and supporting adherence for large numbers of people living with HIV. Many community organisations are regrouping and new organisations are forming, to support efforts in:

- Adherence and retention support including facilitating adherence clubs and collecting ARVs for the clubs.
- Follow up of people living with HIV that are not coming for their medication and routine tests.
- Distribution of condoms and lubricants.
- Linkage to HIV treatment.
- Information on life skills-based HIV and sexuality education.
- HIV, SRH and health promotion, including linkage to VMMC and PrEP.
- HIV testing.
- Treatment literacy.
- TB screening and referral for testing.
- DOTS support (for TB treatment).
- Follow up for other co-morbidities such as hypertension.
- Legal services.
- Legal literacy.
- Needle-syringe distribution.

The Global AIDS Strategy 2021-2026 goal is for community-led organisations to deliver:
- 30% of testing and treatment services
- 80% of HIV prevention services
- 60% of programmes supporting the achievement of societal enablers.

The specific goals for community-led prevention and treatment recognise the critical role of communities and have encouraged renewed emphasis on support for community efforts. However, funding still largely flows to, or at least through, organisations based in donor countries and large national organisations located outside of high prevalence communities. There are efforts to develop ways to better monitor and account for the volume of services being delivered by community-based organisations, including organisations of people living with HIV and of key populations. To achieve these goals, there is an urgent need for adequate resourcing for community groups to sustain the vital work they do. Critical questions remain regarding care worker remuneration and the impact of unpaid care work by family, mostly women, still happening in homes. These issues require greater consideration and inclusion within strategic planning.

Many community groups are supporting HIV prevention, testing, access and adherence to treatment

Let us Grow, a Voice and Choice SAF grantee working in Orange Farm, an informal settlement south of Johannesburg, is an organisation that provided home-based care at the height of the AIDS crisis in the early 2000s. It now supports community and government efforts for HIV prevention, focusing on condom distribution, providing safe spaces for men who have sex with men to come forward for HIV testing and access to treatment and follow up of people living with HIV who are defaulting on their ARVs. Let us Grow has a number of male volunteers, thus meeting one of the SADC Gender Protocol's targets of increasing male involvement in care work.

Many other organisations have peer supporters from affected groups. For example, many programmes around the world include Mentor Mothers, sometimes under different names. Along with other issues, Mentor Mothers often support pregnant women living with HIV to prevent vertical transmission to their children. There are also Mentor Brothers who support other men, as well as peer sex workers and peer young people.

Condom distribution initiative by Orange Farms' Let us Grow organisation in South Africa. Photo: Let us Grow

The case study below is an example of peer adolescent girls and young women who are promoting access to SRHR and HIV prevention in Zimbabwe.

Adolescent girls and young women peer Advocacy Champions for HIV Prevention

Youth Aspire Development Trust, a Voice and Choice SAF grantee, worked with 25 adolescent girls and young women (AGYW) Sexual and Reproductive Health and Rights (SRHR) Advocacy Champions in Chitungwiza, not far from Harare in Zimbabwe. The young women received comprehensive training on SRHR, HIV prevention and advocacy skills to become effective advocates with their peers and others within their communities.

The Advocacy Champions led many outreach activities, such as workshops, seminars, and one-on-one sessions, which increased SRHR & HIV awareness and knowledge. Tanatswa[37] for example, educated her peers about the importance of HIV testing and safe sexual practices. She organised weekly discussion groups at her school, where she shared information and answered questions. Her efforts led to a number of students getting tested for HIV. Tanatswa's leadership and dedication earned her recognition from both her peers and the school administration. Altogether, champions held 109 school-based sessions within the first six months of 2024.

In collaboration with local health facilities, the programme helped link young people to SRH and HIV services, including HIV counselling, testing and treatment. Two clinics in Chitungwiza

Advocacy Champions led many outreach workshops, seminars, and one-on-one sessions in Chitungwiza, Zimbabwe. Photo: Youth Aspire Development Trust

[37] All names in the case study are pseudonyms.

(PZAT and Population Services Zimbabwe) attested at a feedback meeting that the SRHR Advocacy Champions' work increased the number of young people using their services. The Champions referred and sometimes accompanied young girls and women, including some with disability, to the clinics. Health workers applauded YADT for training and supporting the Champions and also recommended they should be well compensated to keep them motivated and ensure continuity.

The Champions also influenced behaviour change, for both adopting safer sexual practices and being more confident to seek SRH services. Tanyaradzwa focused on reaching out to young women in her neighbourhood. She made door-to-door visits, providing information on SRHR services and encouraging young women to visit local health facilities. Tayaradzwa's personal approach helped break down barriers and build trust. As a result, many young women previously hesitant to seek SRHR services felt more comfortable doing so. Tanyaradzwa's efforts contributed to increased uptake of contraceptive services.

Another key achievement was engaging with the community and community leaders to tackle stigma and misconceptions surrounding HIV and SRHR. More than 500 community members, including parents, teachers and local leaders, participated in dialogues and awareness campaigns. This broader community involvement helped create a more supportive environment for young people seeking SRHR and HIV services without fear of judgment or discrimination.

Open dialogues can reduce misconceptions - Chitungwiza, Zimbabwe.
Photo: Youth Aspire Development Trust

Marvellous addressed stigma and HIV misconceptions in her community. She organised community dialogues and invited local leaders to participate. Through honest conversations, Marvellous helped change negative attitudes and reduce stigma associated with HIV. After the dialogues, the United Methodist Church and Apostolic Faith Mission (AFM) Assembly have held open discussions with youth about HIV prevention and stigma.

Raising awareness in the Chitungwiza, Zimbabwe community.
Photo: Youth Aspire Development Trust

The sessions have increased awareness and understanding among young people, reducing misconceptions and promoting a supportive environment for those living with HIV. These churches are playing a crucial role in changing community attitudes and encouraging proactive health behaviours among youth. This has strengthened the community's overall response to HIV.

Champions also focus on women leaders in churches and held a workshop with 30 of these from 12 churches in early 2024. Women leaders such as pastors, chairwomen, youth leaders and Sunday school teachers better understand the issues that girls now face.

2263 young people in Chitungwiza were engaged through school visits, community workshops, and social media campaigns, which broadened the project's impact by the end of June 2024, nearing the project's target of 2500 by the end of December. This case study highlights the importance of peer-led initiatives in addressing SRHR and HIV prevention challenges and underscores the potential for scaling up such programmes.

Source: Youth Aspire Development Trust, report to Gender Links. October 2024.

Next steps

SADC, which is still the most heavily affected region in the world by HIV, must continue urgent steps to eradicate AIDS as a public health threat by 2030. These include:

Redoubling efforts for HIV prevention:

- New and innovative ways must be found to keep raising awareness about the reality of HIV and influence behaviours to reduce risk and encourage testing to be aware of one's status.
- Urgently review legislation that criminalises sex work and men who have sex with men/women who have sex with women, to enable service provision to everyone.
- Engage community leaders and communities, the media, politicians and opinion leaders to address stigma and discrimination at all levels.
- Mobilise political will at all levels to address gender inequalities and the GBV epidemic facing girls and women in SADC.
- Continue to focus on prevention of vertical transmission of HIV to children, with a particular focus on adolescent and young mothers.
- Embrace the Education Plus Initiative with comprehensive sexuality education and seek to have as many adolescent girls and boys as possible in secondary school.
- Be prepared to roll out new technologies such as long-acting PrEP swiftly.

Generate new impetus for HIV control particularly in Madagascar where the epidemic could spiral out of control.

Continue efforts to focus more on testing, treatment and care for children.

Continue to invest in the search for an effective vaccine, even as new therapies and treatments are developed.

Seek to integrate HIV services with other services e.g. adolescent health, school health, SRHR including control of STIs, maternal and child health, services for older people etc.

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 for pre-adolescent girls against the human papilloma virus (HPV), which predisposes women living with HIV to develop cervical cancer, as well as regular cervical cancer screening for all women living with HIV and enhancing TB case finding and treatment.

Support and effectively resource community-led responses for major aspects of the HIV response. The need for multi sectoral collaboration is very clear. Health services must collaborate with community initiatives. Expand collaboration with social and education services. Acknowledge the critical role of the community in HIV prevention, care and support and find simple ways to demonstrate the contribution of community organisations to the overall programme.

Scale up domestic resource mobilisation for the HIV response!

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Gender-based Violence 6

Sixteen Days of Activism 'Take Back the Night' campaign in Alexandra Township, Johannesburg. Photo: Colleen Lowe Morna

Key points

- GBV remains one of the most flagrant violations of human rights in the region.
- South Africa's first comprehensive GBV study shows that 35.5% of women have experienced physical and/or sexual violence at least once in their lifetime[1].
- In South Africa, 1.3% of men perpetrate sexual violence against other men, and 2.3% of men experience sexual violence during adulthood[2].
- Almost eight in 10 South Africans (78%) say domestic violence should be treated as a criminal matter, while 18% see it as a private matter to be resolved within the family.
- South Africa's high court has ruled that rape suspects can no longer rely on the subjective belief that a complainant consented.
- Fifteen out of 16 SADC countries do not meet the minimum standards for the elimination of trafficking, as highlighted in the US State Department 2024 report on *Trafficking in Persons*[3].
- The DRC and Tanzania have yet to enact specific domestic violence laws.
- Survivors are often displaced and subjected to violence while seeking essential resources such as food and firewood in conflict-affected areas such as the DRC.
- As access to technology increases, there are parallel risks for the perpetuation of technology-facilitated gender-based violence (TFGBV).

[1] Zungu NP., Petersen Z., Parker W., Dukhi N., Sewpaul, R., Abdelatif N., Naidoo I., Moolman B., Isaacs D., Makusha T., Mabaso M., Reddy T., Zuma, K. and The SANSHEF Team (2024). The First South African National Gender-Based Violence Study: A Baseline Survey on Victimisation and Perpetration. Cape Town: Human Sciences Research Council. Available at: https://hsrc.ac.za/news/latest-news/results-of-the-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).
[2] Ibid.
[3] United States Department of State, 2024 Trafficking in Persons Report. Available at: https://www.state.gov/reports/2024-trafficking-in-persons-report/ (Accessed: 26 October 2024).

Introduction

GBV 16 days of Activism March by multisectoral organisations, Pietermaritzburg, South Africa. Credit: Incema

Gender-based violence (GBV) continues to be pervasive in the Southern African Development Community (SADC) region, with notable differences in prevalence and impact.

In the post-COVID-19 period, GBV continues to pose significant health risks and social consequences, resulting in adverse effects on physical, mental, sexual, and reproductive health. In conflict-affected regions such as the Democratic Republic of the Congo (DRC), sexual violence further complicates existing challenges within the health system, highlighting the need for comprehensive humanitarian responses.

Despite the economic downturns caused by COVID-19 lockdowns and the severe impacts of climate change, countries must remain focused on the economic disparities that significantly contribute to women's vulnerability to GBV. Initiatives such as Gender Links' Sunrise campaign aim to economically empower women, reduce GBV, and promote economic justice in the region.

The recent study from South Africa offers new insights into intimate partner violence (IPV) and childhood experiences of violence for both women and men. Data from the 2023 SADC Scorecard, UN Women, and WHO estimates have been utilised to present current and lifetime statistics on intimate partner violence and other indicators.

South Africa has witnessed a significant court ruling which promotes a more victim-centred approach by invalidating sections of the Sexual Offences Act, which permitted defendants to assert unreasonable beliefs regarding consent.

Maintaining compliance with international standards and implementing effective anti-trafficking measures is critical as trafficking becomes more widespread. All but one SADC country falls below the minimum standards for combatting human trafficking.

This chapter examines the changing landscape of GBV in the digital age. It includes updates from the SVRI conference regarding global and regional initiatives to address technology-facilitated gender-based violence (TFGBV). There is optimism that the SADC Model Law on Gender-Based Violence, along with efforts to adapt training programmes for GBV responders will enhance national legislation and response to TFGBV. The chapter emphasises the importance of projects incorporating mobile applications to prevent TFGBV and promote inclusive decision-making in technology governance. Such initiatives are essential for creating safer digital environments.

Community-driven projects, such as those funded by Voice and Choice Southern Africa (VCSAF)[4] and initiated by traditional leaders' wives in Zimbabwe, promote gender equality and empower women. Successful rehabilitation programmes in Mauritius and community engagement strategies in Malawi further highlight the importance of integrated approaches to end GBV.

The role of the media in increasing awareness and influencing policy changes through campaigns such as the 16 Days of Activism against GBV is highlighted. The chapter emphasises the necessity for integrated approaches and sustained advocacy to combat this pervasive issue effectively.

The chapter examines the extent, drivers, effects, responses, support, and prevention efforts regarding GBV in the SADC region. Table 6.1 summarises available information on extent of and response to GBV.

[4] https://vcsafund.org/

Table 6.1: Key data on the 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 ever-partnered women aged 15-49 years experiencing IPV and/or sexual violence at least once in their lifetime[5, 6]	13 countries	38	34	8.3	47	n/d	40	44[7]	30	n/d	30	27	n/d	23.9[8]	38	41	35
Proportion (%) of ever-partnered women aged 15-49 years experienced IPV and/or sexual violence at least once in the previous 12 months[9, 10]	13 countries	25	17	5.2	36	18	16	n/d	17	n/d	16	16	n/d	6.4[11]	24	28	19
*SDG 5.2.1 Proportion (%) of women & girls aged 15 years & older subjected to physical & sexual violence by a partner in the previous 12 months[12]	14 countries	21.7	26.2	12	5	4.6	n/d	15.5	24.3	1.1	18.8	33	0.4	6.4	n/d	47	39.6
*SDG 5.2.2 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[13]	Ten countries	4.5	2.9	10.1	25.4	0.2	n/d	n/d	14	n/d	7	n/d	n/d	27	10.1	n/d	14
Laws on domestic violence[14]	14 countries	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Laws on sexual assault[15]	15 countries	Yes	Yes[16]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Bill in place[17]	Yes	Yes	Yes	Yes
Human trafficking laws[18]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual harassment laws[19]	All 16 countries	Yes	Yes[20]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Integrated approaches: national action plans[21]	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[22]	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[23, 24, 25]	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)[26]	All 16 countries	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

KEY * = indicators measured in the SADC 2023 Milestone Scorecard
n/d = no data available

[5] Global database on Violence against Women (no date) UN Women Data Hub. Available at: https://data.unwomen.org/global-database-on-violence-against-women (Accessed: 8 November 2024).
[6] World Health Organization 2024 data.who.int, Proportion of ever- partnered women and girls aged 15- 49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime (%) [Indicator]. https://data.who.int/indicators/i/BEDE3DB/E0D4E17 (Accessed on 22 November 2024)
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[9] Global database on Violence against Women (no date) UN Women Data Hub. Available at: https://data.unwomen.org/global-database-on-violence-against-women (Accessed: 8 November 2024).
[10] World Health Organization 2024 data.who.int, Proportion of ever- partnered women and girls aged 15- 49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime (%) [Indicator]. https://data.who.int/indicators/i/BEDE3DB/E0D4E17 (Accessed on 22 November 2024)
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[12] SADC SRHR SCORECARD 2023 Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 6 October 2024).
[13] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2024).
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[15] 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.
[16] Between (October 2nd, 2020 - October 1st, 2021), Angola enacted legislation protecting women from sexual harassment in employment. It also adopted criminal penalties for sexual harassment in employment. World Bank: https://wbl.worldbank.org/content/dam/documents/wbl/2022/snapshots/Angola.pdf
[17] 'Sexual Offences Bill 2021 - Proposed Model Law by the Child Law Reform Committee' (2021) The Judiciary of Seychelles, 26 July. Available at: https://www.judiciary.sc/news/sexual-offences-bill-proposed-model-law-by-the-child-law-reform-committee/ (Accessed: 8 November 2024).
[18] United States Department of State (2020), Trafficking in Persons Report, https://www.state.gov/reports/2020-trafficking-in-persons-report, accessed 5 June 2021.
[19] 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.
[20] Between (October 2nd, 2020 - October 1st, 2021), Angola enacted legislation protecting women from sexual harassment in employment. It also adopted criminal penalties for sexual harassment in employment. World Bank: https://wbl.worldbank.org/content/dam/documents/wbl/2022/snapshots/Angola.pdf
[21] Gender Links, Policy and action plans, https://genderlinks.org.za/what-we-do/justice/policy-and-action-plans/, accessed 18 June 2021.
[22] 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.
[23] 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.
[24] 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.
[25] 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.
[26] 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.

Accessing current data on GBV and especially IPV indicators remains challenging. Table 6.1 mostly shares slightly adjusted numbers to those in the 2022 Barometer. This 2024 Barometer relies on the 2023 SADC SRHR Scorecard for the latest data on two SDG indicators: 1) SDG 5.2.1 Proportion (%) of women and girls aged 15 years and older subjected to physical and sexual violence by a partner in the previous 12 months.[27] and 2) SDG 5.2.2 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[28] - measured as non-partner sexual violence in the scorecard. The UNWomen data hub[29] and the WHO Estimates data portal[30] have been used for data on the Proportion (%) of ever-partnered women aged 15-49 years experiencing IPV and/or sexual violence at least once in their lifetime[31]. Thirteen countries have prevalence data estimates for ever-partnered women aged 15-49 years experiencing IPV and/or sexual violence at least once in their lifetime. This ranges from 8.3% in Comoros to 47% in the DRC.

The proportion of ever-partnered women facing IPV or sexual violence in the past 12 months ranges from 5,2% in the Comoros to 36% in the DRC. South Africa's newest 2022 study shows 6.4% of ever-partnered women aged 15-49 years experienced IPV and/or sexual violence at least once in the 12 months before the study. The figures for IPV in the lifetime and past 12 months for the DRC are very high. This reveals significant challenges regarding violence against women and girls, as well as the legal framework surrounding these issues.

Only ten countries have data on non-partner sexual violence, with high levels in South Africa of 27% and one-quarter of female respondents in the DRC reporting this type of violence, compared to a lowest level of 0,2% in Eswatini.

Most data on other indicators remain essentially unchanged, and the scarcity of regular data gathering makes this outdated. For more than a decade, GL worked to address these data gaps, spearheading seven comprehensive violence against women and girls (VAWG) and 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.[32] GL is working to secure funding for a follow-up study in Lesotho in 2025. Findings from the South African survey are very similar to findings by GL, especially on the widespread prevalence of emotional abuse.

Other indicators show that:

- Fourteen SADC countries now have domestic violence legislation, and 15 have sexual assault legislation. Seychelles has a sexual offences bill in place.
- The DRC and Tanzania have yet to enact specific domestic violence laws.
- Angola now has legislation on sexual harassment, and
- All 16 SADC countries have human trafficking laws.

Kwanele app for survivors-by-survivors South Africa. Credit: Sonke

[27] SADC SRHR SCORECARD 2023 Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 6 October 2024).
[28] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2024).
[29] Global database on Violence against Women (no date) UN Women Data Hub. Available at: https://data.unwomen.org/global-database-on-violence-against-women (Accessed: 8 November 2024).
[30] World Health Organization 2024 data.who.int, Proportion of ever- partnered women and girls aged 15- 49 years subjected to physical and/or sexual violence by a current or former intimate partner in their lifetime (%) [Indicator]. https://data.who.int/indicators/i/BEDE3DB/E0D4E17 (Accessed on 22 November 2024)
[31] ibid
[32] The studies can be accessed on the GL website: https://genderlinks.org.za/what-we-do/justice/research/violence-against-women-baseline-research/

Prevalence

Table 6.1 shows statistics on the prevalence of GBV across SADC which varies between different countries. The following section analyses prevalence statistics of different forms of GBV in South Africa.

First GBV study reveals alarming statistics

The *First South African National Gender-Based Violence Study, 2022* is based on a national survey with a total sample of 10012 (5603 women and 4409 men).

Table 6.2: First South African National Gender-Based Violence Study, 2022 findings

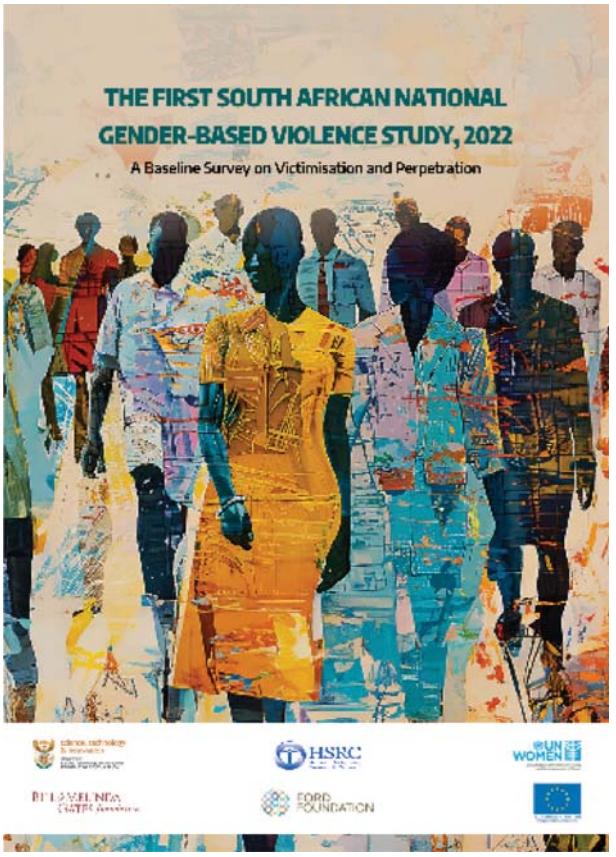
Type of violence	Victimisation		Perpetration	
	Recent (%)	Lifetime (%)	Recent (%)	Lifetime (%)
VAW, regardless of partnership status				
Physical and /or Sexual violence	7%	35,5%		
Physical	6,1%	33,1%		
Sexual	2%	9,8%		
Intimate Partner Violence (IPV)				
Emotional Abuse	10,0%	25,1%	7,2%	33,7%
Physical and/or Sexual IPV	6,4%	23,9%	4,0%	20,5%
Physical IPV	5,2%	22,4%	2,4%	16,7%
Economic Abuse	4,5%	13,1%	5,3%	14,8%
Sexual IPV	2,5%	7,9%	2,3%	7,5%
Psychological: Controlling behaviours		57,6%		77,2%
Non-partner violence (NPV)				
Physical/Sexual NPV	3,7%	27,0%		
Physical NPV	3,4%	24,6%		
Sexual NPV	0,6%	5,9%		
Perpetration by men towards other men				
Sexual				1,3%
Victimisation of men during adulthood (outside the home)				
Physical		20,4%		
Sexual		2,3%		
Prevalence of Childhood Abuse among ALL women before age 15				
Physical		58,0%		
Sexual		4,0%		
Prevalence of Childhood Abuse among ALL men before age 18				
Physical		74,6%		
Sexual		15,7%		

Source: First South African National Gender-Based Violence Study, 2022[33]

Table 6.2 summarises selected findings from the report. Some key findings are:

- Over one-third (35.5%) of women experience physical and/or sexual violence in their lifetime.
- Extensive psychological abuse and controlling behaviours (57,6%) and emotional abuse against women in intimate partnerships.
- Significant rates of physical and/or sexual non-partner violence (NPV) against women (27%).
- Notable prevalence of physical violence against men outside the home (20.4%)
- 1.3% of men perpetrate sexual violence against other men, and 2.3% of men experience sexual violence during adulthood. This highlights that sexual violence is not exclusively directed towards women but also occurs between men.

[33] Zungu NP., Petersen Z., Parker W., Dukhi N., Sewpaul, R., Abdelatif N., Naidoo I., Moolman B., Isaacs D., Makusha T., Mabaso M., Reddy T., Zuma, K. and The SANSHEF Team (2024). The First South African National Gender-Based Violence Study: A Baseline Survey on Victimisation and Perpetration. Cape Town: Human Sciences Research Council. Available at: https://hsrc.ac.za/news/latest-news/results-of-the-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).



Overall, women experience higher rates of violence than men. In terms of Non Partner Violence (NPV), physical violence is more common than sexual violence, with most of the physical NPV (31%) from the survivors' family (parent, sibling, parent-in-law, or another male family member.)[34] For intimate partner violence (IPV), there is a high prevalence of controlling behaviours and emotional abuse. Additionally, the study highlights that Black African women experience the highest rates of IPV.

The study sheds new insights on violence against women with disabilities who experience a significantly higher rate of lifetime violence (40.4%) compared to women without disabilities.

The study found that a small proportion of women reported experiencing violence during the COVID-19 lockdown, primarily by their partners. Specifically, 1.8% reported physical violence, 0.9% sexual violence, and 2.7% emotional abuse. 1.1% of men self-reported perpetrating physical violence. 0.8% sexual violence, and 1.9% emotional abuse. The study cautions that these findings reflect a specific period with unique factors like restricted movement and alcohol sale prohibitions and should not be compared to recent or lifetime experiences of IPV.

The study notes the under-reporting of GBV. Despite high awareness of GBV laws, effective implementation remains challenging. Continued efforts in prevention, intervention, and support services are needed for victims of violence in South Africa. Recommendations from the study include: targeted community-based initiatives, enhanced mental health support, and improvements in law enforcement and policy frameworks.

Critical insights from the study can inform policies and interventions to curb GBV and femicide in South Africa and other SADC countries facing similar challenges. For countries with high rates of violence against women, particularly those with entrenched patriarchal systems, the insights into community and household dynamics can aid in tailoring interventions. Additionally, identifying key risk factors, such as economic dependence among women and mental health issues among men, can guide targeted prevention strategies across the region. SADC countries are strongly urged to emulate South Africa's example by conducting dedicated GBV studies.

Emerging forms of GBV: technology facilitated GBV (TFGBV)

The Sexual Violence Research Initiative (SVRI) 2024 forum, which took place in Cape Town, South Africa, from October 21 to 25, delved into the complexities of TFGBV, examining its manifestations across different regions and contexts. Participants discussed the impact on victims and communities, shared research, and explored measures to enhance understanding and address gaps. The forum aimed to advance practical policies and interventions to combat TFGBV, emphasising the importance of data safety and ethical considerations.

[34] Media pack: First South African National Gender-Based Violence Study, 2022 - HSRC (2024). Available at: https://hsrc.ac.za/media-pack-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).

Drivers of GBV

A complex interplay of factors drives gender-based violence in SADC countries. Key drivers include entrenched patriarchal norms, economic inequalities, and high levels of poverty and unemployment. Weak legal frameworks and inadequate enforcement exacerbate the issue, while cultural practices and societal attitudes often normalise violence against women and children. Additionally, factors such as armed conflict, humanitarian crises, and substance abuse further contribute to the high prevalence of GBV in the region. Understanding these drivers is crucial for developing effective interventions and policies to combat GBV across SADC countries.

South Africa: Key societal factors contributing to high rates of GBV

The persistence of gender inequality is a critical factor contributing to GBV in South Africa. Deeply ingrained societal norms and structures perpetuate male dominance and reinforce gender hierarchies. This unequal power dynamic fosters an environment where violence against women is normalised and accepted as part of social interactions, particularly in intimate relationships.

Cultural beliefs play a significant role in shaping attitudes toward gender relations. A considerable proportion of men and women subscribe to harmful gender norms that justify male violence and control over female partners. These norms often exhibit strong cultural reinforcement such as concepts of masculinity that equate toughness with exerting control which contribute to the normalisation of violence.

Economic factors are profoundly intertwined with GBV. Women's dependency on men for financial support can leave them vulnerable to violence. Many women in South Africa report relying on grants or limited financial resources, making it difficult to leave abusive relationships. Economic abuse is widespread, where perpetrators restrict access to necessary financial resources, further entrenching women's dependency.

South Africa's history of institutionalised racism and sexism has enduring effects on current societal attitudes towards violence. The legacy of apartheid, which fostered systemic inequalities, still contributes to a culture where violence remains a tool for asserting power and control.

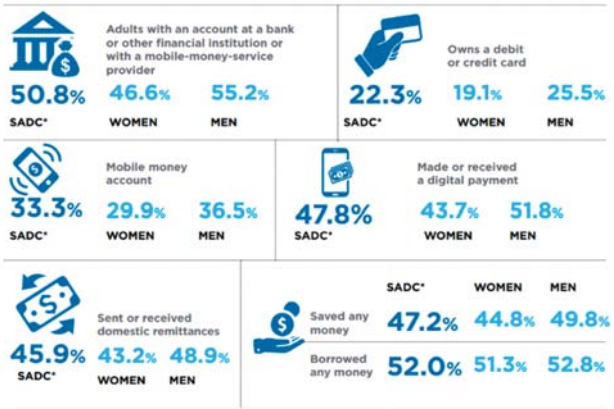
Mental health crises and substance abuse are also pivotal in understanding GBV. High levels of alcohol and substance abuse are correlated with increased violence, particularly in intimate relationships. The combination of mental health challenges, poor social support systems, and historical trauma exacerbates the risk for both victims and perpetrators.

Addressing GBV in South Africa requires a multifaceted approach that recognises and dismantles these deep-rooted societal factors through education, economic empowerment, and policy reform.

Source: First South African National Gender-Based Violence Study, 2022.[36]

[35] Results of the first South African National Gender-Based Violence Study, 2022 - HSRC (2024). Available at: https://hsrc.ac.za/news/latest-news/results-of-the-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).
[36] Results of the first South African National Gender-Based Violence Study, 2022 - HSRC (2024). Available at: https://hsrc.ac.za/news/latest-news/results-of-the-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).

The economic status of women in SADC



SADC Gender and Financial Inclusion Fact Sheet: Source, UNWOMEN

The SADC Gender and Development Monitor 2022[37], highlights several glaring parity gaps regarding women's economic status in the region:

1. Women continue to constitute more than 50% of the poorest segment of the SADC population. This economic disparity significantly impacts overall economic growth and hinders progress on women's economic empowerment.
2. The report emphasises that sustainable poverty reduction can only be achieved when women have guaranteed access to and participation in all economic sectors. This is crucial for mobilising their potential for sustainable development and poverty alleviation.
3. Various initiatives are being implemented to enhance women's economic independence. These include capacity-building programmes, entrepreneurship training, and efforts to integrate women into local economic development plans.
4. Despite ongoing efforts, challenges such as high levels of poverty, unemployment, and lack of financial inclusion persist[38]. However, regional cooperation and policy reforms pave the way towards a more equitable and prosperous future for all SADC citizens.

Women's financial inclusion in the SADC region still lags.[39] According to a UN Women 2024 study, although there have been some improvements, leading to narrowing of gender gaps in financial inclusion since 2016, women remain significantly more financially excluded than men in more than half of the SADC member states.[40] When women are financially excluded, they lack access to essential financial services like banking, credit, and insurance, which are crucial for economic empowerment and independence. Without financial stability, women are less able to invest in business opportunities or secure loans to grow their enterprises, further limiting their economic participation and reinforcing cycles of poverty and dependence. This financial dependency can trap women in abusive relationships, as they may lack the resources to leave or seek help. Addressing financial inclusion is, therefore, critical in reducing women's vulnerability to GBV and promoting their overall economic and social well-being.

Gender attitudes

GBV is rooted in gender inequity, manifested in social norms that legitimate men's control and dominance over women. The following findings from the Afrobarometer survey show perceptions of GBV in South Africa and Lesotho. In both countries, GBV is identified as the most critical women's rights issue that needs to be addressed by the government and society.

[37] SADC Gender and Development Monitor 2022 - English | SADC (no date). Available at: https://www.sadc.int/document/sadc-gender-and-development-monitor-2022-english (Accessed: 4 November 2024).
[38] Financial inclusion and gender in the SADC region - Her Finance, Her Future Building Stronger Economies One Woman at a Time (no date) UN Women - Africa. Available at: https://africa.unwomen.org/en/digital-library/publications/2024/10/financial-inclusion-and-gender-in-the-sadc-region-her-finance-her-future-building-stronger-economies-one-woman-at-a-time
[39] Financial inclusion and gender in the SADC region - Her Finance, Her Future Building Stronger Economies One Woman at a Time (no date) UN Women - Africa. Available at: https://africa.unwomen.org/en/digital-library/publications/2024/10/financial-inclusion-and-gender-in-the-sadc-region-her-finance-her-future-building-stronger-economies-one-woman-at-a-time (Accessed: 4 November 2024).
[40] Ibid.

Table 6.3: Findings from Afrobarometer surveys on perceptions about GBV

Respondents who said	South Africa[41]	Lesotho[42]
violence against women and girls is a:		
"somewhat common" or	23%	28%
"very common" occurrence in their community	25%	25%
it is "never" justified for a man to use physical force to discipline his wife	78%	85%
a woman will be criticised, harassed, or shamed if she reports GBV to the authorities:		
"somewhat likely"	25%	29%
"very likely"	18%	27%
the police are likely to take cases of GBV seriously	76%	79%
domestic violence should be treated as a criminal matter rather than as a private matter to be resolved within the family	78%	53%

Areas in which similar views were exhibited in both countries were: significant proportions acknowledge that violence against women is a common occurrence in their communities; large majorities believe that it is never justified for a man to use physical force to discipline his wife; most believe that the police are likely to take GBV cases seriously, indicating a level of trust in law enforcement's response to such incidents.

However, there are notable differences. In South Africa, 48% say violence against women and girls is common, whereas in Lesotho, this figure is slightly higher at 53%. When it comes to reporting and stigma, 43% of South Africans think it is likely that a woman will be criticised or harassed if she reports GBV, compared to 56% in Lesotho. Furthermore, 78% of South Africans believe domestic violence should be treated as a criminal matter, while this view is held by only 53% of the respondents in Lesotho.

These insights highlight the importance of tailored approaches to address GBV in each country, considering the commonalities and differences in perceptions. Awareness and education efforts are crucial to reduce the justification of violence and to encourage reporting.

Effects of GBV

Studies show that exposure to GBV leads to many adverse health outcomes.[43] This includes HIV 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). Globally, the World Bank highlights that exposure to GBV can negatively affect women's physical, mental, sexual, and reproductive health and may increase the risk of acquiring HIV.[44] In SADC, research has long identified GBV as a significant determinant of HIV infections among women. Thus, activists champion interventions to eradicate violence against women to fight the spread of HIV.

[41] AD738-South-Africans-see-gender-based-violence-as-a-top-priority-Afrobarometer-24nov23.pdf
[42] AD546-In-Lesotho-gender-based-violence-tops-womens-right-issues-needing-attention-Afrobarometer-31aug22.pdf
[43] Garcia-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.
[44] Violence against women (no date). Available at: https://www.who.int/news-room/fact-sheets/detail/violence-against-women (Accessed: 29 October 2024).

Injuries and trauma from sexual GBV in Sub-Saharan Africa

A 2024 systematic scoping review to explore the injuries and trauma resulting from sexual and gender-based violence (SGBV) among survivors in sub-Saharan Africa[45], identified significant research gaps and highlighted the urgent need for targeted interventions to address the consequences of SGBV. The review included 20 studies published between 2012 and 2023. Most of the studies (15%) were conducted in South Africa, with 75% adopting a cross-sectional design and focusing on women. The findings highlighted the prevalence of physical injuries and trauma from SGBV, such as genital injuries, cuts, bites, scratches, abrasions, bruises, sprains, dislocations, fractures, vaginal bleeding, and genital trauma with varying prevalence rates of injuries between urban and rural settings. The studies emphasised the urgent need for effective interventions and support services, noting the significant impact of SGBV on mental health, including psychological trauma, depression, PTSD symptoms, and other adverse outcomes.

The review revealed substantial challenges in accessing healthcare, especially in rural areas highlighting barriers such as limited availability and affordability of services and survivors' hesitancy to disclose abuse to medical professionals. These findings underscore the importance of addressing healthcare gaps to ensure comprehensive support for survivors. The review also identified limited research on healthcare access and support services for SGBV survivors. The authors call for increased research in other sub-Saharan African countries to effectively mitigate SGBV effects and improve healthcare access and support for survivors.

Source: Arch Public Health.[46]

One of the Amplify Change Partnership (ACP) grantees, the Women's Action Group (WAG), based in Zimbabwe, plans to offer emergency funds to assist survivors in marginalised communities to access SGBV services.[47]

South Africa's comprehensive GBV study confirms that GBV can have severe effects on victims. 41.6% of women who ever experienced physical or sexual violence by an intimate partner reported being injured because of IPV. Of these women, 38.8% reported being injured once, 35.6% two to five times, and 25.7% more than five times.[48]

Mental health effects

Gender-based violence has severe impacts on the mental health of women. Some examples from the SADC region illustrate the devastating mental health consequences of GBV.

[45] Kuupiel, D., Lateef, M.A., Adzordor, P. et al. Injuries and /or trauma due to sexual gender-based violence among survivors in sub-Saharan Africa: a systematic scoping review of research evidence. Arch Public Health 82, 78 (2024). https://doi.org/10.1186/s13690-024-01307-3
[46] Kuupiel, D., Lateef, M.A., Adzordor, P. et al. Injuries and /or trauma due to sexual gender-based violence among survivors in sub-Saharan Africa: a systematic scoping review of research evidence. Arch Public Health 82, 78 (2024). https://doi.org/10.1186/s13690-024-01307-3
[47] WAG report on planned activities for the ACP
[48] Results of the first South African National Gender-Based Violence Study, 2022 - HSRC (2024). Available at: https://hsrc.ac.za/news/latest-news/results-of-the-first-south-african-national-gender-based-violence-study-2022/ (Accessed: 23 November 2024).

South Africa: Effects of GBV entrenched in cultural fabric

Photo: Colleen Lowe Morna

In South Africa, GBV is a significant public health issue. Women and men who experience GBV often suffer from mental health problems, including depression and Post-Traumatic Stress Disorder (PTSD). The trauma from GBV also leads to long-term psychological issues, affecting their ability to function in daily life.

Dr. Jarred H. Martin, of the University of Pretoria, discusses the deep-rooted impact of GBV in South Africa in his paper, *'The effects of GBV are entrenched in SA's cultural fabric'*[50], emphasising how its psychological effects extend beyond victims to the broader society. Prevalent GBV leads to chronic fear, anxiety, and vulnerability in women which contributes to mistrust and stigmatisation. There are also psychological effects on men. In a culture that often perpetuates toxic forms of dominance and control as part of masculinity, boys and men may grapple with conflicting expectations. There is pressure to conform to aggressive and dominating behaviour, on the one hand, and societal condemnation of violence, on the other. The internalisation of these conflicting norms can result in a distorted sense of self and contribute to heightened levels of stress and aggression.

The intergenerational impact of GBV is highlighted as children witness violence, which fosters emotional and behavioural issues, perpetuating a cycle of trauma. The societal ramifications include a breakdown of social trust vital for community cohesion, thereby weakening responses to violence. The article stresses the importance of unpacking cultural norms that support violence and creating effective mental health support systems for survivors. It argues for educational initiatives to foster empathy and healthy relationships while acknowledging the potential for community activism that promotes non-violent gender identities. A collaborative effort to transform societal attitudes and strengthen support networks is essential for progress toward a resilient, empathetic community.

Source: University of Pretoria, Psychology News.[51]

Effects of GBV in conflict-affected areas

GBV is a serious issue in conflict-affected areas that worsens conditions for women and girls

Gender-based violence in conflict-affected areas is a serious issue that worsens conditions for women and girls. Armed conflict and social breakdown increase the risks of physical, sexual, and psychological violence. Survivors often face limited access to support services, legal protection, and healthcare, compounding their trauma. Urgent and comprehensive interventions are needed to protect and support the most vulnerable populations in these settings.

[49] Diko, M. (2023) 'Gender-Based Violence (GBV) in South Africa: An Interdisciplinary Discourse of One Selected isiZulu and One Selected isiXhosa Literary Text', African Journal of Inter/Multidisciplinary Studies, 5(1), pp. 1-11. Available at: https://doi.org/10.51415/ajims.v5i1.1147.
[50] 'The effects of GBV are entrenched in SA's cultural fabric' - UP psychology lecturer | University of Pretoria (no date). Available at: https://www.up.ac.za/psychology/news/post_3204132-the-effects-of-gbv-are-entrenched-in-sas-cultural-fabric-up-psychology-lecturer (Accessed: 30 October 2024).
[51] 'The effects of GBV are entrenched in SA's cultural fabric' - UP psychology lecturer | University of Pretoria (no date). Available at: https://www.up.ac.za/psychology/news/post_3204132-the-effects-of-gbv-are-entrenched-in-sas-cultural-fabric-up-psychology-lecturer (Accessed: 30 October 2024).

DRC: Health worker perspectives on conflict-related sexual violence

A report by Physicians for Human Rights (PHR) highlights the severe escalation of conflict-related sexual violence in the eastern DRC since the re-emergence of the M23 rebel group in 2021. The escalating violence has resulted in widespread displacement, increased food insecurity, and a striking rise in sexual and gender-based violence, with over 113,000 cases documented in 2023 alone, and a twofold increase in the first half of 2024 compared to 2023. The report is based on interviews with healthcare professionals who shared challenges in providing care for survivors, including medical and psychological needs and the barriers they face due to a weak health system and stigma. The findings reveal instances of horrific sexual violence, such as multiple perpetrator rape and penetration with foreign objects, affecting both adults and children as young as three. The report highlights the healthcare system's strain and the urgent need for improved medical and psychosocial support and forensic documentation. It urges coordinated action from local, regional, and international parties to address the humanitarian crisis and accountability for violations of international human rights and humanitarian law. For instance, in describing the complex trauma seen in their clinic, one healthcare worker reported that survivors *"may undergo physical traumas, organ (traumas), destruction… of the genitalia… sexually transmitted diseases that endanger their lives, their future. They can contract unwanted pregnancies, and with those unwanted pregnancies, face the risk of becoming disabled…"*

Members of multiple armed groups, including those supported by the DRC's neighbours and the DRC military itself, were identified by survivors as perpetrators who used sexual violence to instil fear, intimidate, and control affected communities. While violence and displacement caused by armed groups drove survivors away from their communities, clinicians received survivors living in IDP camps who had been forced to travel to insecure areas to access essential resources and who were attacked while searching for food or firewood around IDP camps. One nurse recounted, *"The child told me she went to the field to look for food. Then, arriving at the field, she ran into two soldiers. Then the soldier told her: I'm going to have sex with you. If you refuse, I will kill you."*

Source: Physicians for Human Rights

Response

SADC Gender Protocol Article 20.1: State parties shall:
(a) Enact and enforce legislation prohibiting all forms of GBV.
to prevent and eliminate all harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and female genital mutilation; and
(c) Ensure that perpetrators of GBV, including domestic violence, rape, femicide, sexual harassment, female genital mutilation, and all other forms of GBV are tried by a court of competent jurisdiction.

SADC Gender Protocol Article 20.6: State parties shall ensure that cases of GBV are conducted in a gender-sensitive environment.

[52] "'Massive Influx of Cases": Health Worker Perspectives on Conflict-Related Sexual Violence in Eastern Democratic Republic of the Congo' (no date) PHR. Available at: https://phr.org/our-work/resources/massive-influx-of-cases-sexual-violence-drc/ (Accessed: 30 October 2024).

SADC Gender Protocol Article 20.7: State parties shall establish special counselling services and legal and police units to provide dedicated and sensitive services to survivors of gender violence.

SADC Gender Protocol Article 20.3: State 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.

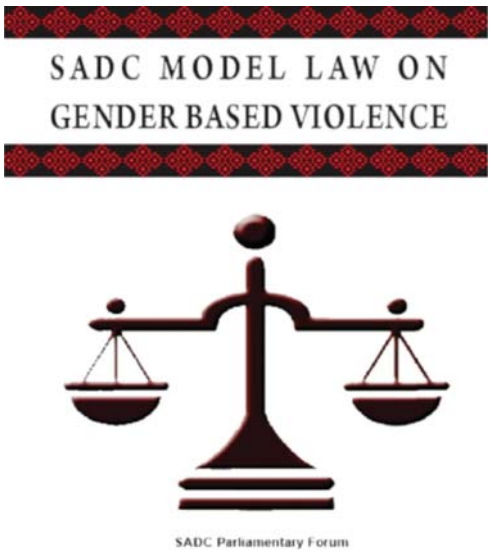
SADC SRHR Strategy Outcome 10: Remove barriers - including policy, cultural, social, and economic - that serve as an impediment to the realisation of SRHR in the region (SDGs 5.1 and 5c).

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.

Responding effectively to GBV requires legislation and services some of which are tailored for specific forms of GBV such as harassment and trafficking.

Legal frameworks

SADC has established a comprehensive framework to address GBV. Launched in 2021, the SADC Model Law on GBV aligns with Article 20.1 of the SADC Gender Protocol, which stipulates that member states must enact and enforce legislation prohibiting all forms of GBV, develop strategies to eliminate harmful social and cultural practices and ensure that competent courts prosecute offenders. This section highlights the model law's provisions as well as response to several forms of GBV within SADC.



The SADC model law on GBV:

The SADC Model Law on GBV is designed to assist member states in developing or reforming their national GBV laws. It highlights the shortcomings of existing legislation and emphasises the need for reforms to meet international human rights standards. The law advocates for the prohibition of all forms of GBV, ensuring access to justice and protective measures for victims while promoting preventive measures and public awareness campaigns.

The model law encompasses various types of GBV, including physical, psychological, sexual, and economic harm. It addresses issues such as domestic violence, sexual violence, exploitation, trafficking, discrimination, harmful practices, acid attacks, femicide, cybercrimes, and honour crimes. This comprehensive scope aligns with international and regional standards, including the SADC Gender Protocol and the SADC Regional Strategy and Framework for Action 2018-2030.

Critical protections for survivors include ensuring their safety during legal proceedings, protecting their identity, and providing restraining orders and witness protection. The law also mandates special measures for children and persons with disabilities involved in legal processes, ensuring their dignity and privacy. The law prohibits the introduction of a complainant's sexual history in legal proceedings unless it is directly relevant and disallows certain defences, such as claims of honour or intoxication.

The model law promotes awareness, training, and capacity building among stakeholders to handle GBV cases effectively, including in digital contexts. It establishes compliance notices for entities that do not adhere to GBV laws and outlines an institutional framework for coordinated action among police, healthcare providers, social services, and judicial entities.

Community involvement and awareness-raising initiatives are encouraged to enhance case reporting and support for victims. Judicial processes should be efficient and sensitive to victims' needs, ensuring swift and compassionate responses to complaints.

Governments are required to submit annual reports on GBV to the SADC Parliamentary Forum and other relevant bodies, detailing the measures taken to prevent and eradicate GBV.

In summary, the SADC Model Law ensures the protection of legal rights, the establishment of support mechanisms, and sensitivity to the needs of survivors. Its successful implementation relies on multi-sectoral collaboration, promotes legal consistency across the SADC region, and aligns with international human rights standards. Member states can strengthen their national frameworks by adopting these best practices.

Source: Author's perspectives on the SADC Model Law on Gender-Based Violence.[53]

Member states must proactively implement legal reforms and establish comprehensive new laws to address GBV, as illustrated by the recent legislative actions in Angola and South Africa.

Angola: Sexual harassment in the workplace legislation enacted

Angola has introduced new legislation aimed at protecting women from sexual harassment in the workplace, which includes clear definitions and explicit prohibitions against such behaviour in employment settings. The law establishes criminal penalties for individuals found guilty of committing sexual harassment, serving both as a deterrent and a means of providing legal recourse for victims. These reforms were enacted between October 2020 and October 2021 as part of a broader global effort to enhance gender equality and safeguard women's rights at work. Angola's initiatives are highlighted in the World Bank's 2022 report on Women, Business, and the Law, marking significant progress toward creating safer and more equitable work environments for women.

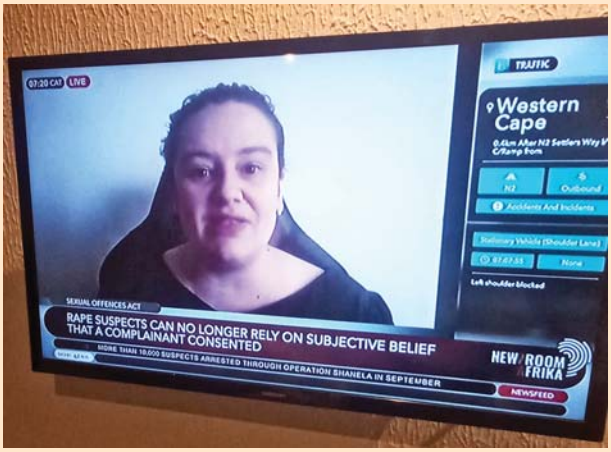
Source: World Bank's Women, Business and the Law 2022 report.[54]

[53] Model Law on Gender Based Violence. Available at: https://gbv.sadcpf.org/ (Accessed: 30 October 2024).
[54] https://wbl.worldbank.org/content/dam/documents/wbl/2022/snapshots/Angola.pdf

Sexual harassment is a serious issue that is often misunderstood and stigmatised, leading to a lack of open discussion. There are various forms of sexual harassment, including ogling, catcalling, stalking, unwanted attention, and online harassment, among others.

South Africa: Key steps on GBV laws

In May 2024, President Cyril Ramaphosa signed the National Council on Gender-Based Violence and Femicide Bill into law alongside the National Prosecuting Authority Amendment Bill, aiming to combat crimes against women and children in South Africa. He emphasised that GBV has become a severe crisis in the country, necessitating immediate governmental action. Recent statistics reveal nearly 200 GBV incidents recorded in the third quarter of last year alone, with over 1,500 attempted murder cases involving women under investigation.[55] Ramaphosa called for collaboration, "Now I do believe that we will continue to count on your support, as well as the support of labour and business, to combat the scourge of gender-based violence." The signing into law of these bills underlines the government's commitment to addressing GBV. The legislative framework includes provisions for better coordination among law enforcement bodies and the justice system, aimed at strengthening accountability mechanisms to address and reduce crimes against women and children effectively.



Dr Sheen Swemmer, head of the Gender Justice programme at the Centre for Applied Legal Studies at the University of the Witwatersrand, reviews the High court ruling on News Afrika, South Africa. Photo: Kevin Chiramba

A September 2024 judgment by the Gauteng Division of the High Court has **declared certain sections of South Africa's Sexual Offences Act unconstitutional**, specifically those that do not criminalise sexual violence when a perpetrator holds an unreasonable belief in consent.[56]

The Embrace Project, a non-profit focused on combatting GBV, initiated a constitutional challenge due to the Act's problematic definitions of consent and the requirement to prove intent for rape. The high court's ruling highlighted that the current law violates victims' rights to equality, dignity, and security. The ruling has closed a loophole that allowed perpetrators to rely on unreasonable beliefs about consent, particularly in cases where the victim is incapacitated.

The ruling has several implications for the justice system. These include:

- Unreasonable beliefs about consent are no longer a valid defence.
- Ruling targets egregious cases where consent is absent.
- Ruling does not change the burden of proof, which remains on the state to show beyond reasonable doubt that there was no consent.
- Ruling does not alter the presumption of innocence.
- Ruling is not a silver bullet, as only 8% of sexual offence reports result in convictions[57].

[55] Ramaphosa signs GBV law (no date) Bing. Available at: https://www.bing.com/search?pglt=171&q=Ramaphos+signs+GBV+law&cvid=35e97f773af24290b6709d7159985cad&gs_lcrp=EgRIZGdlKgYIABBFGDkyBggAEEUYOTIGCAEQABhA0gEJMTQ4NjZqMGoxqAIsAIB&FORM=ANSPA1&PC=DCTS (Accessed: 1 November 2024).

[56] Metelerkamp, T. (2024) High court rules parts of Sexual Offences Act unconstitutional, Daily Maverick. Available at: https://www.dailymaverick.co.za/article/2024-10-02-not-a-dry-eye-in-the-room-as-court-rules-parts-of-sexual-offences-act-unconstitutional/ (Accessed: 9 October 2024).

[57] News Afrika Interview with Dr Sheen Swemmer, Gender Justice programme head at the Centre for Applied Legal Studies at the University of the Witwatersrand.

- All entities in the criminal justice system need to perform their roles effectively for the new ruling to be impactful.

The high court ruling is poised to significantly influence future legislative changes regarding GBV in South Africa. Firstly, the verdict highlights a critical shift in the legal understanding of consent and the burden of proof in sexual violence cases. By rejecting the previous requirement that perpetrators demonstrate a belief in consent, the court has paved the way for a more victim-centric approach. This could lead to the re-drafting of legislation to ensure that consent is explicit and does not hinge on the subjective beliefs of the accused. It is anticipated that the case will be sent to the constitutional court for confirmation. Parliament will then have 18 months to amend the identified constitutional defects in the legislation, demonstrating a direct path toward reform.

Secondly, the ruling has galvanised advocacy efforts around GBV, bringing attention to the inadequacies of the current legal framework. Organisations like the Embrace Project, should leverage this momentum to advocate for comprehensive reforms that address other aspects of GBV including prevention, support for survivors, and prosecution of offenders.

Furthermore, if the constitutional court upholds the high court's decision, it could influence how cases of sexual violence are prosecuted. Legal experts and advocates anticipate that a more precise and reasonable standard for proving intent in sexual violence cases will increase the likelihood of successful prosecutions which will encourage more survivors to come forward.

In summary, the ruling may lead to substantial changes in legislation that will enhance the protection of GBV victims in South Africa, fostering a legal environment that prioritises the rights and experiences of survivors while holding offenders accountable.

Source: NewsRoom Afrika.[58]

Trafficking in persons (TIP)

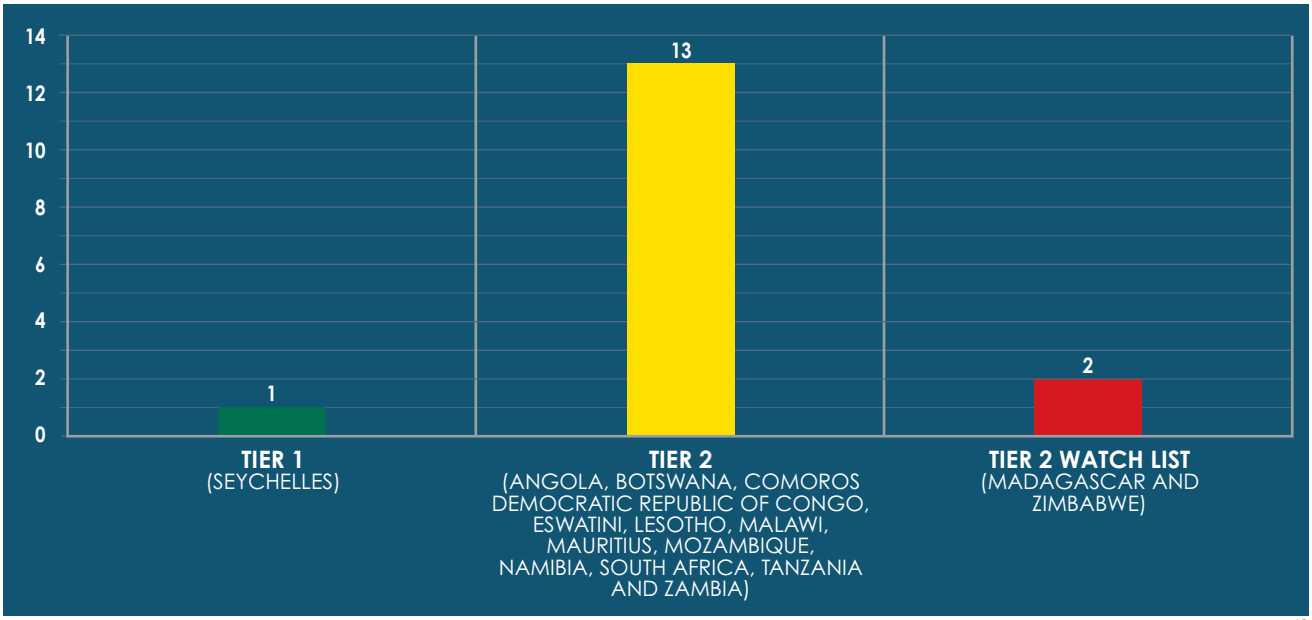
SADC Gender Protocol Article 20.5: State parties shall:
(a) Enact and adopt specific legislative provisions to prevent trafficking in persons and provide holistic services to the victims, with the aim of re-integrating them into society.
(b) Put in place mechanisms by which all relevant law enforcement 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 that 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.

[58] ibid

The US State Department 2024 report on Trafficking in Persons shows that trafficking continues in SADC. While all sixteen countries are making some efforts to address trafficking, fifteen of them do not meet the minimum standards for the elimination of trafficking.[59]

Figure 6.1: 2024 Tier placements for SADC countries regarding trafficking



Source: 2024 Trafficking in Persons Report.[60]

Figure 6.1 provides a tiered classification of Southern African countries regarding human trafficking for the year 2024, as outlined in the US Department of State's Report. Countries are categorised into three tiers reflecting their efforts to combat human trafficking and adherence to the minimum standards for the elimination of trafficking as set by the Trafficking Victims Protection Act (TVPA).[61]

Other than Seychelles, SADC countries do not meet the minimum standards to address trafficking

Tier 1, which includes Seychelles demonstrate robust measures and commitment to preventing human trafficking. They comply with the minimum standards set by the TVPA. They are recognised for their proactive initiatives, such as vigorous law enforcement, victim support services, and public awareness campaigns to reduce trafficking incidents. Tier 2, which includes Angola, Botswana, Comoros, Democratic Republic of Congo (DRC), Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Tanzania, and Zambia, are recognised for significant efforts to combat trafficking but may not fully meet the minimum standards. These countries often face challenges such as limited resources, varying enforcement of existing laws, and insufficient victim support systems. Their classification suggests ongoing improvements but highlights areas needing further attention to align with international standards. Tier 2 Watch List, which includes Madagascar and Zimbabwe,

[59] United States Department of State, 2024 Trafficking in Persons Report. Available at: https://www.state.gov/reports/2024-trafficking-in-persons-report/ (Accessed: 26 October 2024).
[60] ibid
[61] Human Trafficking | Key Legislation (2016). Available at: https://www.justice.gov/humantrafficking/key-legislation (Accessed: 26 October 2024).

are not addressing human trafficking adequately. They have insufficient anti-trafficking measures with slow progress, posing an increased risk of trafficking and exploitation. There is urgent need for comprehensive action and reform in their anti-trafficking strategies.

Only two countries in SADC are now on the Tier 2 watch list, down from seven in 2022. However, the two, Madagascar and Zimbabwe, have dropped from Tier 2 to the Tier 2 watch list.[62]

Namibia dropped its ranking from Tier 1 in 2022 to Tier 2 in 2024. This re-evaluation may indicate a decline in efforts to combat trafficking, or it could reflect an increase in trafficking incidents or reports of abuse that the government has not addressed effectively. The tier placements underscore varying levels of commitment and effectiveness in combatting human trafficking across SADC, necessitating tailored approaches to address the specific challenges faced.

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 a serious issue that is often misunderstood and stigmatised, leading to a lack of open discussion. The United Nations defines sexual harassment as "any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another."[63] There are various forms of sexual harassment, including ogling, catcalling, stalking, unwanted attention, and online harassment, among others. Perpetrators can be individuals or groups of both genders and may be known or unknown to the victim. Reporting incidents of harassment can contribute to a more robust understanding of its prevalence and support community-based efforts to combat it. In the SADC region, sexual harassment remains a significant challenge, with countries having legislation, policies and programmes to address the issue in public and private spheres.

Verbal harassment, including catcalling and inappropriate comments, is widespread in **Mauritius**, particularly in urban areas. The Equal Opportunities Act addresses sexual harassment, but enforcement is weak due to limited awareness and cultural norms that often trivialise the issue.[64]

A 2020 study on sexual harassment conducted in Mauritius found that 90% of women and one-third of men reported having experienced sexual harassment at least once in their lives, with 28% of women facing it over ten times within five years. A significant proportion of respondents reported verbal (75%) and physical harassment (50%), with 3.9% notifying the police. The survey highlights that 60% of victims suffered long-lasting effects, including depression and altered behaviour. Despite recognising sexual harassment as a serious societal issue (94% agree), there is a prevalent taboo surrounding the topic, which limits open discussion and contributes to

[62] United States Department of State, 2024 Trafficking in Persons Report. Available at: https://www.state.gov/reports/2024-trafficking-in-persons-report/ (Accessed: 26 October 2024).
[63] UN Women | UN System Coordination - Anti-harassment. Available at: https://www.un.org/womenwatch/uncoordination/antiharassment.html (Accessed: 7 February 2025).
[64] Sexual Harassment in Mauritius: Survey Report and Statistics (2020) Le Mauricien. Available at: https://www.lemauricien.com/le-mauricien/sexual-harassment-in-mauritius-survey-report-and-statistics/391687/ (Accessed: 27 October 2024).

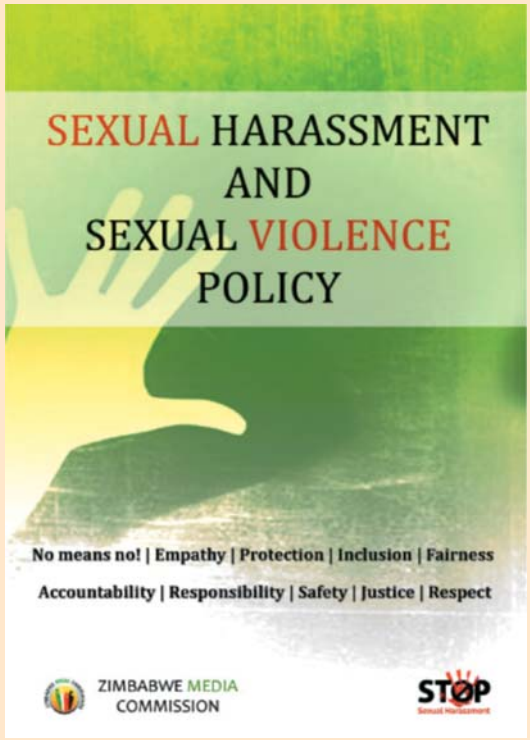
a lack of sexual education. The study concludes that effective change requires action from educational institutions, religious authorities, and the government to increase public awareness and address the roots of sexual harassment comprehensively.[65]

Zimbabwe: Media Industry Sexual Harassment and Sexual Violence Policy launched

The Zimbabwe Media Commission (ZMC) plans to address potential resistance to reporting incidents of sexual harassment by implementing the newly launched Media Industry Sexual Harassment and Sexual Violence Policy. The policy adopts a zero-tolerance approach to sexual harassment, requiring all media organisations to create internal policies for both physical and digital environments. Its goal is to ensure a safe and respectful workplace through prevention, clear reporting procedures, and support for affected individuals.

The policy aims to empower journalists to report incidents without fearing victimisation. This includes establishing designated offices or individuals within media organisations to oversee implementation of the policy and ensure that it is binding across the sector, fostering accountability. The policy emphasises that sexual harassment is a crime that must be reported promptly, thereby encouraging victims to come forward. By reinforcing that there is protection for those who report harassment, the media industry hopes to reduce the stigma and fear associated with reporting such incidents, leading to a more supportive atmosphere for journalists.[66]

Media personnel will receive training on sexual harassment and violence, with annual refresher courses mandated for each organisation. Employers and management must train those handling complaints to understand employee rights and the complaint process.



An independent committee will be established to address sexual harassment and violence, helping to identify and reduce inappropriate behaviours. The policy also recognises virtual sexual harassment, defined as online behaviour targeting someone's gender, ethnicity, or sexuality. Examples include sending explicit messages or making unwanted advances during remote work. Overall, the policy outlines the responsibilities of media organisations to combat all forms of harassment.

Source: ZMC Sexual Harassment Policy.[67]

[65] ibid
[66] Zimbabwe Media Commission Launches Ground-breaking Policy to Combat Sexual Harassment and Violence in the Media Industry - Zimbabwe Media Commission (no date). Available at: http://mediacommission.co.zw/zimbabwe-media-commission-launches-ground-breaking-policy-to-combat-sexual-harassment-and-violence-in-the-media-industry/ (Accessed: 29 October 2024).
[67] Zimbabwe Media CommSexual-Harassment-Policy.pdf: http://mediacommission.co.zw/download/sexual-harassment-policy/

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.

To comply with Article 23.2 of the SADC Gender Protocol, SADC member states have implemented various measures to support survivors of GBV, including ensuring that police and prosecutorial services are effective and responsive; support for survivors, such as shelters and economic empowerment; as well as training for service providers.

UNODC handbook on police response

The handbook is a comprehensive guide aimed at enhancing police responses to violence against women, outlining definitions, types of violence, and the police's critical role in addressing this pervasive issue. It emphasises that violence against women is a widespread human rights violation, requires systematic intervention, and should not be treated as a private matter. The handbook provides guidelines on international norms and standards that police must adhere to, and the need for a collaborative approach involving multiple agencies in the criminal justice system. Emphasis is placed on victim protection, evidence collection, procedural law, and the psychological sensitivity required when interacting with victims. The document advocates for transparency, accountability in police actions, and a survivor-centred approach to law enforcement and judicial processes. Additionally, it addresses the necessity of specialised training for police officers and advocates for legislative reforms to ensure women's safety and protection from violence.

The Comoran government has conducted training for law enforcement officers in collaboration with international organisations such as UN Women and the United Nations Office on Drugs and Crime (UNODC). The training focuses on understanding GBV, sensitising officers to the needs of survivors, and improving their skills in handling and investigating GBV cases.[68]

[68] https://www.unodc.org/documents/justice-and-prison-reform/Handbook_on_Effective_police_responses_to_violence_against_women_English.pdf

Support for victims of GBV

Beyond specialised police officer training, member states must ensure that funding support for survivors is sustained so that they recover and are empowered. In the Comoros, the United Nations Population Fund (UNFPA) has supported the provision of social services and amenities where survivors can access protection services, medical care, and psychological support.

At just 13 years old, when she returned from school, Mariama* was sexually assaulted by a neighbour. Forced into early motherhood, she told UNFPA, "At 16, I have a daughter who is almost one and a half years old." In the Comoros, some 17 per cent of women have experienced at least one incident of physical or sexual violence in their lives, and more than 30 per cent of girls are married while they are still children. Young girls reported most cases of violence, explained Said Ahamed Said, from the Ministry of Health: "Last year we received 173 reports of sexual violence, of which 162 were against young girls under age 17."

I want my daughter to be able to defend better herself and other young girls who may suffer any form of abuse

Mariama turned to the UNFPA-supported Listening and Protection Service for Children and Women Victims of Violence in the capital city, Moroni, for guidance. The centre provides midwifery, contraceptive services, post-rape care and screenings for sexually transmitted infections, as well as referrals to hospitals. Since 2021, a psychologist also helps women and girls left to care for their families alone. The centre provided Mariama with medical and legal assistance and followed up on the case in court after the man's arrest.

UNFPA strengthens essential sexual and reproductive health support, such as the Listening Service. It also supports programmes to end all forms of violence against women and girls through capacity-strengthening for partners, medical and legal assistance as well as a toll-free hotline that survivors can call for help.

Changing social and gender norms can take a long time and requires long-term, sustained investments. Working towards ending gender-based violence will only show results over time. In the 17 years since the Listening Service has existed, change has started after continuous awareness among communities. "People are becoming more conscious now, and they can denounce violence compared to how things were before," explained Mr. Said.

The goal is to lay a solid foundation for ending GBV by setting up social services and amenities where survivors can access appropriate protection services that help them rebuild their lives and contribute to transforming social norms with partners and local communities on the ground. "I want my daughter to be able to defend better herself and other young girls who may suffer any form of abuse," said Mariana.

Source: UNFPA Comoros/Melvis Kimbi.[69]

[69] Core resources support survivors of gender-based violence in the Comoros (no date). Available at: https://www.unfpa.org/updates/core-resources-support-survivors-gender-based-violence-comoros (Accessed: 3 November 2024).

Prioritising Survivor Leadership: One of the critical discussions at the SVRI Forum 2024 was the need to involve survivors in decision-making processes. Kolbassia Haoussou, a torture survivor and activist from Chad but based in the United Kingdom (UK), stressed that survivors should lead the efforts to address GBV. This approach ensures that interventions are grounded in the real experiences and needs of the affected. Drawing from his experiences of torture, Haoussou's message was, "It's not enough to hear their stories. We need to involve them in decision-making," he said. "I think about how decisions are often made for survivors but not with them. To prevent future violence, we must understand the impact of what's already been done. Survivors should not just be consulted, but they should lead." Haoussou's work with the "Survivors Speak Out" network challenges the systems that often treat survivors as helpless victims, instead placing them at the heart of policymaking and advocacy. "For me, it's about shifting the culture from seeing survivors as helpless victims to recognising them as leaders and experts in the fight against sexual violence and torture."[70]

It's not enough to hear their stories. We need to involve them in decision-making. Survivors should not just be consulted, they should lead

Shelters for survivors

Supporting GBV survivors through providing shelters gives them a safe and supportive environment where they can access essential services. One such shelter is GL's Safe Haven Halfway Home in Mauritius.[71]

Mauritius: Safe Haven Halfway Home

The Gender Links Safe Haven Halfway Home is a beacon of hope and empowerment for individuals seeking support on their journeys toward independence and resilience. Founded to provide a safe, inclusive, and empowering environment, the halfway home is a nurturing space where individuals can heal, develop, and acquire skills and confidence for successful reintegration into society. Safe Haven offers holistic support, empowerment, and personal and professional development opportunities for individuals facing transition or crisis.

Since its opening in 2017 until mid-June 2024, the home has accommodated 310 residents, including 155 children (77 girls and 78 boys). In 2023, the home provided refuge for 91 residents (45 adults, 29 girls, and 17 boys), including 28 existing residents. Among the 91 residents in 2023, 72 were victims of domestic violence (28 adults and 44 children), six came from children's shelters, 12 experienced homelessness, and one woman arrived from a women's prison. From January to June 2024, the home accommodated 41 residents: 19 female adults, 15 girls, and seven boys, comprising 34 new and seven existing residents.

Photo: Colleen Lowe Morna

[70] Davey, D. (2024) 'SVRI Forum 2024: From crisis to change', The Mail & Guardian, 24 October. Available at: https://mg.co.za/partner-content/2024-10-24-svri-forum-2024-from-crisis-to-change/ (Accessed: 7 November 2024).
[71] 'Mauritius: The Safe Haven Halfway Home project' (no date) Gender Links. Available at: https://genderlinks.org.za/casestudies/mauritius-gl-provides-a-safe-haven-for-girls-too-old-to-be-children/ (Accessed: 23 November 2024).

Economic justice

Economic justice in the SADC region is crucial for addressing the persistent inequalities within member states. SADC's Vision 2050 highlights sustainable economic growth, good governance, and social equity as foundational pillars.[72] The Sunrise Campaign, initiated by Gender Links, supports key development goals outlined in Agenda 2030 and SADC's Vision 2050. It has two main objectives: to help women gain access to all economic sectors and to reduce violence by enhancing women's confidence and agency. Ultimately, this empowers women to take greater control of their lives.

Sunrise campaign

In 2013, Gender Links (GL) piloted an Empower Women, End Violence programme[73], to test the hypothesis that increasing women's agency, confidence, and economic power would result in less violence for women in abusive relationships and more control over their lives. Rebranded the Sunrise Campaign[74] in 2016 because of the "new beginning" that this model offered to survivors of GBV, the programme focused on an integrated approach to Life Skills and Entrepreneurship training, including confidence building, decision making, business management, use of IT, networking and addressing the underlying structural inequalities between women and men.

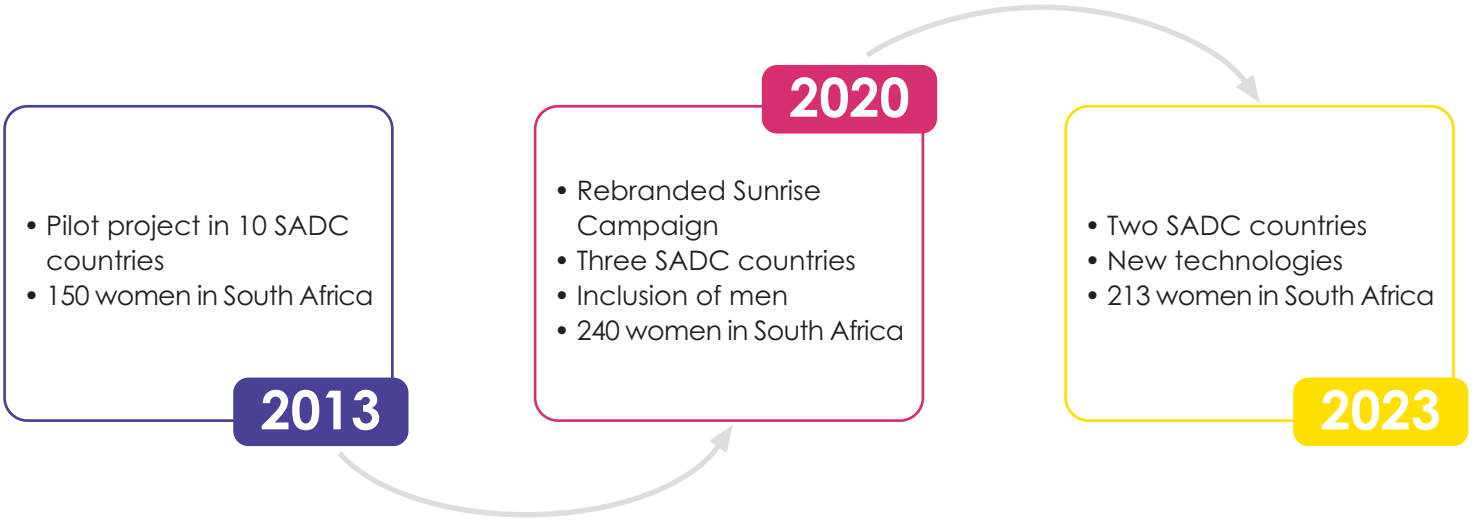
Over the past decade, the Sunrise Campaign, "*End Violence, Empower Women*", has gained significant momentum across SADC. It has reached over 3,000 women in 10 countries, including 600 in South Africa. This programme has provided evidence of the critical link between economic empowerment and sustainable solutions to GBV. Highlighting the policy-level impact of this initiative, South Africa's National Strategic Plan on Gender-Based Violence and Femicide (NSP GBVF) adopted in 2020, includes a dedicated pillar on Economic Power.

GL's approach to addressing GBV targets multiple levels of the ecological model. The project connects GBV survivors to Local Economic Development opportunities at the individual level and provides life and IT skills training to enhance their agency. At the household level, it involves family members, including former perpetrators, in rehabilitation programmes. At the community level, it integrates into GL's gender-responsive governance work through Centres of Excellence (COEs) in Local Government, where councils commit resources, run campaigns to end GBV and empower women economically. A unique feature is that these councils, having undergone a ten-stage process to become COEs, include support for GBV survivors in their action plans. The outcomes include increased agency and economic independence for survivors.

Interventions include forming Women in Local Economic Development (WLED) Networks, and integrating economic power into local GBV action plans. This approach seeks to address the high levels of GBV in South Africa, which compromise women's ability to exercise their rights, with many remaining in abusive relationships due to economic dependence.

[72] SADC Vision 2050 | SADC (no date). Available at: https://www.sadc.int/pillars/sadc-vision-2050 (Accessed: 4 November 2024).
[73] 'Economic Justice' (no date) Gender Links. Available at: https://genderlinks.org.za/what-we-do/justice/entrepreneurship/ (Accessed: 4 November 2024).
[74] Emerging Entreprenuers Archive (no date) Gender Links. Available at: https://genderlinks.org.za/emergingentrepenuers/ (Accessed: 4 November 2024).

Figure 6.3: Evolution of Sunrise programme



The campaign has evolved over three phases, illustrated in Figure 6.3, incorporating new learning and becoming a robust model with a total reach of 13 540, including 3010 GBV survivors trained as entrepreneurs, an average of three family members per household (including, where appropriate, former perpetrators); Gender Focal Persons; members of GBV and Local Economic Development (LED) committees. The programme has demonstrated the link between economic power and reducing GBV.

Funding Leadership Opportunities for Women (FLOW) in the Netherlands supported the first phase from 2013 to 2015 in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe. The United Nations Trust Fund (UNTF) to End Violence Against Women funded the project in South Africa, Madagascar and Eswatini from January 2020 to December 2022. Important innovations included a focus on young women and the inclusion of men. The project gained momentum in Zimbabwe in 2023 with funding from the Swedish Development Agency (SIDA) for Local Economic Development in 12 councils, with the Sunrise Campaign as a central pillar. In South Africa, the Irene M. Staehelin (IMS) Foundation, based in Switzerland, supports the project in ten municipalities across four provinces as summarised in Table 6.4.

Table 6.4: The current Sunrise programme in South Africa

Province	Council	No of women
Gauteng	Emfuleni	20
Gauteng	Midvaal	21
Limpopo	Greater Tzaneen	21
Limpopo	Maruleng	20
Limpopo	Phokwane	20
Northern Cape	Magareng	20
Northern Cape	Platfontein	19
Northern Cape	Sol Plaatjie	20
Western Cape	George	17
Western Cape	Knysna	23
Grand Total		**201**

In the programme's third year, GL will collaborate with the councils and women entrepreneurs to implement campaigns highlighting the connection between economic empowerment and the prevention and reduction of GBV that include localised information, educational materials, communications, and a video documenting the programme's results. In November 2024, the entrepreneurs received R20,000 from IMS to invest in their businesses. Local mentors will support the women entrepreneurs.

In the pilot phase (2013 to 2015), 1350 survivors of GBV trained as entrepreneurs. 91% completed a business plan, and 79% followed through. 533 survivors of GBV in nine Southern African countries were mentored in the follow-up phase in 2016. Average income increased by $35 per month after the first phase to $328 per month in the follow-up phase. 85% (post-training) and 97% (follow-up) of participants said they now experience less or much less GBV (Gender Links, 2019). Overall, the relationship control index increased by four percentage points to 66%.

Participants' accounts illustrate significant outcomes through "I" stories and interviews. Some are summarised in the following narratives.

The first group of women in Phalaborwa during the pilot training workshop.
Photo: Susan Mogari

The participants aimed to achieve increases in their income. "I have learned that it is essential to budget before spending money. My spending habits have improved, and I now avoid purchasing unnecessary items. I am selling my goods on a cash basis or require my customers to provide a deposit before releasing any products. Previously, I was selling sweets and cigarettes, but now I focus on beauty products, ladies' handbags, and offering loans. We were taught to save the profits from our business and to refrain from using the money we've earned."

Eva from Phalaborwa.*

Some women were already running small businesses before the project, and there is evidence that they have improved their business management or have started more promising ventures: "I found the training very helpful and interesting. The most useful thing about the training was that I was taught how to save money from a business. This was a major lesson for me, and I can see improvement. Before I attended the training, I had a small business selling cool drinks and airtime at my house. In June 2015, I started to venture into a new business, renting out rooms. I hope to finish the building of all the rooms by June 2016. So far, I have built two rooms with bathrooms for rent. It was at the Gender Links workshop that I got the information and the encouragement to build these rooms. I am managing to do this project all by myself".

Maria Mathebula from Phalaborwa.*[75]

[75] A * denotes a pseudonym as the participant does not want to be identified.

Training of service providers

SADC Gender Protocol Article 24: State parties shall introduce, promote, and provide:
(a) Gender education and training for 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.

To effectively respond to and support survivors of GBV, SADC countries must prioritise ongoing training for all service providers involved in GBV response. This includes police officers, judicial personnel, healthcare workers, and social workers. Continuous professional development is crucial for addressing emerging forms of violence, such as online abuse, and tackling persistent issues like human trafficking and the clinical management of rape survivors. By equipping these professionals with up-to-date knowledge and skills, SADC countries can ensure a more effective and compassionate response to GBV, enhancing the support provided to survivors. Several gender education and training programmes and tools have been introduced in SADC countries to improve their capacity to handle GBV cases effectively. These include:

SADC regional training guidelines: SADC has developed comprehensive tools[76] to curb GBV across the region. These include the Regional Sexual Gender-Based Violence (SGBV) Training Guidelines and the Guideline for Developing Standard Operating Procedures (SOPs) on SGBV. These tools aim to strengthen the capacity of law enforcement and other first responders to address SGBV effectively. For instance, the guidelines cover critical areas such as victim rights, crisis intervention, crime scene management, and evidence collection. These tools have been used to train police officers, social workers, and judiciary members across SADC member states.

Capacity strengthening in member states: The European Union-funded Support to Peace and Security in the SADC Region (SPSS) programme aims to raise awareness of the SADC Protocol on Gender and Development, focusing on the provisions addressing GBV,[77] and the SADC Regional Strategy and Framework of Action for Addressing Gender-Based Violence (2018 - 2030). This initiative has provided extensive training to service providers in Botswana, Eswatini, Malawi, Mozambique, Namibia, Tanzania, Zambia, and Zimbabwe. Additionally, the SPSS programme has conducted Regional Training of Trainers (TOT) for investigators and engaged prison and corrections commissioners in rehabilitating SGBV perpetrators. These efforts have led to a critical mass of trained professionals capable of effectively responding to GBV, coordinating interventions, and raising public awareness.[78]

[76] SADC Develops tools to Curb GBV across the Region | SADC (no date). Available at: https://www.sadc.int/latest-news/sadc-develops-tools-curb-gbv-across-region (Accessed: 4 November 2024).
[77] SADC-EU Support to Peace and Security Programme (SPSS) | SADC (no date). Available at: https://www.sadc.int/project-portfolio/sadc-eu-support-peace-and-security-programme-spss (Accessed: 4 November 2024).
[78] SADC makes considerable progress in strengthening capacity to effectively prevent and respond to sexual and gender-based violence in Member States | SADC (no date). Available at: https://www.sadc.int/latest-news/sadc-makes-considerable-progress-strengthening-capacity-effectively-prevent-and-0 (Accessed: 4 November 2024).

The UN Women's handbook on gender-responsive police services offers detailed training materials for law enforcement agents to ensure they provide gender-responsive services.[79] It includes modules on understanding GBV, effective communication with survivors, and legal frameworks for protecting women's rights.

National training programmes: Many SADC member states have developed national training programmes. For example, **South Africa**'s National Strategic Plan on Gender-Based Violence and Femicide (NSP GBVF), adopted in 2020, is organised around six pillars, one of which focuses on strengthening the criminal justice system's response to GBV.[80] This includes comprehensive training programmes for police, prosecutors, and judiciary members to ensure they handle GBV cases effectively and with sensitivity.

These initiatives highlight the significant progress made in strengthening the capacity of service providers to address GBV in SADC, ensuring better protection and support for survivors. However, with the increase of technology-facilitated GBV, SADC countries are recognising the need to adapt their training programmes to tackle TFGBV. Some key measures being implemented are:

Incorporation of online violence modules: Some training programmes for police and judiciary now include specific modules on TFGBV.[81] For example, in October 2024, the **Seychelles** Judiciary conducted a two-day intensive training session on handling digital evidence in modern trials. This training, organised by the International Law Enforcement Academy and led by experts from the United States (US) Secret Service, covered critical topics such as the authentication of digital evidence, privacy versus security, and the complexities of handling digital technology in legal proceedings. These sessions are part of a broader effort to equip judges and legal professionals with skills to address the challenges posed by the rapid advancement of digital technology, including TFGBV.

Similar training programmes have been conducted in **Botswana**. The ILEA in Gaborone, Botswana, offers a range of specialised courses, including those focused on handling digital evidence and addressing TFGBV.[82] The ILEA Gaborone provides comprehensive training that includes modules on forensics, primary case management, and investigating and prosecuting organised crime, which are crucial for effectively addressing online violence.

Judge James Hudson and Deputy Criminal Chief for National Security and Cybercrime Ryan Locker addressing participants in Seychelles.
Credit: ILEA

[79] Handbook on gender-responsive police services for women and girls subject to violence (2022) UN Women - Headquarters. Available at: https://www.unwomen.org/en/digital-library/publications/2021/01/handbook-gender-responsive-police-services (Accessed: 4 November 2024).
[80] https://www.justice.gov.za/vg/gbv/NSP-GBVF-FINAL-DOC-04-05.pdf
[81] 'Seychelles Judiciary: Judges and Researchers Trained on Handling Digital Evidence in Modern Trials' (2024) The Judiciary of Seychelles, 15 October. Available at: https://www.judiciary.sc/news/seychelles-judiciary-judges-and-researchers-trained-on-handling-digital-evidence-in-modern-trials/ (Accessed: 4 November 2024).
[82] Gaborone, U.S.E. (2024) International Law Enforcement Academy, U.S. Embassy in Botswana. Available at: https://bw.usembassy.gov/international-law-enforcement-academy/ (Accessed: 4 November 2024).

Prevention

SADC Gender Protocol Article 21.2: State parties shall, in all sectors of society, introduce and support gender sensitisation and public awareness programmes to change behaviour and eradicate GBV.

With the Southern Africa region experiencing extremely high rates of GBV, especially Intimate Partner Violence, there is urgency to prevent GBV. Governments have included GBV prevention among their top priorities, and numerous grassroots organisations have campaigns and awareness programmes around GBV prevention. They actively employ social media, mobilise communities and collaborate with local leaders, especially during the annual 16 Days of Activism against GBV. Other strategies are the media, tech solutions, restorative justice and working with men and boys. Collaboration and integrated approaches are critical for GBV prevention. This section examines some of the innovative approaches to GBV prevention that have emerged.

Social Innovation Lab: Exploring new ways for GBV prevention in Southern Africa[83]

The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ) through its regional programme "Partnerships for Prevention of Gender-Based Violence in Southern Africa" (PfP II), launched social lab platforms for addressing complex social challenges through an iterative and agile approach. Social labs are helpful under conditions where the situation is complex and requires multidisciplinary and systemic responses; existing good practices still need to be discovered, are insufficient, or need further development; and there is a willingness to collaborate with others to find and enact solutions.[84]

Multi-stakeholder teams from Namibia, Lesotho, South Africa, Zambia, and Zimbabwe representing civil society organisations and public and private sector actors, participated in a year-long in-country and regional process to learn from one another and develop strategies to strengthen and expand meaningful GBV prevention efforts in their countries and across SADC.

The social lab methodology allowed participants to explore different perspectives, focus on listening, analyse the underlying factors that perpetuate GBV, and embrace the diversity of experiences shared within the GBV context under the following umbrella themes:

- Mainstreaming GBV prevention in other sectors (including climate, infrastructure, health, SRHR and education)
- GBV, diversity and inclusion
- GBV in the digital space
- Masculinities

The Social Innovation Lab is a platform for uniting change agents in collaboration that transcends

[83] Partnerships for Prevention (no date). Available at: https://partnershipsforprevention.org/article-view/the-social-innovation-lab-exploring-new-ways-for-gbv-prevention-in-southern-africa-23 (Accessed: 5 November 2024).
[84] ibid

borders.[85] The participants' represent education, health and psychosocial support, positive masculinities, inclusion, and research sectors with backgrounds from policymaking to activism through fundraising, education and social development. Each sector has a different focus and approach to GBV prevention all of which are important in tackling GBV at its very roots. Participants' different perspectives and expertise catalyse the creation of new GBV prevention ideas. The ideas conceptualised collaboratively in the Lab are ready for implementation. The country teams developed ten primary GBV prevention initiatives.[86] These were presented to funding partners at a pitching event during the SVRI Forum 2024. The event highlighted the importance of integrating local wisdom and insights with contemporary prevention strategies to build resilience and promote sustainable, context-relevant solutions.

Working with traditional leaders

Involving traditional leaders and their wives in the fight against GBV has emerged as a powerful strategy to address GBV, particularly in rural and traditional communities where traditional leaders hold significant influence and respect, making them critical allies in shifting cultural norms and attitudes perpetuating GBV. For example, Chief Chikosha's wife, Mai Chikosha, has mobilised community support and advocated for women's rights in Ward 16 of Bindura Rural Council, Zimbabwe.[87]

Zimbabwe: Chief's wife joins the fight against GBV

This case study highlights the significant role that the wives of traditional leaders, particularly Mai Chikosha, play in addressing GBV in rural Zimbabwe. ROOTS Africa, a Voice and Choice Southern Africa Fund (VCSAF) grantee, focuses on improving gender equality and reducing GBV through community engagement and advocacy in the country's Mashonaland Central Province. In rural areas, traditional leaders, including chiefs and their wives, significantly influence community norms. Chiefs have considerable authority and are vital in mobilising support for educational and awareness initiatives. Mai Chikosha, the wife of Chief Chikosha from Musiiwa in Bindura Rural, has taken a stand against GBV in her community, which faces challenges like child marriage and sexual exploitation.

Mai Chikosha speaking during a community dialogue session. Credit: ROOTS

ROOTS works with Mai Chikosha who actively participates in community dialogues, advocating for education and support for women and girls, and mobilises other chiefs' wives to form a collective network against GBV. Despite facing challenges such as cultural resistance and resource limitations, her efforts demonstrate the effectiveness of grassroots leadership in fostering a supportive environment for discussing GBV and empowering women within the community.

Mai Chikosha began her advocacy through personal experiences and gained influence after

[85] Ibid
[86] ibid
[87] 'Zimbabwe: Chief's wife joins the fight against GBV' (no date) Gender Links. Available at: https://genderlinks.org.za/driversofchange/zimbabwe-chiefs-wife-joins-the-fight-against-gbv/ (Accessed: 7 November 2024).

representing the Chief in a community dialogue, where she stressed the need for an equal society. Her most impactful contribution has been leading community dialogues that discuss the impacts of GBV and educating the public on the importance of girls' education and the risks of early marriage. By relating these issues to cultural values, she has helped shift community perspectives.

Beyond her community, Mai Chikosha collaborates with other chiefs' wives to share knowledge, forming a supportive network that champions gender equality and GBV prevention. During meetings with ROOTS staff, she emphasises the need for more support for women in leadership roles.

These efforts are beginning to reshape community norms regarding GBV and gender equality. Despite pushback from some traditional leaders, Mai Chikosha advocates for collaboration between traditional and modern governance, promoting human rights while respecting cultural values.

At the national level, these community changes align with initiatives like the Not in My Village campaign, which aims to develop laws addressing child marriage. By combining grassroots efforts with policy advocacy, Mai Chikosha and her peers are working towards comprehensive laws that protect vulnerable individuals and promote gender equity.

Mai Chikosha and ROOTS Africa underscore the pivotal role that traditional leaders and their wives play in addressing GBV in rural communities. By leveraging their influential positions, these women drive meaningful conversations and foster a culture of support and empowerment. Their collaborative efforts highlight the potential for grassroots initiatives to create sustainable change in the fight against GBV.

In Mashonaland Central, supporting and empowering chiefs' wives in their advocacy work is crucial. For example, the Not in My Village campaign is currently aiding the development of provincial laws on child marriages, bringing all the chiefs in the province together. Utilising these existing relationships to bolster the efforts of female leaders like Mai Chikosha[88] is essential.

As communities navigate the complexities of gender issues, the experiences and insights gained from this case study serve as a valuable framework for future interventions. This emphasises the need for inclusive leadership and collective action in pursuing gender equality.

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 eradicating GBV by adopting guidelines that 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.[89]

In this digital age, the influence of print and electronic media in raising public awareness about GBV prevention, response, and support is indispensable. Media plays a pivotal role in fostering a gender-just society by providing accurate reporting, shaping political discourse,

[88] https://www.instagram.com/reel/C8ycOv8tra2/?utm_source=ig_web_copy_link&igsh=MzRlODBiNWFlZA== In This Instagram Post, Mai Chikosha addresses the participants of a community dialogue on the importance of the law.
[89] SADC Protocol on Gender and Development Article 29 (1-7).

and dispelling myths and harmful attitudes. Citizens rely on the media for trustworthy information about GBV and emerging threats like climate change and global political instability. Media campaigns have proven effective in influencing behaviour change and reducing GBV, demonstrating the power of media initiatives in driving societal transformation. Beyond highlighting problems, media also offers solutions, leveraging technology to amplify voices and mobilise communities against GBV.

Role of GBV media campaigns in SADC

The media is crucial in addressing and ending GBV in the SADC region. When media outlets highlight the prevalence and impact of GBV, they bring attention to the issue and encourage public discourse. This helps to break the silence and stigma surrounding GBV. By highlighting personal stories and statistics, campaigns, such as the 16 Days of Activism Against Gender-Based Violence, help to bring GBV into the public eye and foster a greater understanding of the need for prevention. For example, sustained media reports have brought to the fore the alleged abuse and rape of Congolese women migrants expelled from Angola.[90]

Media campaigns can influence policy changes. By keeping GBV issues in the public discourse, campaigns can pressure governments to adopt and implement more robust policies and frameworks to combat GBV. For example, during the 16 days of Activism campaigns, various Malawian media outlets highlighted the alarming rates of GBV in the country and the urgent need for more robust policies and enforcement mechanisms. The widespread media attention and public discourse generated by the campaigns put significant pressure on the government to act. There were renewed calls for the implementation of the National Plan of Action to Combat Gender-Based Violence 2014-2020 and for increased funding for GBV prevention and response programmes. This example demonstrates how sustained media campaigns can keep GBV issues in the spotlight, influencing policy changes and encouraging government accountability.[91]

Media campaigns can influence behaviour change

Mass media campaigns can effectively change health behaviours by promoting healthier and discouraging harmful choices. This was evident during the HIV and COVID-19 pandemics. Similarly, media campaigns are crucial in addressing GBV. Behaviour change often stems from altering individuals' beliefs or attitudes. However, studies indicate that changing perceptions of the social environment is more effective.[92] For instance, SADC countries can learn from how Ugandan edutainment videos on domestic violence increased the willingness to report incidents and reduced actual violence over six months.[93] This change was not due to altered attitudes towards violence but rather a shift in how viewers perceived community responses. The videos depicted appropriate handling of reports, leading viewers to believe that the community would support them and that reporters would not face social repercussions. In summary, media campaigns can drive behaviour change by influencing social perceptions and expectations rather than just individual attitudes.[94]

[90] Rolley, S. (2023) 'Dozens raped as migrant workers expelled from Angola to Congo', Reuters, 13 April. Available at: https://www.reuters.com/world/africa/dozens-raped-migrant-workers-expelled-angola-congo-2023-04-13/ (Accessed: 5 November 2024).
[91] Eliminating gender-based violence is possible in Malawi | United Nations in Malawi (no date). Available at: https://malawi.un.org/en/41494-eliminating-gender-based-violence-possible-malawi, https://malawi.un.org/en/41494-eliminating-gender-based-violence-possible-malawi (Accessed: 6 November 2024).
[92] Silva, A. et al. (no date) 'Mass Media, Behaviour Change & Peacebuilding'.
[93] ibid
[94] Ibid

Media initiatives influencing the reduction of GBV in SADC

The Spotlight Initiative, funded by the European Union and implemented by the United Nations, focuses on ending sexual and gender-based violence and eliminating child marriages. It includes extensive media campaigns to raise awareness about GBV and educate communities on available support services. The initiative has strengthened over 40 women's organisations in Mozambique to advocate for women's rights and challenge harmful practices.[95]

Tech: Beyond problems and solutions

When discussing technology as a facilitator of or solution against violence, Jac sm Kee, a feminist activist, writer and researcher from Malaysia and an advocate for feminist digital security, warned against seeing tech as merely a tool, whether for good or harm: "Technology is not neutral. The governance structures, algorithms and platforms all reflect the same offline power imbalances. It's no accident that women, queer people, and marginalised communities face violence the moment they step into public digital spaces. These spaces weren't designed for us." Instead, technology should be seen as an infrastructure that shapes political power, relationships and resource access. For this reason, survivors, women and other marginalised people must be part of decision-making processes regarding the creation and governance of technology.

The UN Women organised sessions that explored digital solutions to combat violence against women and girls. These sessions provided a platform for discussing innovative approaches and best practices from various SADC countries. They highlighted the importance of integrating digital literacy and safety into GBV training programmes for police and judiciary.

> It's no accident that women, queer people, and marginalised communities face violence the moment they step into public digital spaces. These spaces weren't designed for us

Source: SVRI Forum 2024: From crisis to change.[96]

One digital initiative is the GIZ Partnership for Prevention (PfP2) Connected for Change initiative. The initiative is a regional collaboration between civil society organisations working in the digital spaces in Lesotho, South Africa, Zambia, Namibia, and Zimbabwe to scale the use of the Nokaneng app[97] in Lesotho to the other countries.

[95] Freeing women and girls from violence and abuse in Mozambique (2022). Available at: https://www.unv.org/Success-stories/freeing-women-and-girls-violence-and-abuse-mozambique (Accessed: 5 November 2024).
[96] Krige, J. (2024) 'SVRI Forum 2024: From crisis to change', Lifestyle & Tech, 24 October. Available at: https://lifestyleandtech.co.za/just-life/article/2024-10-24/svri-forum-2024-from-crisis-to-change (Accessed: 4 November 2024).
[97] 'Lesotho: Nokaneng app - going digital on GBV' (no date) Gender Links. Available at: https://genderlinks.org.za/casestudies/lesotho-new-app-to-prevent-gbv/ (Accessed: 8 November 2024).

Southern Africa: Connected for Change

The innovative multi-country project focuses on the primary prevention of TFGBV in the Southern Africa region. The goal is to create safer digital spaces and empower communities across Namibia, Zimbabwe, South Africa, Zambia, and Lesotho by leveraging a tailored mobile application, educational resources, and community engagement initiatives. Importantly, this project is designed to be replicable across all countries in Southern Africa, adapting to local contexts and needs. The comprehensive strategy involves conducting participatory workshops, developing localised multimedia content, and fostering interactive digital forums, including advocacy for strengthening legal frameworks and online platform accountability.

The project seeks to actively collaborate with key stakeholders, including government agencies, civil society organisations, educational institutions, and technology companies, to cultivate an ecosystem that effectively addresses the root causes and harmful impacts of online gender-based violence. The initiative would consider the specific conditions of each country by building on 1) similarities (synergies for activities, apps, and materials) and 2) differences (promotion of exchange of lessons learnt and good practices.)

The project aims to raise awareness and promote a culture of respect and accountability in online spaces by targeting women, girls, men, boys, policymakers, and marginalised communities. By collaborating with local organisations and experts in each country, the project will ensure that methods are culturally relevant and practical.

Source: GIZ PfP2 Upcoming Flagships.[98]

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 reintegration programmes for perpetrators of GBV.

Noting that the legal path offered to redress GBV often fails to meet the needs of the survivors and seldom creates a safe place for their experiences within society, alternative methods of dealing with GBV cases are being explored. One such approach is restorative justice.

According to the United Nations, restorative justice is "a way of responding to criminal behaviour by balancing the needs of the community, the victims and the offenders".[99] It can take many forms, such as family group conferencing, survivor-offender mediation and sentencing circles.

[98] Partnerships for Prevention, Nokaneng Digital Solutions. Available at: https://test.pfp.gendel.com/flagships Accessed: 6 February 2025).
[99] https://www.unodc.org/pdf/criminal_justice/Handbook_on_Restorative_Justice_Programmes.pdf

In the context of GBV, restorative justice involves addressing the harm caused by such violence through a process that includes the victim, the offender, and the community. This approach aims to provide healing and justice for the victim while holding the offender accountable meaningfully. However, applying restorative justice to GBV cases is complex and often controversial due to several factors:[100]

- GBV often involves significant power imbalances between the victim and the offender, which can complicate the restorative process.
- Ensuring the safety of the victim is paramount. There is a risk that the restorative process could re-traumatise the victim or expose them to further harm.
- The victim and the offender must voluntarily agree to participate in the process, which can be challenging in GBV cases.
- The process must ensure that the offender takes full responsibility for their actions and that there are mechanisms to prevent future harm.

Despite these challenges, restorative justice can provide a space for victims to voice their experiences and needs, promote offender accountability, and foster community support for both victims and offenders.[101]

Consideration of existing rehabilitation programmes in SADC is crucial for understanding their effectiveness in transforming the behaviour of perpetrators and reducing GBV incidence.

Mauritius: Perpetrator rehabilitation programmes

The Family Welfare and Protection Unit (FWPU) has established several perpetrator intervention programmes to address domestic violence and rehabilitate offenders in Mauritius. One notable programme is the Domestic Violence Perpetrators' Rehabilitation Programme, launched in 2018 with a view to:

- Bring a change in mind-set that would help perpetrators to abstain from committing acts of violence.
- Enable them to manage anger, which often leads to domestic violence.
- Empower them to resolve conflicts in a peaceful manner.
- Educate them to become responsible partners in their relationship.

The programme includes counselling sessions and educational workshops designed to address the root causes of violent behaviour and promote healthier relationships.[102] Additionally, the Protection from Domestic Violence Act (PDVA), which has been amended multiple times since it was promulgated in 1997, includes provisions for the rehabilitation of perpetrators. These amendments mandate counselling and rehabilitation for offenders as part of the legal response to domestic violence.[103] The PDVA's comprehensive approach ensures that perpetrators receive the necessary support to change their behaviour while protecting victims. These programmes are part of a broader effort in Mauritius to create a coordinated community response to domestic violence, involving various stakeholders such as the police, social services, and victim support organisations.[104] By addressing the behaviour of perpetrators and providing them with the tools to change, Mauritius aims to reduce the incidence of domestic violence and promote safer communities.

[100] Government of Canada, D. of J. (2021) Victims of Crime Research Digest No. 14. Available at: https://justice.gc.ca/eng/rp-pr/cj-jp/victim/rd14-rr14/p3.html (Accessed: 6 November 2024).
[101] Government of Canada, D. of J. (2021) Victims of Crime Research Digest No. 14. Available at: https://justice.gc.ca/eng/rp-pr/cj-jp/victim/rd14-rr14/p3.html (Accessed: 6 November 2024).
[102] Family Welfare and Protection Unit (no date). Available at: https://gender.govmu.org/Pages/Family-Welfare-and-Protection-Unit.aspx (Accessed: 7 November 2024).
[103] Family Welfare and Protection Unit (no date). Available at: https://gender.govmu.org/Pages/Family-Welfare-and-Protection-Unit.aspx (Accessed: 7 November 2024).
[104] https://www.academia.edu/21737275/A_CRITICAL_ANALYSIS_OF_REHABILITATION_PROGRAMS_FOR_DOMESTIC_VIOLENCE_PERPETRATORS_IN_MAURITIUS

Mauritius also set up the Victim Empowerment and Abuser Rehabilitation Policy (VEARP) as a workplace initiative in both private and public sectors to address the problem of gender-based violence, particularly domestic violence. The purpose is to enhance the knowledge of both employees and employers on the existing legislation and services and to urge them to be compassionate about domestic violence so that basic assistance can be provided to victims whenever required.

Source: Family Welfare and Protection Unit, Mauritius.[105]

The SVRI Forum 2024 featured several discussions on restorative justice, particularly in the context of GBV. Various workshops focused on innovative approaches to restorative justice, emphasising the importance of community involvement and survivor-centred practices. These sessions explored how restorative justice can be integrated into existing legal and social frameworks to support victims better and hold perpetrators accountable. Researchers presented findings on the effectiveness of restorative justice programmes in different cultural contexts, highlighting successful practices for implementing restorative justice in GBV cases. A significant proportion of the discussions centred on engaging men and boys in preventing GBV, with speakers emphasising the need to challenge harmful gender norms and promote positive masculinity through restorative justice initiatives. Policymakers and practitioners discussed the challenges and opportunities of incorporating restorative justice into national GBV strategies, sharing insights on creating supportive legal and social environments that facilitate the rehabilitation and reintegration of perpetrators while ensuring the safety and healing of victims. These discussions underscored the potential of restorative justice to transform responses to GBV by fostering healing, accountability, and community support.

Engaging men and boys

Restorative justice principles can effectively engage men and boys in preventing violence against women and girls in SADC countries by promoting accountability and empathy. Programmes that use restorative justice encourage participants to reflect on their actions, understand the impact of gender-based violence, and take part in community dialogues for gender equality. By participating in community mediation sessions, men and boys can challenge harmful gender norms and become advocates for change, contributing to the prevention of violence and fostering healthier relationships. The Government of Malawi has made strides by launching a comprehensive male engagement strategy.

Male involvement during the 16 days against GBV in Siteki, Eswatini.
Photo: Thandokuhle Dlamini

[105] Family Welfare and Protection Unit (no date). Available at: https://gender.govmu.org/Pages/Family-Welfare-and-Protection-Unit.aspx (Accessed: 7 November 2024).

The National Male Engagement Strategy

The Ministry of Gender, Community Development and Social Welfare in Malawi has officially launched a National Male Engagement Strategy to implement all male engagement initiatives in the country. Launching the strategy, the gender minister, Jean Muonaouza Sendeza, highlighted the under-representation of men and boys in efforts to combat gender-based violence. The approach focuses on critical areas such as harmful social norms and sexual and reproductive health rights, signifying the government's commitment to achieving sustainable development goals 3, 5, and 10. The minister emphasised that successfully implementing the strategy could significantly enhance gender equality in Malawi.[106]

Community involvement and support systems

Mobilising communities to support the social and psychological rehabilitation of GBV perpetrators is crucial for creating a safer and more equitable society throughout SADC. This process involves several key strategies that leverage community resources, foster positive behavioural change, and ensure the safety and healing of victims.

Community education and awareness campaigns play a crucial role in addressing GBV. These campaigns focus on the root causes of GBV, such as harmful gender norms and social constructions of masculinity. By educating community members about the impact of GBV and the importance of rehabilitation, these initiatives create a supportive environment for change.

Local leaders, influencers, and survivors actively engage in these efforts, amplifying their reach and effectiveness. For example, in **South Africa**, the Sonke Gender Justice organisation operates the Community Education and Mobilisation (CEM) Unit. This unit collaborates with women, men, boys, and girls across the country's nine provinces to tackle gender inequalities, GBV, and the spread of HIV and AIDS. These programmes are contributing to changing attitudes and behaviours regarding GBV.

Integrated approaches

SADC Gender Protocol Article 25: State parties shall adopt integrated approaches, including institutional cross-sector structures, to eliminate GBV.

Gender-based violence remains a pervasive issue across the SADC region, affecting individuals and communities at multiple levels. Despite efforts to address this challenge, a lack of coordinated and integrated approaches has often hindered progress. The SADC Gender Protocol Article 25 emphasises the need for state parties to adopt integrated approaches, including institutional cross-sector structures, to eliminate GBV. This section explores various strategies to enhance

[106] Ministry of Gender launches National Male Engagement Strategy. Available at: http://www.gender.gov.mw/index.php/news-events/news/item/30-ministry-of-gender-launches-national-male-engagement-strategy (Accessed: 6 November 2024).

collaboration, update and implement National Action Plans (NAPs), ensure sustainable funding, monitor and evaluate interventions, engage communities, and reform legal and policy frameworks. By adopting these comprehensive measures, SADC countries can create a more effective and unified response to GBV, ensuring that survivors receive the support they need and that perpetrators are held accountable.

Strengthening cross-sector collaboration

Collaboration between government agencies, NGOs, and community organisations is crucial for addressing GBV effectively. For instance, the Diamond Trading Company (DTC) in **Botswana** is collaborating with NGOs such as Women Against Rape (WAR) to provide comprehensive support services to survivors.[107] This partnership has improved service coordination, ensuring survivors receive timely and comprehensive care.

Such multi-stakeholder approaches can be replicated across SADC to enhance efficiency in eliminating GBV. Incema, a grantee of the VCSAF, is doing this by forming strategic partnerships with various stakeholders to make significant progress in addressing social challenges.

South Africa: Integrated approach delivers results

Incema, a VCSAF grantee based in KwaZulu-Natal, South Africa, focuses on broad social challenges, particularly Sexual Reproductive Health and Rights (SRHR) and GBV. The organisation aims to enhance its outreach to vulnerable groups such as women, children, and youth while establishing partnerships with diverse stakeholders to increase its programme's scale and effectiveness.

In collaboration with the Human Sciences Research Council (HSRC), Incema focuses on educating young people in rural settings, specifically within schools, to address early misconceptions surrounding SRHR and promote informed decision-making. This initiative targets schools like Ingqwangele High School, Siyanda High School, and Sanzwili Primary School, aiming to improve sexual and reproductive health outcomes for young people.

Incema's GBV Hotspots programme provides essential emergency services to survivors of violence, including access to medical care, legal assistance, and psychosocial support. Incema works closely with local healthcare providers, legal entities, and mental health professionals to ensure survivors receive the help they need promptly and confidentially.

Recognising the critical role men and boys play in ending GBV, the "I Am a Man and I" Campaign challenges traditional notions of masculinity and encourages men to reflect on their role in preventing violence. The campaign involves workshops, social media engagement, and community discussions, where men are encouraged to take responsibility for their behaviour and become allies in the fight for gender equality.

[107] 'DTC Botswana Supports WoMen Against Rape in Maun - DTC Botswana' (no date). Available at: https://www.dtcbotswana.com/dtc-botswana-supports-women-against-rape-in-maun/ (Accessed: 8 November 2024).

Incema's multi-faceted approach is part of its strategy to facilitate long-term impact by confronting the root causes of SRHR and GBV. The organisation advocates and collaborates with government bodies and local communities to amplify its efforts. These initiatives signify a positive and expected development in Incema's commitment to fostering gender equality and healthier communities.

Beyond its work in SRHR and GBV, Incema has a history of collaborating with various stakeholders on initiatives to improve community well-being. For instance, Incema has partnered with the Department of Health to ensure its projects align with national strategies and policies. These partnerships have enhanced the reach of Incema's work and allowed the organisation to tap into government resources to support its initiatives.

Incema also focuses on women's economic empowerment, an essential strategy for reducing GBV. By providing women, particularly survivors of GBV, with access to vocational training, entrepreneurship workshops, and financial literacy programmes, Incema helps women achieve financial independence. This empowerment enables survivors to break free from abusive relationships, which are often perpetuated by economic dependency. Through these programmes, Incema fosters resilience and self-reliance among women, creating opportunities for them to thrive economically and socially.

'I Am a man and I' campaign launch in Pietermaritzburg in November 2023, South Africa.
Credit: Incema

As part of its next steps, Incema plans to continue its engagement with schools to ensure sustained awareness and education around SRHR and GBV. By leveraging data and feedback from surveys conducted at participating schools, Incema aims to refine its programmes and address emerging needs among the youth. Furthermore, fostering partnerships with local government and health entities will remain a priority. These collaborations will support current initiatives and help establish a foundation for future outreach efforts, ultimately contributing to long-term, transformative change within rural communities.

Incema's expanded focus and innovative programmes highlight its commitment to comprehensively addressing SRHR and GBV, promoting gender equality, and fostering healthier communities in KwaZulu-Natal and beyond.

Source: Incema.[108]

Ensuring sustainable funding for GBV in the wake of dwindling GBV funds

At the SVRI Forum 2024, discussions on dwindling funds highlighted the urgent need for sustained and increased funding to combat GBV, especially in low and middle-income countries where resources are often limited. The forum underscored that while laws and policies have improved, more financial support is needed to ensure implementation. Activists and survivor-leaders emphasised that with adequate funding, efforts to prevent and respond to GBV would be sufficient and cohesive.[109] Key agreements that emerged from the discussions were:

[108] https://www.incema.org.za/
[109] Davey, D. (2024) 'SVRI Forum 2024: From crisis to change', The Mail & Guardian, 24 October. Available at: https://mg.co.za/partner-content/2024-10-24-svri-forum-2024-from-crisis-to-change/ (Accessed: 7 November 2024).

- Participants agreed to explore innovative funding mechanisms to ensure sustainable financial support for GBV programmes. This includes leveraging public-private partnerships and encouraging international donors to commit to long-term funding. The establishment of dedicated GBV funds was emphasised.
- The forum called for a unified global advocacy effort to highlight the importance of funding GBV initiatives. This includes raising awareness about the impact of GBV and the critical need for resources to support survivors and prevent violence. The role of international organisations, such as the UNTF, in mobilising resources and providing technical support was emphasised.
- Another agreement was the importance of investing in data collection and research to inform policy and programme decisions. Accurate data is essential for understanding the scope of GBV and evaluating the effectiveness of interventions. This evidence-based approach can help advocate for more resources and ensure funds are used efficiently.

The SVRI Forum 2024 highlighted the critical need for sustained and increased funding to combat GBV effectively. By prioritising survivor leadership, exploring innovative funding mechanisms, fostering global solidarity, and strengthening data and research, stakeholders can work towards a more coordinated and impactful response to GBV.

Namibia Secures EU and UNFPA funding to combat GBV

In a significant move to tackle GBV in Namibia, the European Union (EU) and the United Nations Population Fund (UNFPA) have committed funds[110] to support initiatives aimed at eradicating GBV and promoting gender equality, focusing specifically on Zambezi, Ohangwena, Khomas, Kunene, and Omaheke. The rates of GBV in Namibia remain alarmingly high, ranging from 28% to 42% in certain regions. In September 2024, the Ministry of Gender Equality, Poverty Eradication, and Social Welfare (MGEPESW) of Namibia, in collaboration with the EU and UNFPA, held an inception meeting for the Gender Equality/Combatting Gender-Based Violence Project for 2024-2027[111]. This meeting provided an opportunity to review potential areas for collaboration among partners. Participants shared information and best practices related to GBV prevention and response and emphasised the importance of implementing cross-sectoral programmes and policies to tackle GBV effectively.

The EU and UNFPA view the initiative as essential for improving the well-being and empowerment of women and girls in Namibia, representing a significant step toward achieving gender equality in the country.

Source: The Namibian[112], UNFPA Namibia[113]

[110] Nakashole, P. (2023) 'Over N$30 million invested in combating GBV', The Namibian, 30 November. Available at: https://www.namibian.com.na/over-n30-million-invested-in-combating-gbv/ (Accessed: 7 November 2024).
[111] Stakeholders gather for Inception Meeting of Gender Equality/ Combating GBV Project in Namibia (no date) UNFPA-Namibia. Available at: https://namibia.unfpa.org/en/news/stakeholders-gather-inception-meeting-gender-equality-combating-gbv-project-namibia (Accessed: 7 November 2024).
[112] Nakashole, P. (2023) 'Over N$30 million invested in combating GBV', The Namibian, 30 November. Available at: https://www.namibian.com.na/over-n30-million-invested-in-combating-gbv/ (Accessed: 7 November 2024).
[113] Stakeholders gather for Inception Meeting of Gender Equality/ Combating GBV Project in Namibia (no date) UNFPA-Namibia. Available at: https://namibia.unfpa.org/en/news/stakeholders-gather-inception-meeting-gender-equality-combating-gbv-project-namibia (Accessed: 7 November 2024).

Next steps

Prevalence

- SADC countries need to establish a centralised and standardised system for collecting and monitoring data on GBV. It is essential to fund and conduct dedicated annual or bi-annual GBV surveys for current data gathering, as some of the IPV indicators are now dated.
- Governments should provide training for local agencies to ensure accuracy in data collection and promote partnerships among government bodies and NGOs for resource sharing.
- The integration of digital tools for real-time reporting and the securing of sustainable funding from local and international sources will further support these ongoing data collection efforts.
- There should be a strong emphasis on improving data collection methods regarding GBV, coupled with strict safety protocols to protect the privacy and well-being of victims. This will help to address gaps in evidence, guide appropriate interventions, and hold responsible parties accountable.

Drivers of GBV

- SADC countries should prioritise the establishment of comprehensive bilateral and multilateral agreements to foster cooperation against trafficking in persons. This should include joint actions among origin, transit, and destination countries, alongside robust capacity-building initiatives for law enforcement and the implementation of awareness-raising campaigns to address and mitigate trafficking issues effectively.
- It is crucial to define and implement effective policies that address both sexual violence in conflict and TFGBV. This should involve interdisciplinary collaboration among researchers, civil society organisations, and government bodies to develop comprehensive solutions that effectively tackle the challenges faced by survivors and at-risk communities.

Effects of GBV

- Addressing GBV in the SADC region requires comprehensive strategies that include immediate support for victims, long-term mental health care, economic empowerment programmes, and community education to break the cycle of violence.

Response

- Member states need to review legislation to conform to the SADC GBV model law guidelines and to be responsive to the realities of TFGBV.

Support

- It is recommended that community involvement in restorative justice processes is strengthened to ensure they are survivor-centred and that the needs of victims are prioritised, thus fostering a support network that aids both victims and offenders in their rehabilitation journey.

GBV Prevention

- It is crucial to explore and establish innovative funding mechanisms, including public-private partnerships and dedicated GBV funds, to secure long-term support for GBV programmes. Advocating for global solidarity and mobilising resources through international organisations will also play a vital role in addressing funding shortages.
- There is a need to look at prevention strategies holistically. More innovative programmes targeted at changing socio-cultural norms that condone and legitimise violence are needed.

Integrated approaches

- Countries should replicate successful multi-stakeholder approaches. Engaging government agencies, NGOs, and community organisations will create a more efficient and comprehensive response to GBV.

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https://www.instagram.com/reel/C8ycOv8tra2/?utm_source=ig_web_copy_link&igsh=MzRlODBiNWFlZA== In This Instagram Post, Mai Chikosha addresses the participants of a community dialogue on the importance of the law.

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Harmful Practices

7

City Council campaign against child marriage in Lusaka, Zambia. Photo: Albert Ngosa

Key points

- All SADC constitutions provide for non-discrimination generally and for non-discrimination on the basis of sex and other grounds, i.e. marital status and pregnancy.
- The constitutions of some countries, including Lesotho and Botswana, still allow for discrimination in personal and customary law. Neither Botswana nor Lesotho have been able to conclude long-awaited and very necessary constitutional review.
- South Africa opened public comment on 10 April 2024 on a new Marriage Bill, which seeks to bring three existing laws together into one.
- Mozambique, Madagascar and Malawi have some of the highest rates of child marriage in the world (Malawi has the 12th highest prevalence of child marriage globally).
- Zambia enacted an amendment to the 1918 Marriage Act, setting the minimum age of marriage to 18 for civil and customary marriages.
- Tanzania is the only SADC country where female genital mutilation (FGM) is practiced widely, concentrated in the six northern regions (out of the country's 18 regions).
- Disability discrimination in Africa, which is rooted in deeply held beliefs that often include a supernatural dimension, is highly gendered, with disproportionate impact on women. In particular, mothers of children with disabilities may be accused of witchcraft or bringing a curse upon the family.
- The Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa, or the African Disability Protocol (ADP), entered into force in August 2024, following ratification by 15 nations, including five in SADC. The ADP has a distinctly African perspective on protecting and promoting the rights of persons with disabilities as compared with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Introduction

Harmful practices are deeply rooted in gender inequality

Harmful practices are grounded in discrimination based on sex, gender, age and other grounds, often with multiple and/or intersecting forms of discrimination. Harmful practices are a violation of human rights, disproportionately affecting women and girls and deeply rooted in gender inequality entrenched in social, cultural and religious norms. These practices have been committed over so long that communities have incorporated them into their culture and consider them acceptable.[1]

For the purposes of this chapter, harmful practices include:

- Clawback clauses, dual legal systems or other legal frameworks allowing discrimination;
- Poor and/or unequal access to justice;
- Marriage and family practices, including polygamy and inheritance, which deny women rights;
- Child marriage;
- Female Genital Mutilation (FGM);
- Discrimination against people with disabilities and their family members, especially mothers of people with disabilities; and
- Violations of the rights of widows and widowers.

Almost all harmful practices are rooted in deeply held gender and social norms. The adoption of dual legal systems in many countries - combining both formal legal frameworks and customary law permitting gender discrimination - contributed to sustaining harmful practices. Countries are gradually changing their laws to promote greater gender equality and remove vestiges of discrimination. This is evident in minimum marriage age laws for instance. Only three countries in SADC still have a minimum marriage age lower than 18 and countries that had exceptions in place are closing these.

Legal reform is a slow process, often delayed even longer due to elections and other changes in countries. What is clear, however, is that legal change alone does not change behaviour. There is also a significant need for raising awareness, education and mobilisation to change long held attitudes.

This chapter discusses current practices and presents legal and programmatic steps being taken to realise change.

Table 7.1 below shows that five of the 16 countries in SADC still have constitutions which include clawback clauses allowing certain rights to be partially limited (also called "limitation clauses"), usually related to personal law, for instance adoption, marriage, divorce, burial and inheritance. Clawback clauses take away non-discrimination protections for women and girls.

There has been slow progress regarding legislation to outlaw child marriage. Only three countries still have legislation setting minimum age of marriage as younger for females than males (Eswatini, Lesotho and South Africa). South Africa, at the time of writing, has a draft Bill before Parliament to remove this anomaly. Other countries have measures in their legislation that allow for marriage at younger ages under certain conditions. The percentage of girls getting married before age 18 varies between two percent in Eswatini and 53% in neighbouring Mozambique, and before age 15 between zero in Eswatini and 17% in Mozambique. The percentage of boys married before age 18 varies between zero in Eswatini and 11% in Madagascar.

[1] Derived from https://www.unicef.org/protection/harmful-practices, accessed 29 October 2024; https://africa.ippf.org/sites/africa/files/2018-09/SOAW-Report-Chapter-6-Harmful-Practices.pdf, accessed 28 August 2024 and https://www.saverauk.co.uk/wp-content/uploads/2020/08/SAVERA_What_are_Harmful_Practices_Factsheet_2020_v4.pdf, accessed 30 October 2024

[2] UNICEF Child marriage Database (2024) https://data.unicef.org/topic/child-protection/child-marriage/, accessed 1 August 2024.

Table 7.1: Key indicators on harmful practices

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Constitution																
Constitution has clawback clauses	No	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No	No	No	No	No	No
Child marriages																
Minimum legal age of consent to marriage for girls/women	18	21	18	18	16	16	18	18	18	18	18	18	18	15	18	18
Minimum legal age of consent to marriage for boys/men	18	21	18	18	18	18	18	18	18	18	18	18	18	18	18	18
Exceptions (female)	15	18	Possible, no age	None	Possible, no age	Possible, no age	Possible, no age	None	None	None	Possible, no age	Possible, no age	16	Supreme Court ordered government to ban marriage of children younger than 18	None	None
Exceptions (male)	16	18		None	Possible, no age	Possible, no age	Possible, no age	None	None	None	Possible, no age	Possible, no age	None	Legislation under appeal	None	None
% girls married by age 18[2]	30	10	21	29	2	16	39	38	No data	53	7	No data	4	29	29	34
% girls married by age 15	8	No data	5	8	0	1	13	8	No data	17	2	No data	1	5	6	5
% boys married by age 18	6	No data	7	6	0	2	11	7	No data	10	1	No data	1	4	3	2

Source: Gender Links (2019) and Girls Not Brides https://data.unicef.org/country/, accessed 1 August 2024.

Constitutional provisions for gender equality and non-discrimination

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.

The SADC Gender Protocol obligates Member States to ensure their constitution, the supreme law of the land, promotes gender equality and equity. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted in 1979 by the United Nations General Assembly, was a defining moment as it required countries to include gender equality in their national constitutions. Most constitutions adopted before CEDAW did not promote gender equality, while those developed after CEDAW all have provisions for gender equality. Furthermore, in some countries emerging from conflict, such as South Africa, Mozambique and Namibia, the development of new constitutions was an opportunity to advocate for much greater emphasis on gender equality and non-discrimination. There are, therefore, significant

differences in the language found in constitutions of SADC Member States and how different constitutions present gender equality.[3]

An analysis of constitutions across different regions (Caribbean, Africa, Asia) found that former British colonies which were supported by the British Colonial office to develop their constitutions were likely to have included what are now known as clawback provisions.[4] These constitutions provided for gender equality, then included clauses exempting personal law from general non-discrimination protection. A common clause found in many constitutions, with almost the same phrasing is, "no law shall make any provision that is discriminatory either of itself or in its effect" except for "with respect to adoption, marriage, divorce, burial, devolution of property on death (inheritance) or other matters of personal law."[5] Many SADC Member States practice a dual system of law for various personal issues - the formal or western approach, as well as customary law. Customary law tends to align with the gender discriminatory approach allowed by these clauses.

Many constitutions developed in the sixties have clauses that allow gender discrimination in matters of personal law

Table 7.2: Key gender provisions in SADC constitutions

Constitution	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Provides for non-discrimination generally	Yes, Art 23	Yes, Sec 15	Yes, Art 2	Yes, Art 11, 12 and 13	Yes, Sec 20	Yes, Ch II, Sec 1 and 18	Yes, Art 8	Yes, Sec 20	Yes, Art 3	Yes, Art 35	Yes, Art 10	Yes, Art 27	Yes, Ch 1	Yes, Art 13	Yes, Art 23	Yes, Sec 17
Provides for non-discrimination based on sex specifically	Yes, Art 21	Yes, Sec 3	Yes, Art 2	Yes, Art 14, 36 and 45	Yes, Sec 20	Yes, Sec 18	Yes	Yes, Art 20	Yes, Sec 16	Yes, Art 36	Yes, Art 10	No	Yes, Ch 2, Sec 9	Yes, Art 9	Yes, Art 23	Yes, Sec 23
Provides for non-discrimination based on sex and other grounds, i.e. marital status, pregnancy	Yes, Art 21	Yes, Sec 15	Yes, Art 2 (sex only)	Yes, Art 40	Yes, Sec 20 (2)	Yes, Sec 18	Yes, Art 8	Yes, Sec 13 and 20	Yes, Sec 16	Yes, Art 39	Yes, Art 14	Yes, Art 30	Yes, Sec 9	Yes, Art 16	Yes, Art 23	Yes, Sec 23
Provides for the promotion of gender equality	Yes, Art 21 and 35	No	Yes, Art 3, 34, 38, 61	Yes, Art 14	Yes, Sec 28	Yes, Ch III, Secs 26 and 30	Yes	Yes, Art 13	Yes, Art 16	Yes, Article 120	Yes, Art 95	No	Yes, Sec 9	Yes, Art 66	Yes, Art 231	Yes, Sec 17. 246
Has other provisions related to gender equality	Yes, Art 36 and 77	No	Yes, Art 34, 38, 61	Yes, Art 16	Yes, Sec 28	Yes, Sec 26	Yes, Art 17	Yes, Sec 19 and 18	No	Decriminalisation of homosexuality and termination of pregnancy	Yes, Art 8	No	Yes, Sec 12	Yes, Art 13	Yes, Art 45, 69 and 231	Yes, Sec 17, 246
Addresses contradictions between the constitution, laws and practices	Yes, Article 239	No	No	No	Yes, Sec 2 and Art 20	Yes, Sec 18	Yes, Art 160	Yes, Art 5	No	Yes, Art 143	Yes, Art 19	Yes, Art 5	Yes, Ch 7, Sec 15 and 30	Yes, Art 30	Yes, Art (1)	Yes, Sec 2

Source: Gender Links and https://constitutions.unwomen.org/en/countries, accessed 15 October 2024

[3] UN Women (2021) Why and How Constitutions Matter for Advancing Gender Equality: Gains, Gaps and Policy Implications. Policy Brief No. 8. UN Women. New York
[4] https://www.unwomen.org/en/digital-library/publications/2017/2/why-and-how-constitutions-matter-for-advancing-gender-equality, accessed 1 November 2024. Nabaneh, S. S. Inglis and L. Waldorf, "Decolonizing the narrative around constitutions, personal laws, and women's rights", 17 May 2023
[5] https://www.openglobalrights.org/decolonizing-narrative-around-constitutions-personal-laws-womens-rights/, accessed 15 August 2024. Ibid.

Table 7.2 illustrates 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 other grounds, i.e. 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. Due to this, and because reform efforts remain incomplete, women and girls still face legal discrimination.

Efforts to review the constitutions of Botswana and Lesotho have been on-going for several years.

Botswana constitutional reform

The Botswana Democratic Party (BDP), which led Botswana from independence in 1966 until elections in 2024, promised constitutional review in its 2019 election manifesto. The President appointed a Commission of Inquiry into the Review of the Constitution of Botswana in December 2021. This initiated a process that was not concluded before the BDP lost October 2024 elections to the opposition Umbrella for Democratic Change. The new government has suggested that it will re-open the consultation process. Civil society expects that the President will speak on the issue in the first State of the Nation address in late November.

The Presidential Commission held consultations in all of Botswana's 57 constituencies and received submissions from a number of bodies, including Gender Links. The Commission submitted its *Report of the Presidential Commission of Inquiry into the Review of Constitution of Botswana* to the President in September 2022.[6] Government released the Government White Paper No. 1 of 2023 and introduced the Constitutional (Amendment) Bill 2024.

A coalition of civil society organisations mobilised against the Constitutional (Amendment) Bill, arguing that the process had been flawed, with several submissions overlooked and participation not sufficiently informed. The organisations suggested that the Bill needed to include provisions such as:

Community kgotla meeting discussion on child marriage in Botswana.
Credit: Keletso Serole

- Right to affordable and culturally appropriate healthcare services, including sexual reproductive health care, mental health care and emergency medical treatment, and the state's obligation to provide healthcare.
- Right to quality education with specific reference to the level of education provided by the state.
- Right to employment/work with emphasis on the creation of decent work.
- Right to land access and assurance of secure tenure.
- Rights of the child, including fundamental nourishment, housing, essential healthcare provisions and social welfare services.
- Cultural rights.
- Environmental rights.

[6] Mosinyi, T. Masisi receives constitutional review report, 29 September 2022. Daily News. https://dailynews.gov.bw/news-detail/69435, accessed 26 August 2024.

- Right to citizenship and nationality.
- Protection from discrimination, including on the basis of multiple citizenship, the entrenchment of equality, and reinforcement of inclusion.
- Reforms around the electoral system, judiciary and judicial system (including creation of a specialised Constitutional Court) and propositions on inclusion.

Subsequently, Parliament did not vote to pass the Bill, it failed at its third reading on 4 September 2024.[7]

Lesotho constitutional reform

Constitutional reform has been ongoing in Lesotho since 2012

The constitutional reform process in Lesotho has been ongoing since 2012 and is rooted in the need to stabilise the politico-legal landscape, including the judiciary, security agencies and civil service. The process included a consultative process from 2018 to 2022.[8] Amongst the proposals from the consultative process was a call to redraft the Bill of Rights so that it:

- Includes political as well as socio-economic rights.
- Removes the clawback clause that currently allows for discrimination of women.
- Addresses the rights of children, youth, people with disabilities and the elderly.[9]

Prior to Lesotho's 2022 elections, the previous government attempted to pass a Tenth Constitutional Amendment, which contained all the recommended changes. The judiciary overturned this as it had not passed through required processes. The current government has divided the changes into three amendments or processes:

1. The Tenth Amendment to the Constitution Bill, 2024, which was passed by the lower house of Parliament in September 2024[10] and must now be approved by the Senate. This Bill ensures greater independence of key institutions such as the Auditor General's office, Human Rights Commission and Public Service Commission. The changes in the Tenth Amendment require a simple majority in Parliament to pass.
2. The Eleventh Amendment to the Constitution Bill, 2024, which is being discussed by Parliament, has changes that require a two thirds majority of Parliament to pass. The changes include the structure and workings of Parliament. The current government does not have a two thirds majority and will need support from other parties.
3. The third group of provisions can only be changed by a referendum and include the revised Bill of Rights which addresses the clawback clause. There is currently no plan for such a referendum.[11]

Several civil society organisations and other actors have criticised this as a piecemeal approach to constitutional reform.

[7] Mungure. MD. Democracy in Action: The Role of Civil Society in Botswana's Failed Constitutional Amendment Bill', ConstitutionNet, International IDEA, 9 October 2024, https://constitutionnet.org/news/voices/civil-society-botswanas-failed-constitutional-amendment-bill accessed 16 October 2024.
[8] Nyane, H. The State of Lesotho's Constitutional Reforms: Progress or Stagnation? ConstitutionNet, International IDEA, 29 June 2023. https://constitutionnet.org/news/state-lesothos-constitutional-reforms-progress-or-stagnation accessed 16 October 2024.
[9] Nyane, H and M. Makhobole, 2019. Expert Report of Constitutional Reforms. Maseru. Government of Lesotho. https://www.gov.ls/download/expert-report-of-constitutional-reforms/ accessed 16 October 2024.
[10] Phakoana, M. Parliament passes 10th Amendment to Constitution, 24 September 2024. https://www.thereporter.co.ls/2024/09/24/parliament-passes-10th-amendment-to-constitution/ accessed 16 October 2024.
[11] Nyane, H. Lesotho needs constitutional reforms to help gain political stability - but the latest attempt is flawed, 22 September 2024 https://theconversation.com/lesotho-needs-constitutional-reforms-to-help-gain-political-stability-but-the-latest-attempt-is-flawed-237905 accessed 16 October 2024.

The Tenth Amendment Bill, which has been passed, does include:
Insertion of Section 20 A: Affirmative action in favour of marginalised groups:
20A. (1) Notwithstanding anything in this constitution, the state shall take affirmative action in favour of groups marginalised on the basis of gender, age, disability or any other reason created by history or law, for the purpose of redressing imbalances which exist against them.
(2) Parliament shall make laws for the purpose of giving full effect to this section.
As well as:

Membership of the Human Rights commission
133b. 2. The composition of the commission shall, as far as possible, be representative of a broad cross section of society such as women, people with disabilities, youth and other marginalised groups.[12]

Access to justice

Article 7: Equality in accessing justice

1. State parties shall enact legislative and other measures that promote and ensure the practical realisation of equality for women. These measures shall ensure:
   - Equality in the treatment of women in judicial and quasi-judicial proceedings, or similar proceedings, including customary and traditional courts and national reconciliation processes;
   - Equal legal status and capacity in civil and customary law; including, amongst other things, full contractual rights, the right to acquire and hold rights in property, the right to equal inheritance, and the right to secure credit;
   - The encouragement of all public and private institutions to enable women to exercise their legal capacity;
   - Positive and practical measures to ensure equality for women as complainants in the criminal justice system;
   - The provision of educational programmes to address gender bias and stereotypes and promote equality for women in the legal systems;
   - That women have equitable representation on, and participation in, all courts, including traditional courts, alternative dispute resolution mechanisms and local community courts; and
   - Accessible and affordable legal services for women.

African experts define access to justice[13] 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." Access to justice is the foundation for women to enjoy a range of other rights and plays a crucial role in fostering their dignity. However, 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.

A study on access to justice in ten East and Southern African countries, including Malawi, Mozambique, Tanzania and Zimbabwe in SADC, found that access to justice for women is strongly influenced by the nexus between culture, politics and economics.[14] Some barriers to accessing justice are: culture and customary specific harmful practices; legislative and policy challenges; corruption; limited access to technology; pervasive low levels of awareness; physical inaccessibility of courts; few women officers in the police and courts; and poverty and inability to pay various fees including for lawyers and for

[12] The Parliament of Lesotho (2024) Tenth Amendment to the Constitution Bill, 2024. https://nationalassembly.parliament.ls/wp-content/uploads/2024/05/Tenth-Amendment-to-the-Constitution, accessed 30 August 2024.
[13] Equality Now, (2024). Gender Inequality in Family Laws in Africa: An Overview of Key Trends in Select Countries. https://equalitynow.org/africafamilylaw accessed 30 August 2024.
[14] UN Women (2021) Multi-country analytical study on access to justice for victims and survivors of violence against women and girls in east and southern Africa. https://africa.unwomen.org/sites/default/files/Field%20Office%20Africa/Attachments/Publications/2021/MULTI%20COUNTRY%20ANALYTICAL%20STUDY%20ON%20ACCESS%20TO%20JUSTICE%20FOR%20VICTIMS%20AND%20SURVIVORS%20OF%20VIOLENCE%20AGAINST%20WO.pdf, accessed 3 November 2024.

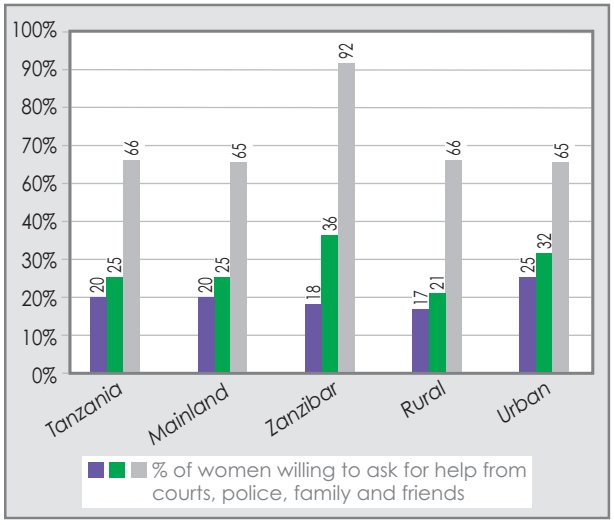
corrupt officials. Despite progressive legislation, policies and procedures, prevailing patriarchal and discriminatory attitudes still often prevent women from accessing justice.

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 and property loss at divorce. Registering marriages is an important way of fighting such practices.

Access to justice is one of the indicators reported on in the Social Institutions and Gender (SIGI) Index study conducted in **Tanzania**. The indicator measures discrimination against women in relation to their access to justice. It considers women's ability to access the country's justice system from the plaintiff's perspective, measuring their confidence and trust in the police or judiciary in cases of conflict. The indicator also measures attitudes towards women's opportunities to go to court or the police freely.[15]

The study found that women have limited ability and willingness to turn to the courts and the police.

Figure 7.1: Women's willingness to ask for help from the court, police or family and friends in Tanzania



Source: SIGI Index, Tanzania

Only 17% of rural women and 25% of urban women would seek recourse in the courts in Tanzania

Figure 7.1 shows that in situations of conflict, only 20% of women would seek access to the lowest court in the judicial hierarchy - Primary Courts in Mainland and Khadi Courts in Zanzibar - and just 25% would seek help from the police. However, about two thirds of women in Tanzania would turn to relatives or friends. Women living in urban areas are more likely to access a court or police to settle a conflict than those in rural areas.

Furthermore, the study found that only 27% of women would turn to religious or traditional leaders, but about 70% of women would turn to local government authorities in a case of conflict. The study also considered attitudes to needing a male partner's permission to access courts or the police. The results are summarised in table 7.3.

Table 7.3: Attitudes to women needing a male partner's permission to access courts or police

Region	Percentage of population who agree women need husband/ partner's permission to access	
	Court	Police
Tanzania	78	77
Mainland	77	76
Zanzibar	98	99
Rural	79	78
Urban	76	75

Source: SIGI Index, Tanzania

Table 7.3 shows that norms and attitudes curtail women's access to justice. The majority of both women and men believe that a woman needs her husband's or partner's permission to contact the police or a court. These norms of restrictive masculinities that promote men's role as protectors and guardians of the household are widely held across all regions of Tanzania as no region had a score below 50%.

[15] OECD (2022), SIGI Country Report for Tanzania, Social Institutions and Gender Index, OECD Publishing, Paris, https://doi.org/10.1787/06621e57-en, accessed 29 October 2024.

Marriage and family rights

Article 8: 1. States 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. States 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.

Community discussion on inheritance rights in Siloe, Lesotho during 16 Days of Activism. Photo: Ntolo Lekau

A 2024 report by Equality Now, *Gender Inequality in Family Laws in Africa: An Overview of Key Trends in Select Countries*, reviewed family laws in 20 countries including Angola, Botswana, DRC, Malawi, Mozambique, South Africa and Tanzania in SADC.[16] The report notes that family law in Africa is a patchwork of legal pluralism resulting from traditional or customary law, overlaid by European statutory and religious (Christian and Muslim) laws. Many provisions in religious and customary laws discriminate against women and girls in areas such as polygamy, divorce and child custody, matrimonial property and inheritance. Often customary law continues to prevail even after statutory law has been reviewed and there is great need for awareness and community mobilisation for implementing new laws.

Many provisions of religious and customary law discriminate against women and girls

[16] Equality Now (2024). Gender Inequality in Family Laws in Africa: An Overview of Key Trends in Select Countries. https://equalitynow.org/africafamilylaw, accessed 30 August 2024.

Some of the findings of the report are:

In **Angola**, the Family Code is based on civil and customary laws. Customary laws should, however, not contradict the constitution. Inequality in family laws exists in Angola in the following aspects: there are exceptions to the legal age of marriage; there are discriminatory customary inheritance laws which facilitate women to be disinherited and even thrown out of their homes; and polygamy also exists in parts of the country. Even though polygamy is outlawed, it is still possible for men to be legally married to one woman and informally married to more.[17]

Malawi recognises and regulates civil marriages, customary marriages, religious marriages, and marriage by cohabitation or reputation. The constitution provides that the State must progressively adopt and implement policies and legislation to achieve gender equality through full and equal participation of women in all spheres of Malawian society; non-discrimination; and implementing policies to address social issues such as domestic violence, security, lack of maternity benefits, economic exploitation and rights to property. Section 24 of the Constitution is dedicated to the rights of women and includes provision for "the right to be accorded the same rights as men in civil law, including equal capacity to enter into contracts; to acquire and maintain rights in property, to acquire and retain custody, guardianship and care of children, and to have an equal right in the making of decisions that affect their upbringing;" as well as for "fair disposition of property that is held jointly with a husband; and to fair maintenance upon dissolution of a marriage."[18]

South Africa has had a fragmented legal system governing marriages with three different pieces of legislation: the Marriage Act, the Civil Union Act and the Recognition of Customary Marriages Act. A new Marriage Bill, which seeks to bring all the laws together into one, opened for public comment on 10 April 2024. This was too late to finalise the Bill before national elections in May.[19] The new Bill sets the minimum age of marriage as 18 for both girls and boys, without exception. It would also require registration of all marriages including same sex marriages and polygamous marriages. The new Bill has been criticised as discriminatory for not allowing women to have more than one partner (polyandry); putting women in polygamous marriages at risk if they struggle to register their marriages (especially after their spouse has died); not referencing Muslim marriages; and not referencing domestic partnerships. The Constitutional Court recognised domestic partnerships as deserving the same legal protection as marriages.[20]

Child marriages

SADC Protocol Article 8.2a: No person under the age of 18 shall marry.

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.

SDGs 5.3: Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation.

[17] Ibid.
[18] Ibid.
[19] Business Tech. New marriage laws for South Africa take the next big step. 10 April 2024. https://businesstech.co.za/news/lifestyle/767324/new-marriage-laws-for-south-africa-take-the-next-big-step/ Accessed 30 August 2024.
[20] Joyi, N and C. Potgeiter. The new marriage bill and its implications in South Africa. 29 September 2023. https://www.csvr.org.za/the-new-marriage-bill-and-its-implications-in-south-africa/ accessed 30 August 2024.

CEDAW Article 16(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent and **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.

International Conference on Population and Development (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.

SADC UN CSW Resolution calls on 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. This includes harmful practices, such as child, early, and forced marriage, female genital mutilation and trafficking in persons. It should ensure the full engagement of men and boys in order to reduce the vulnerability of women and girls to HIV and AIDS.

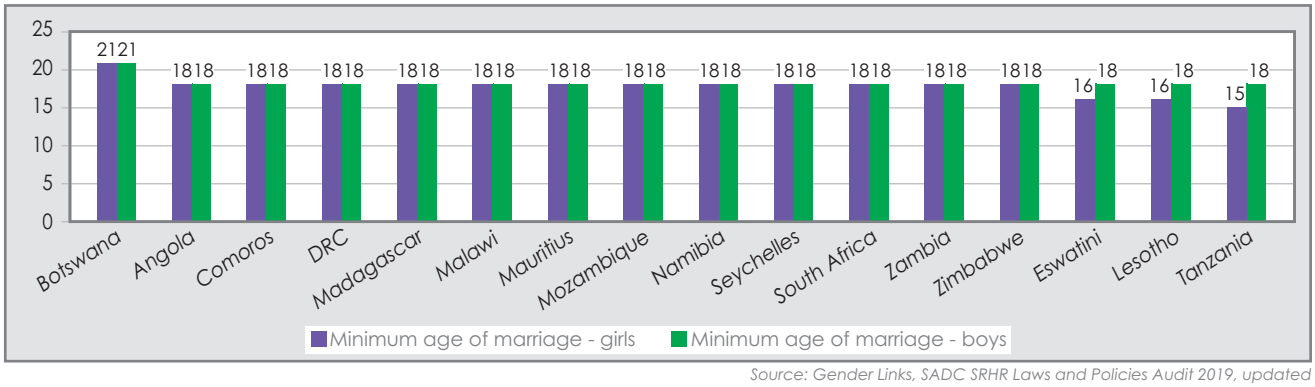
The SADC Model Law on Child Marriage defines "child marriage" as "a statutory or customary union in which one party is a child or both of the parties are children.[21] The same Model Law defines a child as any person under the age of 18 years in line with other international human rights instruments.[22]

Minimum age of marriage

There is slow but steady progress in review of legislation in SADC to ban child marriage

The numerous normative frameworks above, which governments of SADC Member States are signatories to, have called for the elimination of child marriage and setting the minimum age of marriage to 18 without any exception. There is slow but steady progress in revising legislative frameworks across SADC to ensure that this is legislated, with support from the adoption of the SADC Model Law on Child Marriage and other initiatives.

Figure 7.2: Minimum age of marriage for females and males by country



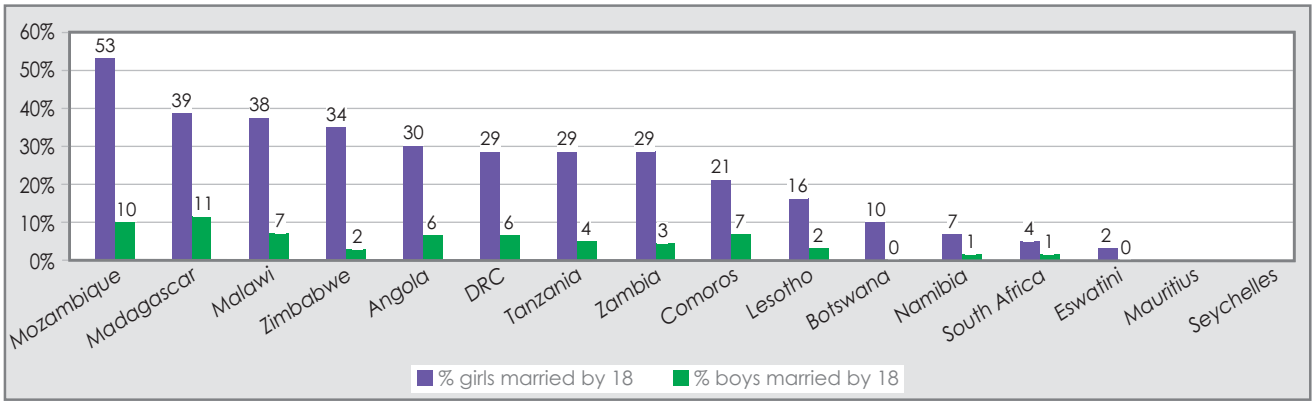
Source: Gender Links, SADC SRHR Laws and Policies Audit 2019, updated

[21] '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.
[22] Article 1 of the Convention on the Rights of the Child defines a child as every human being below the age of 18 years

Figure 7.2 shows that most SADC countries have set the age of consent to marriage at 18. Only Eswatini, Lesotho and Tanzania still have legislation that sets age of consent to marriage lower for girls than 18. However, other countries still have exceptions to their general provisions.

Though there is ongoing legislative change, it will take time for this to change behaviour and bring down the rates of child marriage. Figure 7.3 shows that rates of child marriage are still persistently high across much of SADC.

Figure 7.3: Percent girls and boys married by age 18 in SADC



Source: Gender Links computation from UNICEF Child Marriage Database, 2024

Figure 7.3 shows that rates of girls being married before the age of 18 still varies between zero in Mauritius and Seychelles to 53% in Mozambique. Rates of boys being married before the age of 18 varies from zero in Mauritius and Seychelles to 11% in Madagascar. Mozambique, Madagascar and Malawi have some of the highest rates of child marriage in the world (Malawi has the 12th highest prevalence of child marriage globally). There are much lower rates of boys being married before the age of 18, but there are boys that marry as children.

At the end of December 2023, **Zambia** enacted an amendment to the 1918 Marriage Act to set the minimum age of marriage to 18 for civil and customary marriages. Zambia has, thus, banned child marriages. Zambia has a dual system of statutory and customary law. The 1918 Act previously set the minimum age of marriage at 21, but allowed boys and girls between 16 and 21 to marry with parental consent, and those younger than 16 to marry with consent of a High Court Judge. There was previously no age limits for marriages entered into under customary law.[23]

The First Lady, Mutinta Hichilema, has launched a programme to raise awareness to end child marriage nationwide, including by engaging with chiefdoms about the new legal frameworks.[24]

It is very important that national level legal change is accompanied by local community level change in practice. One way of achieving such change is by working with local leaders. The following case study outlines work with traditional leaders in Zimbabwe to develop by-laws to stop child marriage. This effort complements national legislative change.

[23] Goltom, H. Zambia: Amendment to Marriage Act Enacted, Child Marriage Outlawed. 6 February 2024. https://www.loc.gov/item/global-legal-monitor/2024-02-05/zambia-amendment-to-marriage-act-enacted-child-marriage-outlawed/#:~:text=On%20December%2022%2C%202023%2C%20Zambia,those%20concluded%20under%20customary%20law, accessed 30 August 2024.

[24] UNFPA. Zambia takes bold steps to end child marriage with landmark law. 29 May 2024. https://esaro.unfpa.org/en/news/zambia-takes-bold-steps-end-child-marriage-landmark-law, accessed 30 August 2024.

Traditional leaders in Zimbabwe create by-laws to curb child marriage

The development of by-laws in Shamva District in central Zimbabwe presents a powerful example of how traditional leaders can be partners in ending harmful cultural practices and advance the rights of girls and women. Through strong community engagement and leadership, the by-laws offer a sustainable and culturally relevant solution to child marriages, setting a precedent for other provinces in Zimbabwe and beyond.

Shamva District, especially the Bushu and Nyamaropa chiefdoms, has been grappling with high rates of child marriages and harmful cultural practices such as "*kuzvarira*" (pledging daughters in marriage) and "*kuripa ngozi*" (virgin pledging) which underlie child marriage. These practices perpetuate gender-based violence and violate the rights of young girls. In a ground-breaking initiative, traditional leaders, with the support of Rozaria Memorial Trust (RMT), spear-headed the development of by-laws to curb these harmful practices and end child marriages in their communities.

Mashonaland Central province, in which Shamva is located, has the highest child marriage rates in Zimbabwe, with a prevalence of 50%. Poverty, cultural beliefs, and religious practices drive this practice. Many families in Shamva resort to child marriages as a survival tactic, marrying off young girls in exchange for *lobola* (Southern African variation of dowry) or goods. The district's economy is heavily reliant on small-scale mining and agriculture, exacerbating vulnerabilities for young girls who are often lured into early marriages by promises of financial stability from wealthier men.

Community dialogues being held in Shamva District in Zimbabwe.
Photo: Rozaria Memorial Trust

The process of developing by-laws in Shamva involved extensive consultation and engagement with community members, including chiefs, village heads, local authorities and other implementing partners in the district. The process began with a series of community meetings to gather insights on harmful practices and seek input into the formulation of culturally relevant and legally sound by-laws. With technical support from RMT, the chiefs led the process to create by-laws addressing child marriage and associated challenges in the communities.

Key features of the bylaws
The by-laws explicitly prohibit child marriages and hold community members accountable for practices that violate the rights of children, particularly girls. They also clarify the roles of all people in the community. The key provisions include:

- *Prohibition of child marriages:* no person under 18 is allowed to marry, cohabit or engage in sexual activities. Cultural and religious justifications for child marriage are explicitly banned.
- *Roles and responsibilities of traditional leaders:* Chiefs and village heads are tasked with enforcing the by-laws and are required to supervise and monitor compliance. Any leader found facilitating child marriages is subject to dismissal.
- *Community involvement:* the by-laws emphasise the role of parents, extended families, and the entire community to protect children from harmful practices. Parents are responsible for ensuring their children attend school and are raised with values.
- *Creation of a special court:* a specialised court handles cases of child marriage, with the chief as the presiding authority, to ensure swift justice for victims and deter future violations.

Since adopting the by-laws, reported cases of child marriages in Bushu and Nyamaropa have significantly reduced. Specialised children's courts based with the Chief's Advisory Council, comprised of a social worker, Victim Friendly Unit (VFU) police officer and community-based

outreach workers, have been very successful. The court is a critical part of the initiative to enforce the by-laws. The court ensures that children can participate in proceedings in a safe and supportive environment, with assessors that include young people and individuals with disabilities.

This initiative reflects the Chiefs' commitment to protecting children's rights and promoting inter-generational leadership. Involving traditional leaders to enforce the by-laws empowered the community to take collective action against harmful practices. The Mashonaland Central province reviewed the progress achieved in Shamva and recommended that all chiefs in the province should have similar by-laws. This recommendation led 29 other chiefs in the province adopting the by-laws in September 2024.

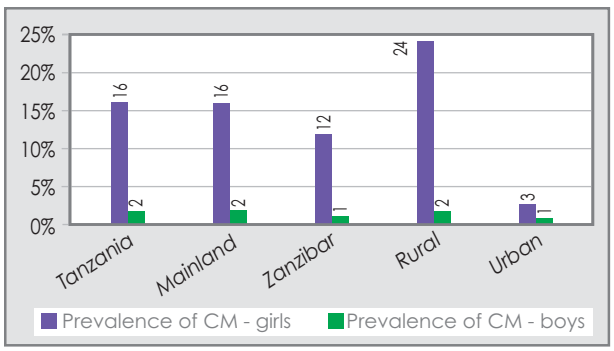
Leading the development of the by-laws strengthened the chiefs' role as custodians of culture while ensuring that cultural practices evolve to respect human rights.

Source: Colleta Zinyama and Loveness Mudzuru, Rozaria Memorial Trust and a Woman of the South Speak Out (WOSSO) fellow

When the Tanzanian government tabled the Child Protection Laws (Miscellaneous Amendments) Bill, 2024, at the end of August 2024, it sparked a debate about why nothing has yet been done to review the outdated 1977 Marriage Act. Two High Court rulings have directed the government to review the law to raise the minimum age of marriage to 18, without exception. A number of Members of Parliament spoke about the need for this review. It is believed that reform faces stiff opposition from religious leaders, especially in the Muslim faith who argue that girls need to be married to prevent them from engaging in sex before marriage.[25]

The SIGI Index study investigated the rates of child marriage in different areas in Tanzania, as captured in Figure 7.4.

Figure 7.4: Prevalence child marriage (CM) in Tanzania

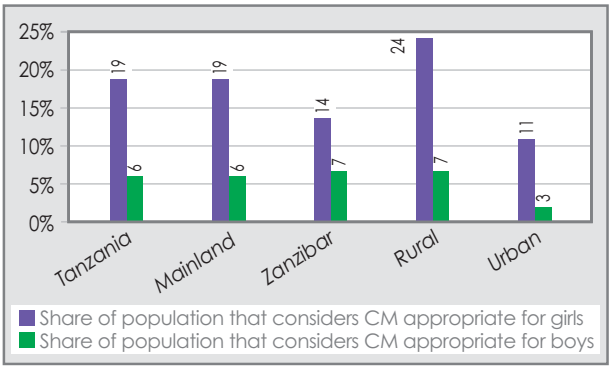


Source: Tanzania SIGI Index

Figure 7.4 shows that child marriage rates are much higher in rural areas than in urban areas in Tanzania. Child marriage rates in boys are very low across all areas.

Another question was about attitudes to child marriage for girls and for boys.

Figure 7.5: Attitudes to child marriage



Source: Tanzania SIGI Index

Figure 7.5 illustrates that there are still significant levels of support for child marriage for both girls and boys across all sectors of Tanzania society, therefore there is still much to be done to change these attitudes.

Even when communities stop children from being married, this may not be enough to prevent child marriage if families still support it. The following case study from rural Zimbabwe illustrates challenges for persuading families that child marriage is not a route out of poverty.

[25] Mosenda, J. Marriage law controversy: A bone of contention in Tanzania. 7 September 2024. The Citizen. https://www.thecitizen.co.tz/tanzania/news/national/marriage-law-controversy-a-bone-of-contention-in-tanzania-4745736, accessed 1 November 2024.

Community efforts to stop child marriage in Zimbabwe

Maranatha Orphans Care Trust trained and supported Gender Champions to be gender-based violence watchdogs in their communities in Matobo District in southwest Zimbabwe. The district has been badly affected by climate change, resulting in very poor crops, deepening poverty and food insecurity. One strategy that desperate families adopt is to marry a young daughter to an older man who will look after the girl and contribute to the family.

In December 2022, Gender Champions heard about a wedding between a 15-year-old girl and a 38-year-old man planned for the following morning. The girl had been in Form Three and had been forced to stop her education to get married to this wealthy man. The Gender Champions went to the office of the Ministry of Women Affairs to notify the District Development Officer (DDO). The DDO and Gender Champions told the local police and social welfare office. The Gender Champions work with a multi-sectoral team to protect themselves against the perpetrators they bring to book.

This team went to the homestead where they found wedding preparations underway and people arriving for the wedding. The team spoke to the girls' parents and told them if they went ahead with the wedding they would be arrested, as arranging for the marriage of a girl below the age of 18 is a criminal offence. The police announced that no wedding would take place and it was cancelled.

The Gender Champions have intervened in several other cases of child marriage. One of these was a 14-year-old from a very poor family who married off their child. The girl dropped out of school, and a customary marriage was concluded with a 30-year-old man.

The Gender Champions reported the case to the police who arrested the 30-year-old man who was convicted and sentenced to 6-months of community service.

Police in Ward 14, Matobo, Zimbabwe holding a dialogue to raise awareness on campaign against child marriage. Credit: Nothabo Sibanda

A year or so after these cases Maranatha investigated to find out what had happened to the young women. The girls told them they had been happy to get married and escape poverty. The white wedding in the first case was cancelled but customary procedures continued, and the families consider the two to be husband and wife. In the second case the man completed his community service sentence and came home to the marriage.

Communities have recommended that programmes to tackle child marriage in rural communities should include livelihoods interventions. Poverty is the root cause of the resurgence of harmful community practices such as child marriage. Young girls, parents and communities also need constant awareness raising on the ills of child marriages and the negative impact these have on young girls' lives.

Some Voice and Choice SAF grantees are also raising awareness about child marriage.

Unlimited Hope Alliance Trust (UHAT) engaged community leaders through dialogues on addressing harmful cultural practices and improving access to sexual reproductive health rights (SRHR) in Goromonzi rural district, not far from Harare, Zimbabwe.

The community dialogues identified and discussed harmful cultural practices, facilitated by respected local figures, including traditional and religious leaders, elders and educators.

Open discussions encouraged participants to share their experiences and concerns, fostering a supportive environment for change. Pre- and post-dialogue assessments revealed a 70% increase in participants' awareness of harmful cultural practices.

Community dialogue organised by Unlimited Hope Alliance Trust in in Goromonzi District, Zimbabwe. Photo: Unlimited Hope Alliance Trust

About 50% of community leaders who participated in the dialogues turned insights into actionable plans to address harmful practices, such as strategies for community awareness campaigns and initiatives to enhance access to SRHR services. The initiative culminated in the development of a localised child protection policy, which complements the established Child Protection Committee.

She Decides is an organisation that works with young women on SRHR issues.

Blessing Mutambara
Photo: Unlimited Hope Alliance Trust

Blessing Mutambara is a young woman from a rural community studying at the Great Zimbabwe University in Masvingo, central Zimbabwe. Mutambara was one of the young women who organised the She Decides Open House where they mobilised religious leaders and young women to have an open discussion on the challenges women in Masvingo are facing regarding SRHR. The discussion highlighted the barriers caused by harmful practises. It was an opportunity to share information on SRHR through theatre performances and to understand the position of the religious leaders on SRHR issues.

Mutambara reflected on the Open House:
"The 'She Decides' open house session we organised was more than just an event - it was a movement. It was a declaration of our rights, our power and our resilience. We broke the silence, shattered the stigma and demanded change. We invited various stakeholders including religious leaders and we discussed issues that affect adolescents and young women in our communities. It's a reminder that we all have the power to create a better world, one story one voice, and one movement at a time."

Source: Nothabo Sibanda, Marantha OVC Project, a Woman of the South Speak Out (WOSSO) fellow; UHAT report to Gender Links, She Decides report to Gender Links

Impact of child marriage on girls and their children

The impact of child marriage on the girls involved as well as their children is devastating. It almost always results in girls dropping out of school, which limits their opportunities for economic activity. Furthermore, child brides are often isolated from friends, social networks and even faith communities, with little support.[26]

Child marriage is associated with adolescent pregnancy and motherhood, which have negative impact on girls' physical and mental health.[27] Despite these negative impacts and legislation to end child marriage, it is still very common.

[26] Girls Not Brides. Impact of Child Marriage on girls' education. https://www.girlsnotbrides.org/learning-resources/child-marriage-and-education/ accessed 2 August 2024.
[27] Girls not Brides. Impact of Child Marriage on girls' health. https://www.girlsnotbrides.org/learning-resources/child-marriage-and-health/ accessed 2 August 2024.

Female Genital Mutilation

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. It is most often conducted on young girls between infancy and age 15. Younger children especially have no say in whether this should be performed or not. FGM is an expression of deeply rooted gender inequality and a violation of girls' and women's fundamental human rights, including their rights to health, security and dignity.

FGM is quite often done by traditional circumcisers, in unsterile conditions and without any anaesthesia, which is very painful and can result in serious complications. However, there are reports of medical FGM performed by trained medical service providers. FGM is believed to discourage sexual behaviour and elevate the female's social status; it is often viewed as a rite of passage into womanhood with deep historical and social origins. In some instances, men will not marry a woman who has not undergone FGM or it has consequences for the bride price that a man will pay.[28]

It is estimated that about 230 million girls and women from 31 countries across three continents have been subjected to the practice. FGM has serious physical and mental health implications for girls and women and can lead to complications during childbirth. UNFPA estimates that over 4 million girls are at risk of FGM each year.

In 2021, an additional 2 million cases of FGM were predicted to occur over the next decade, as a result of COVID 19 related school closures and disruptions to programmes addressing FGM. Girls and women with primary education are 30% more likely to oppose FGM and those with secondary education 70% more likely.[29]

The World Health Assembly passed resolution WHA61.16 on the elimination of FGM in 2008, emphasising the need for concerted action across all sectors including health, education, finance, justice and women's affairs. Concerted global action has succeeded in reducing the incidence of FGM.[30]

Tanzania is the only SADC country where FGM is practiced widely, concentrated mainly in the six northern regions (of Tanzania's 18 regions). However, there are reports of isolated instances of FGM in South Africa, Mozambique, Zimbabwe and Malawi.[31] In the six regions of Tanzania where FGM is practiced prevalence is higher than 30% and rises as high as 58% in Arusha and 63% in Manyara. FGM is about twice as common in rural areas than in urban areas. At least 88% of people in the six regions where FGM is prevalent believe the practice should be abandoned.

As the case study illustrates, organisations are advocating at local levels as part of global efforts to end FGM.

[28] Ayenew AA, Mol BW, Bradford B and Abeje G (2023) Prevalence of female genital mutilation and associated factors among daughters aged 0-14 years in sub-Saharan Africa: a multilevel analysis of recent demographic health surveys. Front. Reprod. Health 5:1105666. doi: 10.3389/frph.2023.1105666. accessed 14 August 2024.
[29] UNICEF (2024). Female Genital Mutilation. https://www.unicef.org/protection/female-genital-mutilation, accessed 27 July 2024.
[30] Mkwananzi, S, and L. Joubert, (2023). Towards ending female genital mutilation by 2030. https://www.unisa.ac.za/sites/corporate/default/Colleges/Human-Sciences/News-&-events/Articles/Towards-ending-female-genital-mutilation-by-2030 accessed 28 August 2024.
[31] The Orchid Project. Where does Female Genital Cutting happen? https://www.orchidproject.org/about-fgc/where-does-fgc-happen/malawi/ accessed 17 August 2024.

Taking a stand against FGM in Tanzania

At just 15-years-old, Katesho[32] took a stand against female genital mutilation (FGM) for herself, despite significant family pressure. With information from a session presented by Salama Foundation, a Voice and Choice SAF grantee in Tanzania, Katesho fled home when her father insisted she should undergo FGM before enrolling in secondary school. He believed the procedure was vital to preserve the family's honour.

"He told me that I had grown up and needed to be cut for our family to be respected," Katesho recalls. Determined to resist, Katesho walked for ten hours to the nearest Local Government Authority office. There, she reported her situation to the authorities, which was a powerful assertion of her independence.

Salama Foundation community dialogues are raising awareness about harmful practices in Tanzania. Credit: Orinah Nyuki

Despite the prohibition of FGM in Tanzania since 1998, the practice persists in remote areas like Mara, which is in northern Tanzania, bordering Lake Victoria. In Mara 32% of women aged 15 to 49 have been subjected to FGM. Katesho met the Salama Foundation when they visited her school during the commemoration of 16 Days of Activism against Gender-based Violence (GBV).

Katesho recalls, "Last year when the Salama Foundation visited our school to discuss the dangers of FGM they provided us with educational materials and fact sheets. I learned about the severe health and psychological effects of this practice, which made me refuse to undergo it. I'm grateful my brother supported me through this ordeal, despite the strong opposition from our parents."

Katesho's mother struggled to understand her daughter's concerns and complained, "You are making me look foolish."

Following her brave escape, Katesho asked the local government executive officer to contact the Salama Foundation for further support as she was determined to continue her education. The Salama Foundation prioritised her case and collaborated with the MKUKI (*Mtandao wa Kupinga Ukatili wa Kijinsia* or Coalition against Gender-Based Violence) to provide assistance.

Today, Katesho lives at Masanga Center in Tarime, where she continues her education and aspires to become a military officer. Her journey represents the growing movement among young women in Tanzania who are rejecting FGM despite societal pressures.

"I am happy to be here, I feel safe because my father is not around and I can continue with school," says Katesho.

The Salama Foundation, in partnership with the MKUKI Coalition (a network of 70 Tanzanian organisations collaborating to end GBV in rural and urban areas), have become an essential force in the battle against GBV in general and FGM specifically. Their initiatives include school programmes, anti-violence clubs and using creative methods like dance to address reproductive health.

Katesho's determination is a testament to resilience and courage. Her fight against FGM underscores the power of ongoing advocacy and education. Her story inspires others to defend their rights and live free from the fear of harmful traditions.

Source: Salama Foundation, report to Gender Links

[32] Pseudonym to preserve her anonymity.

Discrimination against people with disabilities

Article 9: Persons with disabilities: States 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.[33]

The approximately 80 million people with disabilities in Africa face similar kinds of exclusion and discrimination as people with disabilities in other continents. However, they are also subject to discrimination specific to Africa, which is rooted in deeply held beliefs that often link disability with a spirituality or a supernatural dimension. Disability discrimination in Africa is highly gendered, disproportionately affecting women. In particular, mothers of children with disabilities may be accused of witchcraft or bringing a curse upon the family. Consequently, many children with disabilities are hidden and locked away, unable to participate in education or benefit from health services. These children are not able to achieve their potential.

One example of the specific challenges that people with disabilities are subject to in Africa is regarding albinism. Albinism is a genetic condition that causes a person to have little to no melanin, the chemical that gives colour to skin, hair, and eyes. People with albinism at best face social exclusion and at worst are subject to deadly attacks, as their body parts are in great demand for ritual purposes. There are also beliefs that intercourse with a woman or girl with albinism can cure HIV, which has led to widespread sexual violence against women and girls with albinism.[34]

Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa

The Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa, also referred to as the African Disability Protocol or ADP, was adopted by the African Union (AU) Heads of State at the thirtieth ordinary session of the AU Assembly in Addis Ababa on 29 January 2018. The AU announced in August 2024 that the ADP had entered into force following ratification by 15 nations, including Angola, Malawi, Mozambique, Namibia and South Africa[35] in SADC. Zimbabwe also ratified the ADP in May 2024[36] and Lesotho has signed it[37].

While there are many specifically African aspects to discrimination of people with disabilities, there is also a very vibrant community of African disability rights activists, campaigners and organisations

[33] United Nations Convention on the Rights of Persons with Disabilities.
[34] Alexiou, Gus. 2024 "Africa on Verge of its ADA Moment if African Disability Protocol Passes". https://www.forbes.com/sites/gusalexiou/2024/02/11/africa-on-verge-of-its-ada-moment-if-african-disability-protocol-passes/ accessed 23 August 2024.
[35] African Union, 5 August 2024, "African Commission: The African Disability Rights Protocol has entered into force", https://altadvisory.africa/2024/08/05/african-commission-the-african-disability-rights-protocol-has-entered-in-force/ accessed 23 August 2024.
[36] https://www.herald.co.zw/zimbabwe-ratifies-african-disability-protocol-paving-the-way-for-improved-rights-and-inclusion/ accessed 23 August 2024.
[37] https://www.thereporter.co.ls/2024/02/26/lesotho-signs-protocol-on-disability-rights/ accessed 23 August 2024.

of people with disabilities. This community campaigned tirelessly for many years for the ADP and are continuing to advocate with national governments to ratify and implement its provisions.[38]

The ADP has a distinctly African perspective on protecting and promoting the rights of persons with disabilities

The ADP has a distinctly African perspective on protecting and promoting the rights of persons with disabilities compared with the United Nations Convention on the Rights of Persons with Disability (UNCRPD). The ADP has a much stronger focus on the role of families and communities; rights of caregivers to people with disabilities; and women, girls and children with disabilities. Furthermore, the ADP includes sections on youth (including SRHR education) and older persons, which the UNCRPD does not have. The ADP thus addresses issues of intersectional discrimination.

In several sections, the ADP stresses the right of persons with disabilities to health, including SRHR, and the right of women to have children if they wish, as well as access to contraception.

The ADP's Article 11 specifically protects persons with disabilities from harmful practices:

"State parties shall take all appropriate measures and offer appropriate support and assistance to victims of harmful practices, including legal sanctions, educational and advocacy campaigns, to eliminate harmful practices perpetrated on persons with disabilities, including witchcraft, abandonment, concealment, ritual killings, or association of disability with omens.

States parties shall take measures to discourage stereotyped views on the capabilities, appearance or behaviours, of persons with disabilities, and they shall prohibit the use of derogatory language against persons with disabilities."

The case study of Thandeka Dlamini in rural KwaZulu Natal, South Africa, illustrates the struggles of a mother of a child with a disability.

Journey from child marriage to leader advocating for change

Thandeka Dlamini, who is from a rural area in South Africa's KwaZulu Natal province, is emerging as a leader in the Imbokodo Women Empowerment group. She joined the group after being referred to Incema's SheCAN project by Pastor Sabelo Zungu, a community leader and a member of the Incema Men's Forum. Incema, a VCSAF grantee in South Africa, launched the SheCAN (She Creates, Achieves, and Nurtures) support programme in 2021 to provide a space for women and girls to talk about their issues and challenges and build their economic capacity.

Dlamini, who was forced into marriage at age 15, endured years of abuse. Her first child, born when she was only 16, has severe cerebral palsy. The child cannot sit, stand or speak. To ensure proper care for her child, Dlamini enrolled her in a facility in Hillcrest, a small town close to her home. She is using the child's government provided disability grant to pay for the service.

The SheCAN programme is helping Dlamini to turn her life around. She received counselling and psychosocial care which helped her

[38] Kesamang, Lefoko, AK Dube, G Antwi-Atsu, E Orowe, 14 December 2023, Why countries must ratify the African Disability Protocol, https://africanarguments.org/2023/12/why-countries-must-ratify-the-african-disability-protocol/#:~:text=%5B2%5D%20As%20of%2029th,Republic%2C%20South%20Africa%2C%20Uganda accessed 23 August 2024.

emotional healing and empowered her to leave her abusive marriage to start a new chapter in her life. She has also learnt about bodily autonomy, contraceptive use and self-awareness. This knowledge has been critical in helping her regain control over her life to ensure healthier futures for herself and her children. Dlamini moved to a town closer to Hillcrest to be able to visit her child over weekends. And found a job in a factory not too far away.

Incema is negotiating with a local Technical and Vocational Education and Training (TVET) college to provide Dlamini with skills that can help her generate income and break free from dependence on abusive environments. While waiting for formal bursary opportunities and skills programmes that may be available in 2025, Dlamini enrolled in a six-month Civil Engineering Technical Construction course. She is balancing her studies, job and motherhood. Her priorities are challenging, as she struggles to prioritise her mental health while focusing on providing for her children. She is participating in on-going therapy at Incema, where she receives guidance and emotional support to navigate her challenges.

Thandeka Dlamini is a member of the Imbokodo Women Empowerment group in South Africa. Credit: Thenjiwe Ngcobo

The Imbokodo Women Empowerment group is comprised of young women at Incema who were married as children. Together, the young women raise awareness about child marriages, with plans to run educational programmes for young girls in schools, and develop income-generating initiatives such as sewing, beadwork, and baking. The group is a safe space for members to discuss their challenges and support one another in their healing journey. Dlamini has taken a leadership role in the group.

The Incema Men's Forum that began in 2021 is comprised of traditional and other community leaders who are committed to addressing gender-based violence (GBV) and domestic violence. Members of the Men's Forum work with other stakeholders, to ensure proper referrals and support. Traditional authorities from four local communities (KwaMpumuza, Inadi, KwaMafunze and Incwadi) are represented in the forum. Traditional and other community leaders play a crucial role in promoting change within their communities. They plan and implement activities to address GBV in the communities.

Dlamini's story is a testament to the profound impact of combining community-based support with traditional leadership engagement. With Incema's guidance and the support, she is determined to break free from the cycle of abuse and ensure that her daughters grow up free from patriarchal oppression. Dlamini's journey from a victim of child marriage to a leader advocating for change reflects her resilience and the power of the SheCAN programme, which focuses on SRHR and gender equality. She continues to advocate for the rights of young women in her community, seeking to end the harmful cultural practices that have affected so many lives.

Reflecting on her journey, Dlamini says, "I want to go back to my community and be an example, to bring hope to other women who are victims of child marriages."

Source: Incema, report to Gender Links

Countries are adapting their laws as well as institutions to provide more comprehensive care to people with disabilities as illustrated in the cases below:

The **DRC** promulgated Organic Law No. 22/003 in June 2022 to protect and promote the rights of people with disabilities. The law, which aligns to the Convention on the Rights of People with Disability (CRPD), enshrines the rights of people with disabilities, including the rights to non-discrimination, participation and access to all services. It also creates a national framework for implementation throughout the DRC's 26 provinces. It has been hailed as a milestone by organisations that support people with disability.

There is now a coordinated effort to make the provisions of the law widely known throughout the country.[39]

Several countries have bodies responsible for coordinating services and programmes to uphold the rights of people with disabilities. Two of these are Zambia and Seychelles.

The **Zambia**n Persons with Disabilities Act No. 6 of 2012 established the Zambia Agency for Persons with Disabilities (ZAPD) under the Ministry of Community Development and Social Services. The ZAPD was established to plan, promote, regulate and coordinate services for persons with disabilities. It recently developed a Strategic Plan 2023 - 2026 which heavily emphasises mobilising and using resources effectively.[40]

The National Council for Disabled Persons in **Seychelles**, established by the National Council for Disabled Persons Act, is responsible for promoting and protecting the rights of persons with disabilities. It coordinates activities of private and public organisations to provide support and care to people with disabilities. The Council promotes services and programmes, including education, sports, vocational training and job placement.[41]

The rights of widows and widowers

Article 10: Widow and widower rights

1. States 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 spouse 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.

Across most of SADC there is slow progress on reviewing legislation, policy and practice to prevent discrimination against widows especially, and also widowers. As with many other aspects of personal law, laws governing inheritance are subject to formal, traditional or customary and religious nuances. Traditionally, widows had few rights to ownership of land or property and were often dispossessed of homes, property and the means to care for themselves and their children when their husbands died. There is gradual change in both formal legislation providing protection for widows and their children and family and community understanding of the protection of widows.

[39] CBM. New Law Protects Disability Rights in the DR Congo. 19 April 2023. https://www.cbm.org/news/news-regions/news-africa-west-and-central/new-law-protects-disability-rights-in-the-dr-congo/, accessed 14 October 2024.
[40] Zambia Agency for Persons with Disabilities with Ministry of Community Development and Social Services, (2023). Zambia Agency for Persons with Disabilities Strategic Plan 2023 - 2026. https://www.undp.org/sites/g/files/zskgke326/files/2024-02/zapd_strategic_plan.pdf , accessed 14 August 2024
[41] Kamga, GEK. (2022) 'Country report: Seychelles' African Disability Rights Yearbook 187-201 http://doi.org/10.29053/2413-7138/2022/v10a9/ , accessed 14 August 2024.

Lesotho promulgated the *Administration of Estates and Inheritance Act of 2024* which superseded several acts that have been repealed.[42] The new Act introduced several reforms and provides an efficient, transparent and inclusive framework for dealing with inheritance issues. Some of the reforms it includes are:

- Inheritance rights for all children, irrespective of gender and whether born in or out of wedlock.
- The Master of the High Court now has responsibility to administer intestate estates under both civil and customary systems.
- Recognition of the complexities of modern family arrangements, including blended families resulting from remarriage.
- Clarity of property inheritance, especially in cases of polygamy.
- Rules for drafting, registering and monitoring wills.
- Transparency in estate planning.
- Provides different management for estates of different values.
- Protection for those that are most vulnerable i.e. mentally ill, critically ill or intellectually incapacitated.
- Upholds the rights of customary widows with equal protection for both women and men in customary marriages.

Lesotho's new Administration of Estates and Inheritance Act has introduced a number of reforms to how Lesotho handles inheritance issues

Norton Junior councillors take a stand against child marriage in Zimbabwe. Photo: Tapiwa Zvaraya

[42] LexAfrica, (2024), The New Administration of Estates and Inheritance Act No.2 of 2024: Key Changes and Implications. https://lexafrica.com/2024/09/lesotho-estates-and-inheritance-act/#:~:text=Lepule%20in%202016.-,The%20Harmonization%20of%20the%20rights%20of%20Customary%20Widows%20with%20the,in%20the%20administration%20of%20estates, accessed 1 November 2024.

Next steps

Harmful practices are a violation of human rights, deeply rooted in social norms that sustain gender inequality. This chapter has illustrated several progressive steps forward, showing that change is possible.

Key recommendations include:

- **Promote constitutional review** and specifically removal of all clawback clauses, especially in Lesotho and Botswana which have already invested much effort in this process. Ensure all personal legislation (marriage, inheritance, etc) respects the rights of women.
- **Promote women's access to justice** at all levels, including by advocating for more women to be hired and promoted in the police and justice system.
- **Continue legal review to eliminate** any chance of **child marriage** in the law in all countries. Promote programmes to mobilise communities to embrace changes to custom and tradition. Encourage programmes to incorporate efforts to address livelihoods for families so that they are not tempted to "marry off" their daughters as a strategy to escape poverty.
- **Continue efforts to improve education**, to support the millions who dropped out of school during the COVID 19 pandemic, encourage girls and boys to complete secondary school.
- **Continue legal review to address all forms of discrimination in marriage** and to protect the rights of women in marriage. This includes addressing discrepancies between customary and formal legislation, including regarding custody of children and ownership of property. The principle of non-discrimination must govern laws and practices in case of death of one spouse as well as in cases of dissolution of the marriage for whatever reason.
- **Be vigilant against all forms of FGM.** Promote programmes to raise community voices against FGM, including in countries where it is not very common.
- **Support girls and young women already in child marriages** to overcome the most deleterious impacts.
- Encourage all member states to **ratify the Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disability in Africa** and to develop plans and institutions to implement its provisions.

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Sexual orientation and gender diversity

8

LGBTQI+ South Africans, activists, and allies march in the Johannesburg Pride parade on 26 October 2024 in Sandton. The event marked 35 years since the city's first Pride parade, an annual event that activists see as an essential opportunity to advocate for equal rights Credit: Khensani Mabase

Key points

- Resistance against LGBTQI+ rights has grown in intensity in many countries, with recent examples of anti-LGBTQI+ backlash in Botswana, Malawi, Eswatini, and DRC.
- Religious and cultural fundamentalism continues to fuel violence and discrimination against LGBTQI+ people across the region.
- Equaldex's equality index shows that LGBTQI+ acceptance differs across the region, from a high of 71% in South Africa to just 6% in Zambia.
- While Botswana joined four Southern African countries (Angola, Mozambique, Seychelles, and South Africa) in 2019 and decriminalised same-sex relationships by declaring sections of its penal code unconstitutional, religious leaders recently challenged the ruling, providing lawmakers an opportunity to stall debate on the topic.
- Conservative groups and decision-makers have joined forces to appeal similar court orders in Eswatini and Namibia.
- In a landmark vote in April 2024, the UN Human Rights Council adopted a resolution calling on member states to enhance efforts to combat discrimination, violence and harmful practices against intersex people.

Introduction

Lesbian, gay, bisexual, transgender, queer and questioning and intersex people have seen both significant advancements and many setbacks in claiming their rights in recent decades. The movement for equal rights for this group typically employs the acronym LGBTQI+ to include all members, with the "+" acknowledging that it is not an exhaustive list of terms because different cultures - historically and today - use an array of language to describe the wide range of sexual orientations and gender expressions. This chapter will also use the term SOGIESC, which stands for sexual orientation, gender identity, gender expression and sex characteristics.

The global evolution of the LGBTQI+ equal rights movement represents a significant shift in societal attitudes, legal frameworks, and cultural representations. Once relegated to the shadows of public discourse, its fight for equality and recognition has emerged as a powerful campaign and coalition, garnering both attention and support from diverse advocates and allies.

Southern Africa has a mix of both progressive and regressive laws and practices in this area. While Tanzania and Zambia maintain harsh restrictions and penalties for same-sex relationships, South Africa recognises sexual orientation in its Constitution and was the first country in the world to do so. In 2006, South Africa was also the first country in Africa - and among the first in the world - to legalise same-sex unions. More countries in the region have begun to loosen restrictions on LGBTQI+ rights. However, a strong backlash has accompanied this, led largely by conservative politicians and religious and cultural leaders and communities.

This chapter explores the historical context of LGBTQI+ rights, tracing the journey from marginalisation to recognition and highlighting the milestones that define the ongoing struggle for dignity, acceptance, and protection against discrimination and violence. It also highlights that the journey is not linear; as rights progress, so too does backlash and resistance to their attainment.

Central to this discussion is the understanding that LGBTQI+ rights are fundamentally human rights. Recognising these rights is not just about legal protections but also about challenging social norms, promoting visibility, and fostering environments in which all individuals can live authentically without fear of discrimination and persecution. This chapter will examine the movement's complexities as well as critical legislative changes, landmark court rulings, the impact of grassroots activism, and the cultural shifts that contribute to a broader understanding of gender and sexual diversity.

Equaldex, a collaborative knowledge base for the LGBTQI+ movement, aims to crowdsource every law related to LGBTQI+ rights to provide a comprehensive and global view of its work. It produces the Equality Index - a wealth of information about new developments in LGBTQI+ rights - which shows that governments across the globe have introduced more than 730 legal changes in this area over the past five years. It also finds that the Southern African Development Community (SADC) lags behind other regions.

Equaldex's Equality Index has three measures:

The **Equality Index**: a rating from 0 to 100 (with 100 being the most equal) to help visualise legal rights and public attitudes towards LGBTQI+ people in each region. The Equality Index is an average of two indexes: the legal index and the public opinion index.

Meanwhile, the **LGBT Legal Index** measures the current legal status of 13 different issues, such as the legal status of homosexuality, same-sex marriage, transgender rights, discrimination protections, and censorship laws.

The **LGBT Public Opinion Index** looks at public attitudes using surveys and polls from reputable organisations. Equaldex scores it by averaging the results of all surveys in each region.

Table 8.1: Equality, legal and public opinion indexes for Southern Africa[1]

Country	Equality	Legal	Public opinion
South Africa	71	84	59
Seychelles	60	53	66
Mauritius	54	55	53
Angola	53	66	40
Mozambique	53	60	46
Namibia	53	64	42
Botswana	49	59	39
Lesotho	39	49	29
Madagascar	31	44	19
Eswatini	27	21	32
DRC	21	33	10
Comoros	16	15	16
Zimbabwe	16	21	10
Tanzania	11	8	14
Malawi	10	15	5
Zambia	6	6	6

Source: Equality Index, 2024

Table 8.1 ranks countries from highest to lowest on the Equality Index, illustrating that LGBTQI+ people struggle for equality and rights across the SADC region. Rankings range from a high of 71% in South Africa to 6% in Zambia. Only six countries scored more than 50%. Notably, legal scores rank higher than - or equal to - public opinion scores in all but three countries (Eswatini, Seychelles and Tanzania) where public opinion is higher than the legal index. The two metrics align closely in Comoros, Mauritius, and Zambia, with Seychelles logging the highest public opinion score at 66%.

Angola, Madagascar and South Africa show the biggest discrepancies between the legal and public opinion indexes, with public opinion well behind legal provisions.

Growing backlash

This chapter illustrates that the formidable opposition to the attainment of LGBTQI+ rights has become better organised and funded. Conservative figures, including policymakers, religious authorities, and cultural leaders, spearhead these opposition groups. These individuals play a significant role in shaping public sentiment and mobilising public support against the LGBTQI+ movement. SADC communities, many of which remain deeply rooted in conventional values and social norms, actively participate in these opposing efforts, reinforcing the influence of conservative ideologies within society. This collective resistance creates a powerful challenge to any initiatives aimed at change, highlighting the complexities of navigating social transformations in such an environment.

These findings, along with others in this chapter, point to the need for vigorous advocacy and lobbying for policy and legislative changes accompanied by public education and awareness of LGBTQI+ rights. Despite the challenges, LGBTQI+ activists continue their work in the most challenging circumstances. They have ensured that some light shines through the cracks across the region.

Formidable opposition to the attainment of LGBTQI+ rights has become better organised and funded

[1] https://www.equaldex.com/, accessed 30 October 2024.

Tanzania: A symbolic lighthouse for LGBTQI+ rights in rural communities

One committed member of a Tanzanian network fighting for LGBTQI+ rights has described her organisation's advocacy in rural areas as a symbolic lighthouse for her community. Photo: Art Expo portfolio

In a country that regularly sees violence and societal discrimination against the LGBTQI+ community, a group of brave young activists started a feminist network - referred to here as the Consortium - committed to advancing freedom, justice, and bodily autonomy for all womxn* in Tanzania.

They are inspiring a growing movement that nurtures leaders to combat conservative forces, with a focus on building and strengthening partnerships and synergies among feminist and LGBTQI+ movements.

The convergence of these groups promotes a shared understanding of justice and bodily autonomy as a fundamental and inalienable necessity, presenting fertile ground for cross-movement building and exchange of knowledge and insights.

Aneth** uses her space as a leader within the Consortium to drive transformative change around LGBTQI+ rights in her hometown. Through her participation and leadership, she has grown in confidence as she brings these messages home to her rural community.

"My journey unfolds within the confines of an organisation that has become a beacon of hope, tirelessly working towards the advancement of human rights, the eradication of gender-based violence (GBV), and the facilitation of greater accessibility to Sexual and Reproductive Health and Rights (SRHR) for queer womxn in our community," she said.

The Consortium's efforts expand activists' and leaders' ability to offer unified and nuanced advocacy messaging that speaks to the intersectionality of SRHR issues and the complexity of feminist and lesbian, bisexual, transgender and queer women's lives in Tanzania.

"Our involvement in the consortium has extended beyond mere participation," said Aneth. "We actively engaged in the meticulous collection of data, contributing to vital research on gender-based violence and the accessibility of SRHR services within my community."

A leadership training initiative provides activists with an invaluable arsenal of skills, enabling them to set robust standards and navigate the complex terrain of leadership with newfound proficiency.

"In October 2023, I found myself stepping into the limelight, running for leadership roles within the consortium, and eventually securing a significant leadership position," said Aneth. "This achievement reverberates not just in the corridors of the consortium but profoundly in the rural expanse of my community. It is here, in a setting distinct from urban landscapes, that the LBTQ womxn movement can tackle issues hitherto

A growing movement nurturing leaders to combat conservative forces, with a focus on building and strengthening partnerships and synergies among feminist and LGBTQI+ movements

unexplored, such as forced marriages, which catalyse a cascade of problems for LBQ womxn, ranging from violence to sexually transmitted infections (STIs)."

Aneth said the project has kindled a new era of innovative thinking, compelling its members to reimagine and revitalise their approach to community engagement and empowerment. Collaborating with fellow Consortium members, she weaves the fabric of a comprehensive strategic plan, drawing inspiration from the group's collective wisdom and the overarching guidance provided by the Consortium as an inclusive and nurturing umbrella organisation.

Fundraising endeavours have become a communal effort, a testament to the collaborative spirit within the consortium. The ripple effects of advocacy training also offer leaders like Aneth a detailed roadmap for instigating positive changes within a community.

"The positive metamorphosis this project brings is particularly noteworthy for a rural organisation like ours situated on the fringes of urban dynamism," she said. "The consortium's unwavering support and collaborative ethos have empowered us to confront and address the unique challenges faced by LBQ womxn in rural areas. As we chart the course through these transformative waves, the project stands as a symbolic lighthouse, guiding us towards a future where our contributions resonate far beyond my community."

** "Womxn" is an alternative spelling of the word "woman" that aims to be more inclusive of non-binary and transgender people.*

***Not her real name. Aneth requested that she and her organisation remain anonymous for security reasons.*

Source: Driver of Change submitted by a grantee from the Voice and Choice Southern Africa Fund, supported by Amplify Change and managed by Gender Links.

Table 8.2: Sexual diversity indicators in 2024[2]

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Criminalisation of same sex consensual acts																
Consensual same-sex acts decriminalised	Yes, by act of parliament, 2019	Yes. High Court decision of 2019 being challenged	No	Never criminal	No	Decriminalised by Penal Code Act of 2010	Yes, for those older than 21	No	Yes, by Supreme court decision, 2023	Yes	Yes. High Court decision of 2024 being challenged	Yes, by legislation, 2016	Yes, by a court ruling, 1998	No	No, pending since 2021	No, pending since 2006
Gender/s			All genders		Male only		All genders	All genders						All genders	All genders	Male only
Years in prison/other			Up to 5 years/fine		Undetermined			Up to 14 years						Life in prison	14 years to life	Up to ten years or fine
Protection																
Protection against discrimination																
Specific constitutional provisions	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Broad protections	Yes	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Employment	Yes	Only LGB, not trans	No	No	No	No	No	No	Sexual orientation only	Sexual orientation only	Sexual orientation only	Sexual orientation only	Yes	No	No	No
Criminalisation of violence/discrimination against LGBTI communities																
Hate crimes/aggravated circumstances	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
Incitement to hatred/ violence	Yes	No	No	No	No	No	No	No	No	No	No	Yes	Yes	No	No	No
Ban on conversion therapy																
CT banned	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Recognition of LGBTI+ rights																
Same-sex marriages	No	No	No	No	No	No	No	No	Pending	No	Foreign only	Pending	Yes	No	No	No
Civil unions	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Joint adoption of children	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Second parent adoption of children	No	No	No	No	No	No	No	No	No	No	No	No	Yes	No	No	No
Changing identity																
Abilit sex/gender markers	Yes	No legal restrictions	No	No	No	Ambiguous	No	Nominally possible	No	Yes	Requires surgery	No	Requires surgery	No	Ambiguous	Requires surgery
Name change	Possible	Possible	Not possible	Possible	Possible	Possible	Possible	Nominally possible	Possible	Nominally possible	Possible	Possible	Possible	Not possible	Possible	Possible
LGBTI+ organisations																
Able to register	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Able to operate freely			No	No	No	Yes	No	No	Yes	No	Yes	Yes	Yes	No	No	No

Source: https://www.equaldex.com, accessed November 2024

[2] https://www.equaldex.com , Accessed November 2024.

Table 8.2 shows that:

- Five out of 16 SADC countries have decriminalised same-sex consensual acts: Angola, Botswana (though legislators have stalled discussion of the bill that would decriminalise it), Mozambique, Seychelles, and South Africa. DRC never criminalised homosexuality, so laws there require further clarity. Madagascar decriminalises homosexuality for those older than 21 but criminalises it for anyone younger than 21.
- Two countries (Eswatini and Zimbabwe) criminalise homosexuality for men only.
- Only South Africa has constitutional provisions to protect LGBTQI+ people.
- Angola, South Africa and Seychelles have specific legislation that criminalises violence and discrimination against LGBTQI+ people.
- Seven countries (Angola, Botswana, Mauritius, Mozambique, Namibia, Seychelles, and South Africa) have employment protections for some LGBTQI+ people.
- No country in SADC bans conversion therapy.
- Only South Africa recognises same-sex unions, civil unions, joint adoption of children and second-parent adoption of children.
- Six countries (Angola, Botswana, Mozambique, Namibia, South Africa, and Zimbabwe) allow people to change sex and gender markers in their names, although Namibia, South Africa and Zimbabwe require that person to undergo surgery before they can do so.
- LGBTQI+ organisations can legally register in nine countries (Angola, Botswana, Lesotho, Mauritius, Mozambique, Namibia, Seychelles, South Africa, and Zimbabwe) and operate freely in seven countries (Angola, Botswana, Lesotho, Mauritius, Namibia, Seychelles and South Africa).

Legal and policy frameworks

Several global, continental, and regional instruments promote the rights of LGBTQI+ communities. Of the 69 countries that criminalise same-sex relations, 33 are in Africa. Usually, these laws represent the remnants of colonial rule and archaic legislation associated with it. The vague wording of these prohibitions, such as "carnal knowledge against the order of nature" and references to sodomy and "gross indecency," resonate with the beliefs and values of that era. Africa has seen slight progress over the last year in protecting LGBTQI+ rights. However, intense backlash from conservative actors to maintain the status quo or even roll back existing rights, remains a significant challenge.

Global instruments

LGBTQI+ community members take part in an Eswatini Pride event in Mbabane. The country saw its first Pride event in 2018. Photo: Thando Dlamini

The United Nations is the sum of its member states, with many lawmakers within these countries intolerant of LGBTQI+ people and their rights. As such, the Sustainable Development Goals (SDGs) do not include any specific references to LGBTQI+ people or issues. Nevertheless, to ensure that the global development agenda does not leave these 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, violence, health, and education.[4]

LGBTQI+ rights have been on the global agenda for many years, with activists logging gradual but significant progression within the UN system towards recognising and advocating for LGBTQI+ rights, although many challenges and obstacles remain. In the early 2000s, the International Commission of Jurists and the International Service for Human Rights, representing a coalition of human rights organisations, created a framework of international legal principles addressing human rights violations linked to sexual orientation and gender identity.[5] Known as the Yogyakarta Principles, many member states initially adopted them in 2007 and updated them in 2017. They remain non-binding. Nevertheless, they offer extensive guidance to states covering the right to universally enjoy human rights, non-discrimination, and legal recognition; the right to personal and human security; economic, social, and cultural rights; the rights to freedom of expression, opinion, and association; the freedom to move and seek asylum; participation rights in cultural and family life; rights for human rights defenders; and rights pertaining to redress and accountability.[6]

The UN has developed several instruments enshrining social, economic and political rights. SADC countries have signed many of them.

Table 8.3: Overview of key UN instruments and SADC commitments[7]

Instrument/ Country	International Covenant on Civil and Political Rights	International Covenant on Economic, Social, and Cultural rights	Convention on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	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."

[4] Human Rights Watch, Progress and Setbacks on LGBT Rights in Africa - An Overview of the Last Year, 22 June 2022, accessed 1 November 2024
[5] UNDP, PGA (2022). Advancing the Human Rights and Inclusion of LGBTI People: A Handbook for Parliamentarians.
[6] Ibid
[7] ILGA, Kirichenko K, United Nations Treaty Bodies: References to sexual orientation, gender identity,gender expression and sex characteristics 2016 (Geneva: ILGA, November 2017)

2. Signatory means a state has signed an agreement but has not ratified it nationally, indicated with an "S."
3. State party means a state has ratified the instrument at the 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 the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). Meanwhile, Botswana lags in several areas as it has yet to commit to the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESRC), or the CAT. It has only signed up to, but not domesticated, the Convention on the Rights of the Child (CRD) and ICERD.

Activists welcome the ongoing attention to LGBTQI+ human rights issues by the UN structures and encourage mandate holders to strengthen their analysis of specific populations within LGBTQI+ communities. This includes LBQ women, trans or intersex persons, and LGBTQI+ persons with disabilities.

African instruments

At the continental level, the African Union (AU) has developed and ratified several relevant treaties and policy instruments between 1981 and 2018. These include enforceable treaties (binding legal agreements for which African states have a collective obligation to implement and be held accountable) and policy instruments (influential regional governing tools aimed to achieve social, political, economic, health, and other targets or objectives).

The goal of fostering inclusion and enhancing the lives, livelihoods, and equality of all citizens, irrespective of gender or sexuality, is a shared characteristic of these regional treaties and policy instruments. Although these instruments do not explicitly refer to LGBTQI+ individuals, they nonetheless highlight the daily issues faced by people in the LGBTQI+ community and present strong, ambitious visions for inclusivity and practical actions to address their concerns about marginalisation.

The goal of fostering inclusion and enhancing the lives, livelihoods, and equality of all citizens, irrespective of gender or sexuality, is a shared characteristic of regional treaties and policy instruments

Table 8.4: Key AU legal and policy instruments with potential for addressing LGBTQI+ exclusion[8]

Instrument	History	Focus	Key values	Limitations
The African Charter on Human and Peoples' Rights	Enforceable treaty approved in June 1981; came into effect October 1986; ratified by every AU member-state.	Human rights and basic freedoms; civil and political rights; economic, social and cultural rights; peoples' rights and group rights; duties of citizens.	Right to self-determination, development, education, health, equality of all persons before the law, freedom from discrimination, life and personal integrity, freedom from cruel, inhuman or degrading treatment or punishment, rights to due process concerning arrest and detention, freedom of association, freedom to assembly, etc.	No specific mention of vulnerable groups, including LGBTQI+, weak or non-existent monitoring mechanism.
African Charter on Democracy, Elections and Governance	Enforceable treaty Adopted in January 2007.	Democracy and people's participation as individual fundamental rights.	Human rights, rule of law democratic principles, good governance, elimination of forms of discrimination, promoting freedom of expression, citizens' full participation to development processes, protecting social groups with special needs, improving access to basic social services, ensuring education and literacy.	No specific mention of vulnerable groups, including LGBTQI+; weak monitoring of national implementation relative to the Charter and not ratified by all member states.
African Youth Charter	Enforceable treaty endorsed and adopted in July 2006, entered into force August 2009.	Strategic youth participation, empowerment and development activities across Africa.	Freedom of movement, expression, private life and property, right to employment, right to education, right to equitable and ready access to medical assistance and healthcare, information, communication and awareness, elimination all forms of discrimination against girls and young women.	No specific mention of vulnerable groups, including LGBTQI+; weak monitoring of national implementation relative to the Charter and not ratified by all member states.
The Maputo Protocol (also known as The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa)	Enforceable treaty adopted in July 2003; came into effect in November 2005.	Women's civil and political rights, including economic, health, sexual, reproductive, social, cultural and environmental.	Equality, freedom, dignity, elimination of gender-based abuse and discrimination.	Does not deal directly with discrimination on the basis of sexual orientation or gender identity, no clear definition of sexual rights.
The Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights	Enforceable treaty launched in 2015 following the expiration of the Maputo Plan of Action for The Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010. Later extended to 2015.	Women's SRHR, empowerment, individual dignity, and welfare and the right to health.	SRHR of men, women, boys and girls and vulnerable and marginalised groups/ populations.	No clear definition of sexual rights, emphasis on age-appropriate and culturally sensitive comprehensive education on SRH for young people that involves parents and communities. No focus on comprehensive sexuality education, no clear meaning of marginalised groups.
Common African Position on the Post-2015 Development Agenda	AU declarative/ obligatory policy instrument and an African Union-sponsored document published in March 2014.	Structural economic transformation inclusive growth, science and technology, people-centred development, environmental sustainability, natural resource management and disaster risk management, peace and security, and finance and partnerships.	Inclusivity, reduction in inequality, eradication of poverty, gender equality and women's empowerment, universal and equitable access to quality healthcare.	Does not deal directly with discrimination based on SOGIESC, with no clear definition of sexual rights.
Agenda 2063: The Africa We Want	AU declarative/ obligatory policy instrument with an AU policy roadmap. Signed in May 2013 by African heads of state and government.	Gender equality, elimination of GBV discrimination, barriers to quality health and education and ending systemic inequalities, young people and elimination of youth unemployment.	Gender parity in public and private institutions, universal access to social, health and economic rights.	No specific mention of LGBTQI+ persons. Does not deal with or mention discrimination based on SOGIESC.

Source: National Library of Medicine

[8] National Library of Medicine - https://pmc.ncbi.nlm.nih.gov/articles/PMC7887941/, accessed 9 November 2024

Regional instruments

Since lawmakers adopted the SADC Gender Protocol in 2008, the SADC Secretariat Gender Unit has developed several strategies, frameworks and tools to guide member states in developing gender policies and programmes to meet the targets set out in it. These include:

Frameworks and strategies

- SADC Framework for Achieving Gender Parity in Political and Decision-Making Positions by 2015.
- Revised SADC Strategic Plan of Action on Combating Trafficking in Persons, especially Women and Children (2016-2023).
- SADC Strategy and Framework of Action for Addressing Gender-Based Violence (2018-2030).
- SADC Regional Strategy on Women, Peace and Security (2018-2022).

Tools

- SRHR Scorecard to accelerate the attainment of SRHR for the people of SADC.
- Handbook to Promote Effective Gender-Based Violence Prevention Initiatives in the SADC Region (2022).
- SADC Gender and Development Monitor: Women in Politics and Decision-making Positions (2022).
- A draft model law on Gender-based violence (not final).
- Draft GBV Indicators and the GBV Scorecard (not final).

No SADC instruments currently exist specifically to address LGBTQI+ rights. This indicates 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 should continue to lobby and advocate for a regional protocol on the rights of LGBTQI+ people - one that includes global and continental provisions within a SADC context.

On 18-19 April 2023 in Johannesburg, LGBTQI+ organisation Outright International and its partners, in collaboration with the UNDP and the SADC Parliamentary Forum, convened an event with 22 parliamentarians from 12 SADC countries and civil society representatives to discuss conversion practices. The term "conversion therapy" typically describes attempts to change, suppress or divert one's sexual orientation, gender identity or gender expression. The event aimed to enhance the capacity of SADC lawmakers to understand and address harmful conversion practices, including the nature, extent and impact of such practices, and to recognise them as violations of human rights.

Maropene Ramokgopa, South African Minister in the Presidency for Planning, Monitoring and Evaluation, has criticised the SADC region's lack of legal protections for LGBTQI+ people.

Maropene Ramokgopa, South African Minister in the Presidency for Planning, Monitoring and Evaluation, gave the keynote address, during which she noted the persistent lack of legal protections for LGBTQI+ people, despite the development and adoption of key resolutions and protocols by SADC countries.

She noted the significance of enacting protective laws that address discrimination and violence directed towards the LGBTQI+ community and highlighted the need to address patriarchal norms and social values that fuel discrimination and violence. Ramokgopa also emphasised the need for regional solidarity to address violence, especially through the inclusion of community members in the development of policies and advocacy campaigns in rural areas.

"As SADC legislators, it is our role to pass laws to enable our citizens to exercise global, continental and regional protocols and resolutions as enshrined in legislation," Ramokgopa said. "We cannot truly unite as a region, if we are divided by the violation of fundamental human rights, including those of the LGBTQI+ community."[9]

[9] https://www.undp.org/south-africa/news/sadc-parliamentarians-discuss-harms-conversion-practices-africa-1 , accessed 4 November 2024

Constitutional and legal provisions

It is important to include protections for LGBTQI+ people in national constitutions to guarantee sustainable change, along with safeguarding and security for this community. Fourteen SADC countries include equality and non-discrimination clauses in their constitutions, but these 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.

South Africa's Constitution is the only one in the region that recognises sexual orientation, and the country is the only SADC member that recognises same-sex marriage or civil unions.

In several countries in which courts have deemed colonial-area legislation unconstitutional, there is a noticeable trend toward these decisions then paving the way for new legislation that ensures protections for LGBTQI+ people where legislators and religious leaders have strongly opposed them. Examples include Botswana, Eswatini, Malawi and Namibia.

Seychelles and South Africa recently joined Angola to represent the only countries in SADC that have specific hate crime legislation which protects LGBTQI+ people from violence and discrimination.

On 19 September 2024, the **Seychelles** National Assembly passed a Penal Code (Amendment) Bill. The landmark law introduces hate speech as an offence within the Penal Code, imposing penalties on those who incite hatred towards a person or group based on protected characteristics.

It states that "the inclusion of hate as an aggravating factor aims to enhance the severity of penalties when crimes are committed due to bias or prejudice, based on protected characteristics such as race, religious belief, disability, sexual orientation, gender identity, sex characteristics, political affiliation, and HIV/AIDS status."

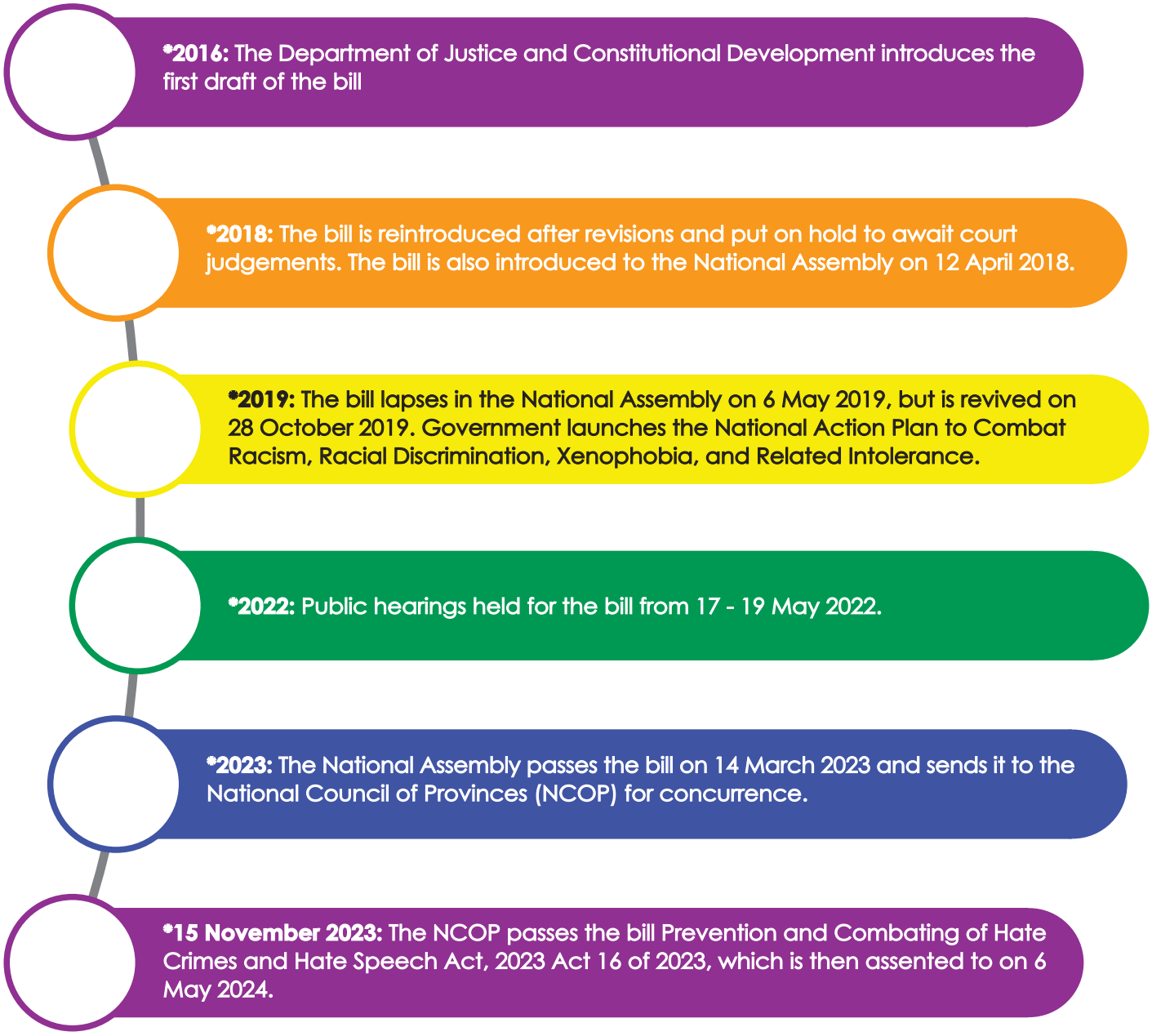
Eighteen members of the National Assembly voted for, and eight voted against, the amendment. This is a significant development for the Indian Ocean island nation, which only scrapped its colonial-era ban on homosexuality in 2016.

Civil society activists celebrated the decision as a strong stance against hate-motivated violence and a welcome step for the LGBTQI+ community in combatting the harms caused by homophobia, transphobia, and other forms of hate. They also hope it encourages victims to report incidents.[10]

In May 2024, **South Africa** saw its own hate crimes and hate speech bill signed into law. Bigots frequently assault and murder LGBTQI+ South Africans, particularly lesbians and transgender people, because of their sexual orientation and gender identity. By assenting to the Prevention and Combating of Hate Crimes and Hate Speech Bill, lawmakers in the National Assembly and the National Council of Provinces took an important step to prevent such crimes. The Bill creates a specific category of criminal offences for hate crimes and hate speech. In August, the cabinet approved a revised National Intervention Strategy to combat violence against LGBTQI+ people. Meanwhile, government leaders elevated the National Task Team that coordinates government and civil society responses to the portfolio of the deputy minister. The journey to this important moment has been long and slow for activists, civil society and government; the bill is the culmination of more than 15 years of work on their part.

[10] Mamba online, Seychelles Passes LGBTIQ-Inclusive Hate Crimes Bill, 28 September 2024, accessed 9 November 2024

Figure 8.1: South Africa's hate crimes and hate speech legislation journey



South Africa played host in recognition of its history and struggle against the oppressive apartheid system and in acknowledgment of its journey towards democracy, rooted in the principles enshrined in its Constitution

Figure 8.1 shows some of the key moments in developing and rolling out the hate crimes and hate speech bill.

South Africa's journey to this point dates even further back, to the Third World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (WCAR) in 2001. South Africa played host in recognition of its history and struggle against the oppressive apartheid system and in acknowledgment of its

journey towards democracy, rooted in the principles enshrined in its Constitution.

The government developed the National Action Plan to Combat Racism, Racial Discrimination, Xenophobia and Related Intolerance (NAP 2003-2019) in consultation with various stakeholders, including the Chapter Nine institutions and civil society organisations (CSOs). Development commenced in 2003, and its authors presented a draft version of the NAP in 2013. Notably, lawmakers only launched it 16 years after its inception, in 2019.

The NAP, at least on paper and in principle, complements existing laws, policies and programmes addressing equality and discrimination, and provides the basis for developing comprehensive public policy against racism, racial discrimination, xenophobia and intolerance. It also aims to monitor and report on such incidents, with a rapid response team reporting to the government and society.

Civil society activists established the Hate Crimes Working Group (HCWG) in late 2009 as a multi-disciplinary coalition of organisations and individuals that work together to develop strategies to address prejudice-related crime. They launched the HCWG in response to the lack of data on the prevalence, nature, and psychological impact of hate crimes. The HCWG contributed to national policy and legislative interventions to combat hate crimes by supporting the speedy enactment of comprehensive hate crimes laws, improving the policing of, and judicial responses to, hate crimes, and assisting in the development of effective mechanisms to monitor hate crimes incidents.[11]

The creation of this legislation in South Africa represented a groundbreaking moment in Africa, as no other country on the continent had implemented similar measures. Seychelles soon followed suit. By recognising and attempting to respond to hate victimisation, South Africa reaffirmed its commitment to democratic values and demonstrated its unequivocal intolerance for any form of discrimination or prejudice.[12]

Recognition of LGBTIQ rights

It is critical for policymakers to recognise the human rights of the LGBTQI+ community and formalise them in legislation and policies. This comprehensive approach guarantees that individuals in the LGBTQI+ community have the same rights and liberties as every other citizen. These rights encompass, among other things, the entitlement for them to marry, adopt children, and express themselves freely.

Status of same-sex consensual sexual relations in SADC

Most SADC countries criminalise same-sex consensual sexual acts or "sodomy" for men through archaic laws and regulations. However, many variations exist in terms of the way countries enforce the legislation.

[11] Hate Crimes Working Group (HCWG) https://hcwg.org.za/about/, accessed 11 November 2024.
[12] Juan A. Nel and Zindi Venter, (South) African perspectives on the prevention, monitoring and combating of hate victimisation, VOL. 23 NO. 3 2024, pp. 192-206.

Table 8.5: Status of same-sex consensual sexual acts

Country	Status
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.[13]
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."
Angola[14]	***Decriminalised (2019) by an act of parliament***
	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). Angola also includes sexual orientation as a characteristic of persecution, which constitutes a crime against humanity (art. 382), protecting sexual minorities in times of extreme violence and internal turmoil.
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 those who "habitually practiced vices against nature." The revised Penal Code came into force in June 2015.
DRC	***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 has yet to be drafted.
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."[15]
Botswana	***Declared unconstitutional***
	In 2019, the High Court unanimously ruled the relevant sections of Botswana's Penal Code (164(a), 164(c), 165, and 167) unconstitutional. The attorney then requested and received leave to appeal the decision, which the Court of Appeal upheld in 2021.
Mauritius	***Penal code declared unconstitutional***
	In October 2023, the Supreme Court of Mauritius ruled that section 250(1) of the Penal Code, which seeks to criminalise sodomy, is discriminatory and unconstitutional.
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.
Comoros[16]	***Criminalised***
	Penal Code of the Federal Islamic Republic of Comoros 138, Article 318 states "(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."

[13] Pat Reber, "South Africa Court Upholds Gay Rights" Associated Press, 9 October 1998 (as reproduced in Sodomy Laws, 11 July 2004).
[14] AfricLaw, Decriminalisation of consensual same-sex acts in Angola and the progress of LGBTI human rights in Lusophone Africa, 5 March 2021, accessed 11 November 2024.
[15] Southern Africa Litigation Centre, Laws and Policies Affecting Transgender Persons in Southern Africa: Lesotho (Johannesburg: SALC, 2017), 92
[16] Human Rights Watch Country Profiles: Sexual Orientation and Gender Identity https://www.hrw.org/video-photos/interactive/2020/06/22/human-rights-watch-country-profiles-sexual-orientation-and

Country	Status
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.[17]
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. Lawyers tested the constitutionality of the 2004 act in court and on 21 June 2024, three judges of the High Court of Namibia determined that these laws constituted unfair discrimination and were therefore unconstitutional and invalid. In July 2024, the Namibian government lodged an appeal against the ruling of the High Court amid strong resistance from religious groups and communities.[18]
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. The constitutionality of these provisions was tested in court in 2023, but Malawi's Constitutional Court rejected a legal challenge and upheld sections 153 and 154 of the penal code.
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.
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."
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."

Source: Equaldex country information

An analysis of Table 8.5 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.
- Consensual same-sex sexual acts remain a crime in Comoros, Eswatini, Malawi, Mauritius, Namibia, Tanzania, Zambia and Zimbabwe.

[17] ILGA World: Eddie Bruce-Jones Lucas Paoli Itaborahy, State-sponsored Homophobia: A world survey of laws prohibiting same sex activity between consenting adults (2012).
[18] Human Dignity Trust, Namibia: Case before the High Court, accessed 11 November 2024.

In October 2023, the **Mauritian** Supreme Court ruled that section 250 of the country's Criminal Code, which criminalises anal sex between two consenting adult men, violates the constitution. The litigant, Abdool Ridwan (Ryan) Firaas Ah Seek, based his case on the right to be free from discrimination, and the court found that the word "sex" in the constitution includes "sexual orientation."

The court also considered international human rights commitments and rejected the state's argument that same-sex relations remain a sensitive issue in Mauritian society. The court held that the threat of prosecution for homosexual men justified the need for protection from discrimination based on sexual orientation.[19]

The decision represents a victory for human rights and a major step towards full inclusion of the LGBTQI+ community in Mauritius. It rejects the criminalisation of same-sex relations, which British rule imposed on the country. The judges underlined the constitutionally protected right to non-discrimination and said that the state must have serious reasons to interfere with how homosexual men choose to have consensual sexual intercourse.

In 2014, the Ministry of Health amended a blood donation policy to allow men who have sex with men to donate blood. However, healthcare staff still sometimes prevent LGBTQI+ people from donating blood.[20]

The region has seen several legal challenges regarding the constitutionality of provisions in archaic penal codes. In some cases, the courts declare the provisions unconstitutional. Conservative parliamentarians, religious leaders and communities have put up strong resistance in all these cases.

Five years ago, the LGBTQI+ community in **Botswana** celebrated a significant legal victory. The country's High Court, in the Letsweletse Motshidiemang v. Attorney General (2019) case ruled in favour of activists seeking the abolishment of gaol sentences for consensual sexual acts between same-sex adults, citing such penalties unconstitutional. The Court ruled that the word "sex" in section 3 of the Constitution of Botswana should be "generously and purposively interpreted to include 'sexual orientation.'" The Government of Botswana then unsuccessfully appealed the High Court ruling. In 2021, Botswana's Court of Appeal emphasised that sections 164(a) and (c) of the Penal Code "have been rendered unconstitutional by the march of time and the change of circumstances" and noted that the code "incentivise[d] law enforcement agents and others to become key-hole peepers and intruders in private spaces." The Court accentuated that this "[is] neither in the public interest nor in the nature of Batswana." However, government leaders need to take further action on the remaining section 167 of the Penal Code, which effectively undercuts the decriminalisation ruling through its banning of acts of "gross indecency" in public and private, commonly interpreted to refer to same-sex activity.

In January 2022, media reported that the President of Botswana had assured the LGBTQI+ community that "the Government of Botswana is led by principles of democratic governance and the rule of law." He noted that the government will uphold the Court of Appeal decision. In July 2023, the LGBTQI+ community anticipated parliament would remove Sections 164(a) and (c) from the penal code, aligning it with the 2019 decision. However, that same month in Molepolole, large groups of anti-LGBTQI+ community members and religious leaders protested the anticipated legislative changes. Media reports showed photos of young children holding placards with strong messaging, such as "We say no to homosexuality," and "Protect our children against homosexuality."

Pastor Pulafela Mabiletswane Siele, representing the Evangelical Fellowships of Botswana, delivered a petition to the parliament. Siele alleged that in passing the bill, legislators "would open floodgates of immorality." Opposition lawmaker Wynter Mmolotsi received the petition on behalf of the parliament and assured protes-

[19] African Liberty, Like Mauritius, other African Countries should Decriminalize Homosexuality, October 13, 2023, accessed 1 November 2024.
[20] UN OCHR - Supreme Court ruling tells LGBTQ people in Mauritius that their dignity is valued: UN expert, accessed 10 November 2024.

ters that policymakers would consider their views in the legislative discussions. He reported the public concerns to parliament, which then abandoned the bill, removing it from the pending debate, with the possibility that legislators would revisit it later. It did not re-emerge in that sitting of parliament, which ended in August 2023, and lawmakers have yet to debate it.

Malawi's penal code also violates its Constitution. Parts of the country erupted in protest in 2024 as activists attempted to leverage this disconnect to bring about progressive change. Its penal code contains several provisions that criminalise adult consensual same-sex conduct, with punishment of up to 14 years in prison.

The government enacted a new anti-homosexuality law in January 2011, amending the penal code to extend the crime of "gross indecency" to women, with up to five years in prison. In 2012 and again in 2015, Malawi's Ministry of Justice announced a moratorium on enforcing these laws. But in 2016, the Mzuzu High Court issued an order suspending the moratorium pending judicial review, which has led to legal ambiguity.

In July 2023, Jan Willem Akstar, a Dutch citizen, and Jana Gonani, a transgender Malawian woman, brought a case challenging the constitutionality of the provisions in the penal code that criminalise consensual same-sex relations. They alleged that it infringes on several rights, including the rights to personal liberty; dignity; equal and effective protection by the law; privacy; and the right to be informed with sufficient particularities of the charge. Malawi's High Court, sitting as a constitutional court, heard a case involving Akstar, who was arrested in 2020 and charged with nine offenses of sexual abuse and sodomy. Meanwhile, a Malawi court sentenced Gonani to eight years in prison for same-sex relations. Dealing a blow to activists hoping for change, Malawi's Constitutional Court rejected the legal challenge to the country's penal code on 28 June 2024, with the three-judge panel upholding its validity.[21]

The following month, several religious groups led street demonstrations to protest the push to legalise same-sex marriage in Malawi. Thousands[22] of protesters, representing the country's major religions - Christianity and Islam - participated.[23] The opposition simultaneously organised protests in several towns. In Blantyre, protesters presented a petition to the office of the district commissioner, appealing to policy-makers not to pass any laws legalising same-sex relations. Meanwhile, Eric Sambisa, the executive director of Nyasa Rainbow Coalition, which advocates for LGBTQI+ rights in Malawi, went into hiding due to death threats he received after criminals burned down his office in Blantyre.

Moving backwards

In the **DRC**, where same-sex consensual conduct has never been criminalised, lawmakers started a push to change the law. In April 2024, National Deputy Constant Mutamba proposed legislation to criminalise, among other things, consensual same-sex sexual acts. The bill's rationale, outlined in a comprehensive "statement of reasons," revolves around cultural preservation, sovereignty protection, and resistance against perceived "neocolonial influences" promoting divergent cultural norms. It contends that homosexuality is incompatible with Congolese heritage, emphasising adherence to the "natural order" and the preservation of "traditional values".

Constant Mutamba, a politician in the DRC, wants to criminalise consensual same-sex sexual acts in the country, which has previously never criminalised gay sex.

[21] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024.
[22] France 24, Thousands rally in anti-LGBTQ protest in Malawi, accessed 10 November 2024.
[23] Macmillan Mhone, Dutch national at centre of homosexuality case in Malawi says he is not gay, Malawi 24, 17 July 2023, accessed 9 November 2024.

The proposed amendments seek to address perceived moral decay by explicitly criminalising "sexual deviations" within the penal code, including consensual same-sex conduct. Furthermore, legislators contended they need to revise rape and assault statutes to extend the criminalisation of homosexuality "in all its splendour," thereby reinforcing a conception of homosexuality that encompasses both consensual and non-consensual acts.[24]

In March 2023, MPs called for more stringent criminalising provisions and the effective enforcement of existing provisions that criminalise same-sex relationships in **Zambia**. One MP specifically highlighted that the country relied on "a piece of legislation that talks about the order of nature" and called for the enactment of a law that will "specifically target those who are involved in homosexuality." In so doing, he also stated that "even those men who are dressing like women must be punished under that law."[25]

The same month also saw Hakainde Hichilema, Zambia's president, deny claims that his government planned to decriminalise homosexuality. Rumours of this have plagued his administration even before voters elected him to office, demonstrating the politicisation of this topic in the country. Hichilema stated that his government would not change any law without extensive consultations with the public and he encouraged Zambia's religious leaders to continue preaching against LGBTQI+ people.[26]

In **Eswatini**, section 185(5) of the Criminal Procedure and Evidence Act - which exists as a remnant of colonial-era Sodomy Act of 1907 - criminalises consensual same-sex relations between men. However, the law is silent on provisions criminalising consensual same-sex relations between women.

The LGBTQI+ community in the country experiences significant discrimination, a reality underscored by research from the Out and Proud: LGBTI Equality and Rights in Southern Africa project. In Eswatini, its findings reveal a troubling perception among the population: only one out of every ten survey participants believe that individuals identifying as LGBTQI+ receive the same level of dignity and respect as others in society. This stark statistic highlights the ongoing challenges faced by the community in achieving equality and acceptance.

Same-sex marriages and civil unions

Only South Africa's legal frameworks provide for same-sex marriage and civil unions. 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 the country's High Court ruled against it. In 2023, the Supreme Court overturned the High Court's decision.

In June 2023, the Supreme Court of **Namibia** advanced the rights of LGBTQI+ people by reversing an earlier decision that had rejected a request to acknowledge same-sex unions registered in other countries. Friedel Dausab, a gay Namibian citizen, successfully argued that the common law offence of sodomy and related charges conflicted with his rights against unfair discrimination under the Namibian Constitution. On 21 June 2024, a three-judge panel of the High Court of Namibia determined that these laws constitute unfair discrimination and are, therefore, unconstitutional and invalid. The court stated that "the enforcement of the private moral views of a segment of the community (even if they are the majority of that community), which are largely based on nothing

[24] ILGA World: Lucas Ramon Mendos and Dhia Rezki Rohaizad, Laws On Us: A Global Overview of Legal Progress and Backtracking on Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics, 1st Edition (Geneva: ILGA, May 2024).
[25] Ibid.
[26] Ibid

more than prejudice" cannot be justified. It stated that criminalising gay men "poses a greater threat to the fabric of society as a whole than tolerance." In July 2024, the Namibian government lodged an appeal against the ruling.[27]

Following this, some members of the Namibian parliament put forward what has come to be known as Ekandjo's Bill. It proposes revising the Marriage Act to explicitly define the term "spouse" to represent only a union between a man and a woman. Lawmakers then enacted additional legislation to modify the definition of "spouse" to exclude transgender individuals from legal unions, stating that "spouse" means "one half of a legal union between a genetically born man and a genetically born woman of the opposite sex." The Ekandjo Bill explicitly references Articles 81 and 45 of the Namibian Constitution, allowing for the courts to overturn a Supreme Court decision if it "is contradicted by an Act of Parliament lawfully enacted." The National Union of Namibian Workers backed the Bill.

Ekandjo's Bill extends beyond simple definitions; it also criminalises celebrating, witnessing, promoting, and advocating for same-sex marriage. Individuals convicted of these offences face significant penalties, including imprisonment for up to six years and fines reaching 100 000 Namibian dollars (US$5500).[28]

Joint adoption of children and second-parent adoption of children

Preventing LGBTQI+ people from adopting children violates their rights, yet South Africa remains 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.

Transgender rights in SADC

Sisonke Pride March. Credit: Sisonke

Transgender serves as an umbrella term to describe individuals whose gender identity, expression, or behaviour differs from the conventional expectations based on the sex they were assigned at birth. Gender identity refers to a person's inner understanding of their proximity to what society consider male, female, both, neither, or something in between, while gender expression is how a person conveys their gender identity to others through behaviours, attire, hairstyles, voice, and physical traits. "Nonbinary" is another term people use to describe genders that do not fall into either the male or female category.

Members of the LGBTQI+ community often use "trans" as a shorthand version of "transgender." However, not everyone who exhibits gender-nonconforming traits will identify as transgender.

[27] Human Dignity Trust, Namibia: Case before the High Court, accessed 11 November 2024
[28] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024

The discourse surrounding transgender individuals in popular culture, academia, and scientific fields is continually evolving, especially as the awareness, understanding, and acceptance of transgender experiences expand and grow.[29]

Transgender people face discrimination and a range of challenges in various aspects of life, including:

Employment discrimination: Transgender people can face discrimination during employment processes, advancement opportunities, or in their treatment at work. Numerous individuals experience harassment on the job or may even lose their positions because of their gender identity and expression.

Healthcare discrimination: Access to appropriate healthcare can be a significant issue for transgender people, who often face discrimination from healthcare providers, denial of care, or lack of knowledgeable practitioners regarding their health needs, including hormone therapy or surgeries.

Housing discrimination: Transgender people may have trouble in securing housing or face harassment in their living situations. Landlords may refuse to rent to them based on their gender identity.

Legal challenges: Many transgender people face barriers when trying to update legal documents (such as IDs and birth certificates) to reflect their gender identity, leading to complications in navigating various systems.

Violence and harassment: Transgender people, particularly those in marginalised ethnic or racial groups, often face higher rates of violence and hate crimes. This includes physical assault, verbal harassment, and other forms of violence, including from police and other state actors.

Education discrimination: In educational settings, transgender students may face bullying, harassment, or denial of access to facilities that align with their gender identity, which can adversely affect their academic performance and mental health.

Stigma and isolation: Transgender individuals often deal with societal stigma that can lead to isolation, mental health challenges, and reduced support from friends and family.

Barriers to public facilities: Many transgender people encounter difficulties accessing public restrooms and facilities that align with their gender identity, leading to discomfort or potential confrontation in public spaces.

All these challenges and types of discrimination can have severe emotional, psychological, and physical consequences for transgender individuals, emphasising the need to expedite comprehensive legal protections and advocate for societal acceptance.

Changing sex designation, name, or gender marker

The ability to change one's gender marker or name is a fundamental right for transgender and gender-diverse individuals, serving as a crucial aspect of their identity and recognition in society. Experts often refer to this process as "legal gender recognition," which plays a significant role in affirming one's gender identity and fostering a sense of belonging.

In many countries where trans people lack the option to modify their gender markers to reflect their true selves, changing their name becomes a necessary but temporary solution. This stopgap measure, while helpful, does not fully address the complexities of legal identity for transgender and gender-diverse people.

[29] American Psychological Association, https://www.apa.org/topics/lgbtq/transgender-people-gender-identity-gender-expression accessed 6 November 2024.

According to research conducted by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), even in regions where individuals have the legal right to change their names and gender markers, the actual process can be fraught with challenges. These range from bureaucratic hurdles and stringent requirements to social stigma and discrimination, creating an inordinately difficult experience for those seeking to have their identities formally recognised. Ultimately, a seamless process for legal gender recognition is essential for the dignity, equality, and human rights of transgender and gender-diverse individuals.[30] In 2022, ILGA launched a toolkit to support global advocacy efforts to support legal gender recognition for transgender people.[31]

In 2019, the High Court of Bulawayo, in **Zimbabwe**, issued a ruling in the case of unlawful arrest, detention and malicious prosecution of a transgender woman. The Court stated that "Transgender citizens are part of the Zimbabwean society. Their rights ought to be recognised like those of other citizens. Our constitution does not provide for their discrimination. It is nothing but delusional thinking to wish away the rights of transgender people. To avoid the recurrence of what happened to the Plaintiff in this case, it might be prudent to construct unisex toilets as an addition to the resting rooms in public places."[32]

This ruling represents significant progress in promoting the rights of transgender individuals in Zimbabwe and across the region. However, trans individuals still encounter difficulties in Zimbabwe that hinder their access to, and enjoyment of, their human rights and freedoms. Zimbabwe has no legal provisions for obtaining gender-affirming healthcare or processes in place for altering gender markers on official documents. This means that transgender people find it challenging to match their legal identities with their gender identities, resulting in daily violations to their human rights.[33]

LGBTQI+ members of the Capricorn District Municipality, in South Africa's Limpopo province, take part in a 16 Days of Activism march in 2023. Credit: Selaleleo Matlakala

[30] https://database.ilga.org/legal-gender-recognition, accessed 4 November 2024
[31] https://ilga.org/news/tlmr-toolkit-towards-trans-liberation-advocacy-lgr/, accessed 17 November 2024.
[32] Southern Africa Litigation Centre, Zimbabwe: Action for damages of unlawful arrest of a transgender person, 15 November 2019, accessed 10 November 2024
[33] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024

Table 8.6: Conditions under which citizens can change gender markers[34]

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 that 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 that 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 they may deem necessary. The Act does not define "change of sex." Applications in terms of s.7B occur on a case-by-case basis - as long as a person can provide medical reports of their "change of sex." Once the application is granted, a trans person can apply for a new identity document and passport. Namibia does not provide gender-affirming healthcare in the public health system, making the Act largely inaccessible. A transgender person who has not had a "change of sex" could use s.12 (1) (a) of the Identification Act 2 of 1996. It states that "if an identity document does not reflect correctly the particulars of the person to whom it was issued, or contains a photograph which is no longer a recognisable 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. Most trans people who have made applications to update their photographs have not been successful.	Comprehensive legislation, barrier in the public health system
South Africa	Alteration of Sex Status and Sex Descriptor Act, No.49 of 2003	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 (DHA) for the alteration of the sex description on his or her birth register. There are no directives from the 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 application processing (averaging between one and seven years), what forms to use, and what documents an 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.			

[34] https://ilga.org/downloads/ILGA_Trans_Legal_Mapping_Report_2017_ENG.pdf

Source: ILGA

Table 8.6 lists the relevant laws and conditions applicable to changing gender markers in those SADC countries which 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:[35]

- 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, such as opening a bank account, applying for a job or driver's licence, and boarding a plane;
- Most countries still use a binary gender system of male and female, which 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.

As early as 2017, the High Court in **Botswana**, in the case of ND v. Attorney General, clearly stated that preventing transgender individuals from changing a gender marker without undue legal obstacles infringes upon essential rights such as identity, dignity, privacy, protection from discrimination, and freedom of expression. The court mandated that the State undertake necessary legislative and administrative measures to ensure that official documents accurately reflect an individual's self-identified gender.

In the same ruling, the High Court affirmed that people have the right to alter their gender marker in accordance with the National Registration Act of 1986. Section 16 stipulates that the law justifies alterations to registered individuals' information in cases of a "material change" to their details. The court emphasised that having a gender identity that differs from the one assigned at birth, as noted in the birth register, qualifies as such a "material change." Once a person makes this adjustment, the registrar must provide a new identity document.

Although in this case the petitioner succeeded in updating their identity documents to reflect their gender identity, it is concerning that, in 2023, the Southern Africa Litigation Centre (SALC) reported that many transgender individuals in Botswana still face significant obstacles in their pursuit of legal gender recognition.[36]

Fighting for recognition: Members of Lesbians, Gays & Bisexuals of Botswana (LEGABIBO) gather outside the Hight Court in Gaborone. It ruled in their favour in 2019, paving the way for law reform and the decriminalisation of LGBTQI+ people. Photo: Gender Links

[35] BeTrue2Me, Gender Marker and Forename Change, accessed 12 November 2024.
[36] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024.

Intersex

Intersex is a term for people born with, or who develop, sex characteristics which are different from what doctors typically consider male or female. These characteristics can include chromosomes, genitals, reproductive organs, and secondary sex traits. Experts estimate that approximately 1.7% of the global population have intersex traits.[37]

Intersex people can have a variety of gender identities and sexual orientations, including male, female, non-binary, transgender, or queer. They come from all races, ethnicities, socioeconomic backgrounds, faiths, and political ideologies. Intersex is not a disease and thus doctors cannot "cure" or "repair" it. However, intersex people may need to address some health conditions related to their anatomy. For example, if someone has a uterus but no uterine opening, they may experience painful menstrual cycles. Surgery to create an opening may be an option in this case.

Most intersex surgeries are non-lifesaving procedures to alter these natural variations in genital appearance or reproductive anatomy, representing what doctors refer to as medical pathologisation. These surgeries can have risks and complications.[38]

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.[39]

Many people misunderstand intersexuality because they believe that gender is strictly binary (male or female), which contributes to the discrimination intersex people face. Intersexuality has often been confused with sexual orientation or gender identity, but it strictly refers to biological variations in sex characteristics. Intersex individuals can identify with any gender and have diverse sexual orientations.

Many people simply lack education about intersexuality, leading to misconceptions and stigmatisation. The lack of representation and dialogue around intersex issues perpetuates ignorance as well as a misunderstanding regarding consent and the rights of intersex individuals, especially regarding surgeries performed on infants or children before they can provide informed consent.

Addressing these misunderstandings will promote awareness and acceptance of intersex individuals and their rights. To this end, various initiatives by the Office of The High Commissioner for Human Rights (OHCHR), UN agencies and regional human rights mechanisms have attempted to address this topic.

In 2019, the Office issued a Background Note on human rights violations against intersex people. In 2020, it shared a report and recommendations on addressing the intersection of race and gender discrimination in sport, including its impacts on women with variations in sex characteristics. Last year, it issued a Technical Note for States and other stakeholders on UN recommendations on the rights of intersex people and good practices in their implementation.

In 2024, the Human Rights Council adopted a resolution on Combatting Discrimination, Violence and Harmful Practices against Intersex People. The resolution requests the High Commissioner to present a report and organise a panel discussion at the 60th session of the Council examining discriminatory laws and policies, acts of violence and harmful practices against persons with innate variations in sex characteristics, in all regions of the world. This includes looking at root causes and examining best practices, especially when addressing the realisation of their right to the enjoyment of the highest attainable standard of physical and mental health.[40]

[37] https://www.ohchr.org/en/sexual-orientation-and-gender-identity/intersex-people, accessed 4 November 2024.
[38] https://lgbtq.unc.edu/resources/exploring-identities/intersex/ accessed 4 November 2024
[39] https://isna.org/faq/what_is_intersex/, accessed 4 November.
[40] UN OHCHR - https://www.ohchr.org/en/sexual-orientation-and-gender-identity/intersex-people, accessed 2 November.

Forced and coercive medical interventions

Doctors often perform unnecessary surgeries and other interventions on intersex children with the aim of making their bodies fit into traditional binary sex norms. These procedures, which are often irreversible, can lead to issues such as permanent infertility, pain, incontinence, loss of sexual sensation, and long-lasting psychological distress, including depression. Frequently conducted without obtaining the complete, voluntary, and informed consent of the individuals involved - who are often too young to participate in the decision-making process - these interventions may infringe upon their rights to physical integrity, protection against torture and ill-treatment, and freedom from harmful practices.

Many intersex adults who underwent surgical procedures during childhood highlight the profound sense of shame and stigma associated with efforts to eliminate their intersex characteristics. These experiences often lead to significant physical and psychological suffering, stemming from both the invasive nature of the surgeries and the painful, lasting scars they bear as a result. In addition to the physical repercussions, many intersex individuals experience coercion to conform to specific sex and gender categories that do not align with their authentic identities. This forced conformity can lead to a disconnect from their true selves and ongoing struggles with their sense of identity and belonging.[41]

According to the OHCHR, to ensure the physical integrity of intersex persons, States should:

1. Prohibit medically unnecessary surgery and procedures on the sex characteristics of intersex children;
2. Ensure that experts investigate human rights violations against intersex people and prosecute alleged perpetrators;
3. Ensure that intersex people and their families receive adequate counselling and support, including from peers;
4. Ensure that academics and researchers consult intersex people and organisations so they can participate in the development of research, legislation and policies that impact on their rights; and
5. Provide health care personnel with training on the health needs and human rights of intersex people and the appropriate advice and care to give to parents and intersex children, being respectful of the intersex person's autonomy, physical integrity and sex characteristics.[42]

Prohibit medically unnecessary surgery and procedures on the sex characteristics of intersex children

Zimbabwe took a positive step recently by showing greater acceptance for intersex rights and actively engaging proposals made by Iceland during the 2022 Universal Periodic Review (UPR), a peer review process that allows all UN Member States to review each other's human rights records. The proposal focused on safeguarding minors with intersex variations from non-consensual surgeries and violations of their bodily autonomy. The Zimbabwean government indicated that it is reviewing this recommendation. The acknowledgement of intersexuality as a naturally occurring variation that is part of human diversity marks a promising initial step toward promoting inclusivity and respecting the rights of individuals with intersex variations in Zimbabwe.

However, some members of civil society have raised concerns about the incongruence in the understanding of concepts relating to SOGIESC within Zimbabwe. They caution that, while the country has seen a growing acknowledgement of intersexuality as a biological characteristic, there remains a problematic pathologisation of some identities and the perception that gender identity and sexual orientation are matters of choice or behaviour.

[41] UN OHCHR - https://www.ohchr.org/en/sexual-orientation-and-gender-identity/intersex-people, accessed 2 November 2024.
[42] Ibid

Intersex, transgender and sport

The topic of intersex and transgender identities in the sporting world - particularly who can compete and in which category - remains fraught with complexities and challenges. Proposed regulations to address these often spark considerable debate and backlash, including in South Africa, which is home to intersex Olympic gold medallist Caster Semenya.

Involving the scientific and medical communities is generally not a prerequisite for establishing regulations in sport, but the intricate analysis of gender dynamics increasingly necessitates their input. However, it is important to recognise that sporting experts should not confine their analysis and decision-making solely to these perspectives.

The principle of equity in women's sports lies at the heart of this discussion. Many experts express concern that this debate may undermine women's hard-won progress and liberties in the athletic arena over the past century. This debate raises critical questions about the future of women's sport and the ongoing struggle for inclusive representation and fairness for all women regardless of their sexual orientation, gender identity, or sex characteristics.[43]

Broadly speaking, transgender athletes do not identify with the gender they were assigned at birth. The question as to whether professional athletics should allow transgender athletes to compete following surgery or because of their use of hormonal treatment is not new. These procedures are, in practice, the ones that primarily require regulation within sports federations.

It is also important to distinguish between transgender and intersex athletes. As noted earlier, intersex athletes have sexual characteristics that do not correspond to traditional gender definitions. This could include naturally high testosterone levels in female athletes. Sporting association regulations limiting their access to competition frequently target these athletes, but the legitimacy of these regulations remains in question. What is the difference between a naturally high testosterone level in a sportswoman and an "abnormally" tall volleyball or basketball player from the point of view of sports equity?

Regulations on intersex, transgender and female athletes with abnormally high hormones in international sports have evolved over more than 60 years and remain subject to ongoing debate and revision. After extensive consultation with athletes and international sports federations, the International Olympic Committee (IOC) published a document entitled *IOC Framework on Equity, Inclusion and Non-Discrimination on the Basis of Gender Identity and Intersex* in November 2021. It notes that transgender athletes can compete without undergoing surgery.

The guiding principles of the framework are:

- Transgender male athletes have no particular sporting advantage and should be able to compete in male competitions;
- The same applies to transgender athletes before puberty, who should be able to compete in male or female competitions depending on their identified gender; and
- Experts should assess the situation of athletes who have changed sex after puberty on a case-by-case basis, as testosterone-generating male puberty can, at least in theory, lead to physiological advantages.[44]

The rules focus on hormone levels, particularly testosterone. Trans women (assigned male at birth but identifying as female) can compete in women's events if their testosterone levels sit below a certain threshold for at least 12 months prior to competition. World Athletics, the governing body for track and field, has its own set of regulations. As of 2023, it restricts eligibility for trans women in female categories based on testosterone levels, but it has faced criticism for this stringent criterion.

[43] Pierre Bydzovsky, The status of transgender and intersex athletes in international sports federations, The International Sports Law Journal (2023) 23:357-367.
[44] Ibid

Athletes with intersex variations face different regulations depending on the sport. Some governing bodies have regulations that require their testosterone levels to fall within female limits or that require them to undergo medical interventions to compete in women's categories. This has led to legal challenges and discussions on human rights. Each sport's national governing body may have its own set of rules regarding transgender and intersex athletes, and these can vary widely from state to state and sport to sport.

Female hyperandrogenism

This is a medical condition that causes the body to produce high levels of androgens, or male sex hormones. This occurs in intersex female athletes - also known as Differences in Sex Development (DSD) - and has been the subject of much debate, leading to new and revised rules and regulations about how and when sports bodies permit athletes to participate.

On 23 April 2018, World Athletics published *Rules Governing Qualification in the Women's Category (for Athletes with Differences in Sex Development)* - also known as the DSD Rules. The DSD Rules stipulate that athletes must have a testosterone level of less than five nanomoles per litre to compete in international women's competitions, otherwise athletes must either medically lower their testosterone level or attempt to qualify for men's competitions. World Athletics agreed it can also subject athletes to an "investigation" carried out by members of the National Olympic Committee, including physicians, chief medical officers and Chairs of the IOC Medical Commission.

Caster Semenya challenged these regulations and has led the battle against them since her debut in 2009. In 2019, Semenya filed a request for arbitration with the Court of Arbitration (CAS), challenging the validity of the DSD rules. CAS rejected the request, confirming the validity of the rule. Despite its discriminatory character, officials considered it necessary, reasonable and proportionate for the preservation of sporting equity in women's competitions.[45]

Female hyperandrogenism is a medical condition that causes the body to produce high levels of androgens, or male sex hormones

The Swiss Federal Tribunal upheld a decision regarding the Semenya case on 25 August 2020, emphasising the importance of fairness in sports and ruling that high testosterone levels provide female athletes with an unfair advantage. This decision sparked controversy, with debates over gender discrimination and the conditions for admitting hyperandrogenic and transgender athletes.

On 11 July 2023, the European Court of Human Rights (EUCHR) disagreed with the Swiss ruling, stating that discrimination based on sex is unjustified and highlighting shortcomings in the regulation of testosterone levels. The EUCHR noted the serious side effects of hormone treatment and the lack of evidence supporting the claim that higher testosterone levels confer a significant competitive advantage. Ultimately, the case underscores that regulations solely relying on testosterone tests could lead to discrimination.[46]

[45] Ibid
[46] Ibid

South Africa's Caster Semenya: more than 15 years advocating for an end to discrimination in women's sport

Olympic medallist Caster Semenya is arguably the most well-known intersex sports figure in the world. Her struggle for the right to participate in long distance events as a woman without having to take drugs to reduce her testosterone levels has spanned more than 15 years, inspiring other intersex and hyperandrogenic athletes around the world.

Semenya first started facing questions about her sex and gender in 2009, when she won the 800-metre world-championship in Berlin at age 18. At that time, she underwent two gender-verification tests before her breakout performance. Since then, she has been in and out of court to challenge her rights to participate in female sports without the indignities of gender testing or taking medication to reduce high testosterone levels.

In a 2023 interview with *TIME*[47] following the release of her memoir Race to be myself, Semenya explained the humiliation of the gender verification process. "I wanted to show these people, 'Look, what you're doing is wrong.' You're not going to find anything. Only 'you have a high testosterone level. You are a woman who has no uterus, a woman with no fallopian tube, you are a woman with internal testicles.' Publicising this, they've done me a favour. You're educating people about differences in a human being. That was not humiliating. What was humiliating was how they treated me."

She won the 800-metre gold at the 2016 Rio Olympics and two fellow Africans joined her on the podium: silver medallist Francine Niyonsaba of Burundi and bronze medallist Margaret Nyairera Wambui of Kenya, who both also have DSD and produce high levels of testosterone. They also experienced discrimination and disrespect from their fellow competitors, challenging their right to compete in the event.

Recalling the event Semenya says: "It became a racial situation. Followed by discrimination, then disrespect. Where is the sportsmanship? It shows that the leadership in world athletics have done well to separate women from women. To make sure that we, as women, hate one another. They're not building women's sports. They're teaching people how to discriminate, how to be racist. But the principle of sports is to say no to racism, so say no to discrimination. And it confuses me, when you are a leader, you come in, you want to build a sport, but you're destroying it."

Semenya has been in and out of CAS since she challenged the DSD regulations in 2018. After several hearings over five years, the EUCHR finally ruled in her favour. The ruling did not immediately change World Athletics, but it leaves open the possibility of a different outcome in the future.

Even if she does not compete again, she says "For me, the hope is that such rulings are never made [again]. Human rights need to be considered. People need to be treated with dignity and respect. I'm fulfilled if those young girls can go run, enjoy their youth, enjoy their teenage life, enjoy sport. As much you say sport is for all, at the moment it is not."[48]

The topic remains highly contentious, with advocacy groups calling for more inclusive policies that respect the rights and identities of all athletes while balancing fair competition. Reforms and new policies are under continuous discussion within various sports organisations.

Lawyers have brought several cases and challenges in courts regarding these regulations in recent years, as affected athletes fight for their rights to compete in accordance with their gender identity.[49]

[47] TIME, Caster Semenya Isn't Just Fighting for Herself, 2 November 2023, accessed 14 November 2024
[47] Ibid
[49] Pierre Bydzovsky, The status of transgender and intersex athletes in international sports federations, The International Sports Law Journal (2023) 23:357-367.

Employment

Only six SADC countries protect LGBTQI+ 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 this community. It is crucial for employers to remain vigilant in preventing discrimination against people due to their sexual orientation, gender identity or expression.

A 2014 study by The Williams Institute, a US-based think tank, found a theoretical connection between LGBTQI+ inclusion and economic development in emerging economies. It suggested that including people from this community allows them to achieve their economic potential, which in turn can lead to stronger economic growth and development.[50]

In research released this year, the Other Foundation, an African trust that advances equality and freedom in Southern Africa with a particular focus on sexual orientation and gender identity, found that LGBTQI+ people in South Africa contribute R250 billion (US $13.7 billion) annually to the national economy as consumers, employees, and entrepreneurs, which is about 13% of the government's budget this year.[51] This report definitively quantifies the size of the LGBTQI+ market in South Africa for the first time. It also assesses the scale and qualities of the economic influence that the South African LGBTQI+ population has more broadly.

Up until now, policymakers have largely overlooked the considerable economic influence of LGBTQI+ individuals due to the lack of data regarding their distinct economic contributions. International research has primarily concentrated on the economic damage caused by discrimination against LGBTQI+ people, but very little research has examined their economic potential when recognised as a market segment.

The Other Foundation's research included 400 respondents who completed a 51-question survey on topics such as demographics, economic position, consumption, employment, and entrepreneurship. Some of the key findings include:

- 75% of respondents have part-time or full-time employment.
- 61% are more motivated to buy from inclusive businesses.
- 44% hold managerial positions, showing that, compared to other groups, LGBTQI+ professionals advance significantly more into positions of influence within the workplace.
- 90% of LGBTQI+ people are engaged in some form of income-generating activity.
- 90% intend to start a business.
- 50% live on modest earnings.
- 70% support other people financially.
- 35% have children or are guardians to children.
- 25% believe that they do not benefit from equal opportunities in career advancement in comparison to their non-LGBTQI+ co-workers.[52]

Economic inclusion of LGBTQI+ people is important because it drives overall economic growth through increased productivity, higher consumer spending, and greater entrepreneurial activity. The report underscores the long-term benefits of inclusion and calls for concerted action toward greater LGBTQI+ economic participation.

A socially integrated, legally protected, and economically active LGBTQI+ community can significantly contribute to economic growth, equity, and stability. Removing barriers to inclusion involves eliminating discriminatory practices and actively promoting equal treatment and greater diversity in all spheres of social and economic life. Detailed information about the economic activity of the LGBTQI+ community is also instrumental for evidence-based decision-making and advocacy, enabling key stakeholders to devise targeted and effective initiatives that promote inclusion and fuller economic participation.[53]

[50] The Williams Insttute titled "The Relationship between LGBT Inclusion and Economic Development: An Analysis of Emerging Economies, 2014.
[51] The Other Foundation, Size matters - how big is the LGBTI market in South Africa and what economic influence does the LGBTI population have?, 2024.
[52] Ibid
[53] The Williams Institute titled "The Relationship between LGBT Inclusion and Economic Development: An Analysis of Emerging Economies, 2014.

While **Angola** has made progress in terms of LGBTQI+ rights, sexual orientation remains one of the main reasons for workplace dismissals. In 2019, an act of parliament decriminalised same-sex relationships, which has resulted in greater acceptance of LGBTQI+ people. Meanwhile, implementation of the new penal code has created safer spaces for LGBTQI+-focused events and public gatherings. However, this community still experiences prejudice and discrimination in employment and several remaining non-inclusive policies represent a persistent challenge for LGBTIQ+ people in the country.[54]

For example, Angola still has no law that permits transgender people to change their gender marker on their identification documents. This makes it particularly difficult for them to participate in the mainstream economy. As a result, many trans people resort to sex work and other roles in the informal economy. Arquivo de Identidade Angolano (AIA), an Angolan women-focused LGBTQI+ organisation, works to address this by providing skills to LGBTQI+ youth. AIA's initiated its "I am LGBTIQ+ and I Undertake" project during the economically challenging COVID-19 outbreak to assist LGBTQI+ entrepreneurs in vulnerable situations to establish new businesses or improve their employment opportunities.[55]

Violence and discrimination

LGBTQI+ individuals deserve dignified treatment and to have their fundamental human rights respected, protected, and fulfilled. Unfortunately, governments, justice systems, bigots, and others regularly undermine their rights in alarming ways. This includes acts of violence such as killings and torture, instances of sexual violence, criminalisation based on sexual orientation or gender identity, and arbitrary detention, which occurs across the region with disturbing regularity. Additionally, harmful and outdated practices, such as conversion therapy, forced sterilisation, and non-consensual medical procedures targeting transgender and intersex individuals, remain alarmingly prevalent in the region.[56]

Moreover, pervasive stigma and discrimination permeate various aspects of life. Individuals face harassment and bullying not only in their workplaces but also within their homes, educational institutions, and healthcare settings. Access to housing, sports, and public services remains challenging, with gatekeepers to these spaces taking decisions against the LGBTQI+ community rooted in bias and intolerance. A persistent climate of fear and exclusion highlights the urgent need for comprehensive change to ensure that leaders in the region uphold the rights and dignity of all individuals. Tackling these issues means more than changes in laws and policies - it requires greater acceptance, support and celebration of LGBTQI+ people by everyone in society, including at the family and community levels.

A study on GBV in **Mauritius** analysed questionnaires from 227 LGBTQI+ people and 119 women and found evidence supporting the notion that GBV negatively impacts people's access to education and their ability to participate in school and economic and employment activities. The research indicated that high levels of GBV negatively impacts the economy, encompassing both direct and indirect costs. Victims face hardships as they must use their limited financial resources for medical care, legal assistance, and personal needs, such as paying rent for alternative housing and replacing lost or damaged belongings. These costs become even more significant due to various opportunity costs, including lost time that could have supported education goals, loss of goods and services that victims miss out on because they cannot work, and their inability to carry out daily household tasks. Consequently, GBV has extensive repercussions on the Mauritian economy, where the labour force serves as the primary engine for economic development.[57]

[54] Mambaonline, Angola: A journey to LGBTIQ+ economic inclusion and participation, 15 February 2023, accessed 10 November 2024.
[55] Ibid.
[56] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024.
[57] Kolektif Drwa Imin, Gender-based violence and its impact on the economic cost in Mauritius: A victims' perspective, 2023.

When solidarity backfires

In countries where harsh laws still apply, such as Zambia, activists continue to advocate for legalisation. However, sometimes well-intentioned solidarity action can result in unintended negative consequences. In May 2022, anti-LGBTQI+ sentiment escalated when the Swedish and Finnish embassies in Lusaka displayed the rainbow flag alongside their national flags to express support for LGBTQI+ rights. Rather than encouraging inclusivity as intended, this action prompted a strong backlash that emboldened anti-LGBTQI+ activists and heightened the difficulties faced by LGBTQI+ Zambians.

"Throughout the past year, there has been a crackdown on LGBTI rights following the display of the pride flag by bilateral partners," said an activist who goes by the pseudonym "Alex." He noted that this "was perceived as 'Western 'gayism.'" This incident raises important questions about the effectiveness of bold public activism and advocacy in support of LGBTQI+ rights, such as embassies displaying pride flags, and whether it can inadvertently increase the myriad risks faced by the very communities it seeks to assist.[58] It is an issue for advocates to consider.

LGBTQI+ organisations

Civil society organisations focused on LGBTQI+ issues need to register and operate within a country's legal framework to be most effective. Regionally, LGBTQI+ groups can only legally register in nine SADC countries, with seven others (Comoros, DRC, Eswatini, Madagascar, Malawi, Tanzania and Zambia) outlawing it.

This formal recognition legitimises their efforts and empowers them to better serve their communities and advocate for the rights and needs of their communities. When these organisations operate openly, they can mobilise resources, create awareness, and influence public policy. Additionally, registration provides them with a platform to engage with government entities, NGOs, and other key stakeholders, further amplifying their voice and impact in promoting acceptance and equality.[59]

While some organisations must register by using non-explicit names or descriptions (e.g. referring to their work as on "human rights" or "sexual health" rather than LGBTQI+), laws and systems may still prevent them from effectively conducting their activities and advocacy.

Incidents of homophobia have increased in recent years in **Tanzania**, possibly connected to discussions about the controversial anti-homosexuality bill passed in neighbouring Uganda in March 2023. According to one Tanzanian human rights organisation, anti-LGBTQI+ sentiment escalated in Tanzania around 6 March 2023, when Muslim leaders in Mwanza led a demonstration against homosexuality. A few weeks later, similar demonstrations in Arusha followed. On 27 March, a former member of parliament and minister held a press conference and revealed false information about LGBTQI+ organisations and their work. This stoked the flames of bigotry, increasing incidents of hate speech from religious leaders and other Tanzanian homophobes. Since then, some MPs have raised the issue in parliament, with Abubakar Asenga, MP for Kilombero constituency, encouraging lawmakers to replicate Uganda's hateful bill in the country.

"Safety and security have been a very vital aspect of our organisation work," said one leader of a Tanzanian human rights organisation.

[58] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024
[59] https://database.ilga.org/legal-barriers-freedom-of-association

"Because of the hostile environment that we are operating in, there is a high rate of hate from the society, and politicians have used LGBTQ people as a political weapon to draw people's attention away from issues that will put them in challenging situations."

The leader, who asked to remain anonymous, noted that their organisation had to take extra security measures to implement its projects to prevent putting its members in danger. This includes closing their office space and transitioning to work from home. The result is that their clients no longer have a safe space to visit for wellness and mental health support. "Our shelters have been overpopulated with LBTQ people, and yet it also puts the shelters in a risky situation," they said. "Our organisation has been trying to fundraise to minimise the effects of the current situation. Still, we have yet to receive support as many donors are directing their efforts to support Uganda, where the problem is worse. Our staff also do not feel safe in their homes."

Other measures the group has taken to enhance security include no longer holding meetings and workshops at hotels; destroying all physical and hard copies of materials related to their work; moving meetings online; and reducing the number of participants at all workshops and meetings. "We have been documenting the situation since its beginning; it increases our fear, as every day, there is something said by religious leaders, politicians, or threats from the general population."

In September 2019, the **Eswatini** Registrar of Companies rejected an application by Eswatini Sexual and Gender Minorities (ESGM), a community-based advocacy organisation working to advance the protection of the rights of LGBTQI+ persons, for registration as a non-profit organisation. The Registrar cited several reasons behind the rejection, including that the country criminalises same-sex sexual acts and, therefore, the government cannot register an organisation that promotes the interests and aspirations of LGBTQI+ persons.

[60] Amnesty International, We are facing extinction: escalating anti-LGBTI sentiment, the weaponization of law and their human rights implications in select African countries, Amnesty International 2024.

Members of Eswatini's LGBTQI+ community take part in the country's first Pride march in July 2018. Credit: Mathias Wasik

The ESGM filed a case before the high court challenging the refusal. In 2020, the High Court upheld the Registrar's decision to deny ESGM's registration. In May 2022, ESGM filed a notice of appeal against the High Court decision. In July 2023, the Supreme Court ruled in their favour, publicly declaring that "the approach undertaken by the Registrar in this regard does not meet the legal requirements contained in Section 33 of the Constitution." The court ordered the acting minister of Commerce and Trade to reconsider ESGM's application.

The Ministry of Commerce and Trade then chose to decline the application, declaring that Eswatini's Constitution does not clearly prohibit discrimination based on sexual orientation and gender identity, so the principles and rules of Roman-Dutch Law remain enforceable as the common law of the country. In a statement to Amnesty International in October 2023, ESGM noted, "The court case proceedings have adversely affected LGBTI human rights advocacy [and] have sparked considerable interest from society, as well as local and international human rights organisations and activists. [While] the organisation has received significant support from its members and from political groups... it remains disappointing that the human rights of LGBTI individuals in the country are still not acknowledged."

While the Supreme Court's decision set the stage for LGBTQI+ organisations to register, the response by the government illustrates another example of resistance to LGBTQI+ rights and how laws criminalising the LGBTQI+ community place them in precarious situations and violate their rights, including their rights to freedom of association, expression, equality before the law, and of non-discrimination.[60]

The current climate for LGBTQI+ people in **Zimbabwe** is marked by diminishing space for political engagement. This narrowing of civic space makes it increasingly difficult for the LGBTQI+ community to organise and advocate for their rights. The introduction of the Criminal Law (Codification and Reform) Amendment Bill (Patriotic Bill), a piece of legislation signed into law in May 2023, has worsened the situation. This law, ostensibly designed to protect sovereignty and national interests, has raised significant concerns about diminishing fundamental rights, including freedom of expression, peaceful assembly, and association. It compounds existing challenges in a country with a long history of discrimination against LGBTQI+ people who continue to face police harassment and sexual and physical assaults.

The vague language used within the legislation raises concerns about its potential misuse. Activists also connect a surge in homophobic sentiment in Zimbabwe to the growing influence of Pentecostal churches, which have experienced a significant proliferation in recent years and often propagate anti-LGBTQI+ rhetoric. They believe that this religious shift has intensified the perpetuation of discriminatory attitudes, presenting additional challenges for Zimbabwe's LGBTQI+ community.[61]

Civil society organisations nonetheless continue with their activism and mobilisation and even sometimes partner with traditionally conservative actors, including some churches.

South Africa: Strange bedfellows advocate for LGBTQI+ rights in Limpopo

An unlikely alliance is helping rural South African communities overcome stigma and move toward acceptance for LGBTQI+ community members.

Capricorn ignited LGBTI (CIL), a lesbian-led organisation established in 2017, has joined forces with Limpopo Chaplaincy to advance community development, health care and spiritual services for the LGBTQI+ community in the province.

CIL employs a feminist lens to advocate for women's rights in Limpopo province while the Limpopo Chaplaincy provides health and community care. Its many faith-based chaplains reside in various communities within the province, helping communities with development, health care services, and spiritual assistance.

Partnership between the two groups has played an essential role in mobilising community members and other civil society organisations to collaborate on similar activities that address social challenges, including GBV and femicide.

Community fundraising lunch hosted by Capricorn ignited LGBTI. Credit: CIL

"Our organisation works with everyone and does not discriminate. We are guided by the constitution of South Africa and the laws," said Chaplain Albert Masingi at a meeting to welcome stakeholders. The collaboration has enhanced the visibility of the LGBTIQ+ community while also supporting the faith-based and men's sectors. This cross-sector strategy helps break down stigma and improves working relations between the various groups.

[61] Ibid

Visibility of the LGBTIQ+ community enhances collaboration. Credit: CIL

The pairing has assisted in many community development projects, including building houses for GBV survivors and providing food parcels to needy families. However, the religious group's involvement with the LGBTIQ+ sector meant that some of its members left the organisation because they felt they could not work with LGBTIQ+ people because of their faith-based beliefs.

"I told my members that the door is open if they feel like they cannot work with LGBTIQ+ people because our organisation aims to unite people and not divide them; we work with everyone," said Masingi.

For its part, CIL says it has evolved thanks to its partnership with Limpopo Chaplaincy and the two groups plan further work together, specifically to respond to the needs in harder-to-reach communities in the province.

Source: Mashangu Albert Masingi, driver of change, GL Summit

Funders are also seeing the value of building strong LGBTQI+ movements. One example is the Morang Fund, which launches in 2025.

New fund presents a "ray of sunshine" for a persecuted community

Gender Links, in partnership with the Botswana Network on Ethics, Law and HIV/AIDS (BONELA) and funded by the European Union, will roll out the #VoiceandChoice: Diversity and Inclusion in Southern Africa Programme in 2025. Under the title, the Morang Fund, which means "a ray of sunshine that brings hope" in Setswana, it aims to strengthen LGBTQI+ organisations and movements in Botswana, Lesotho, Madagascar, Mauritius, and Namibia.

BONELA is a national NGO championing the right to health. It has supported strategic litigation for LGBTQI+ organisations' right to register and decriminalise same-sex activity in Botswana. Its ongoing legal battle with partners in Botswana for full decriminalisation illustrates the challenges in achieving legal rights, let alone social inclusion, for LGBTQI+ persons.[62]

BONELA has launched a parallel campaign to include gender equality, sexual orientation, and gender identity in the Botswana Constitution, which is due for a review. As a co-applicant and technical advisor in this proposal, BONELA has created a step-by-step guide for litigation on LGBTQI+ rights in Southern Africa.

BONELA, a national NGO in Botswana, will work with Gender Links in 2025 to support LGBTQI+ organisations in five SADC countries.

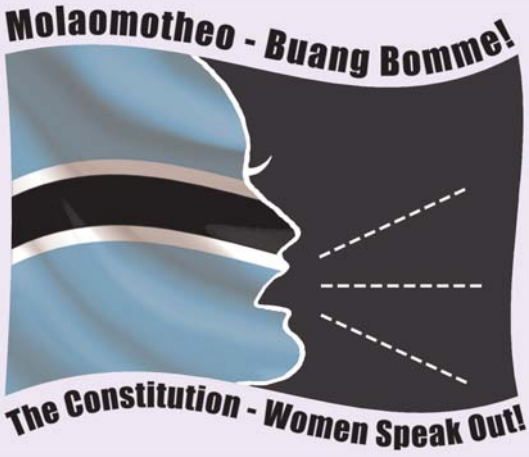
The organisation has a long track record of facilitating collaborative advocacy for policy and law reform in service delivery for key and vulnerable populations (KVPs), including adolescent girls and young women, adolescents and young people, sex workers, men who have sex with men (MSM), LGBTQI+ people, people with disabilities, children, women, people living with

[62] Fair Planet, The African Nation Going Against The Tide On Sodomy Laws, July 20, 2023, accessed 10 November 2024

HIV, prisoners, non-citizens particularly refugees, and asylum seekers.

BONELA also supported the emergence of Botswana's first LGBTQI+ and sex work organisations. These include the Lesbians, Gays, and Bisexuals of Botswana (LEGABIBO), Rainbow Identity Association (RIA), and Sisonke Botswana.

GL Botswana worked with BONELA to lead an initiative, called *Molaomotheo-Buang Bomme!* (The Constitution: Women Speak Out) around the country's constitutional review. The submission argued that ensuring compliance with global, African, and regional commitments to attain gender equality represents a compelling reason for reviewing Botswana's 55-year-old Constitution. The submission, supported by women politicians across the political spectrum, also made the case for recognising LGBTQI+ rights in the Constitution.



Source: Gender Links

LGBTQI+ people and the media

When media outlets rely on, and perpetuate, negative stereotypes about LGBTQI+ individuals, it can lead to further misunderstanding and prejudice

When media outlets rely on, and perpetuate, negative stereotypes about LGBTQI+ individuals, it can lead to further misunderstanding and prejudice. Depicting LGBTQI+ people solely through a negative or stereotypical lens reinforces harmful perceptions. Some media coverage of LGBTQI+ issues sensationalise them, focusing on extreme cases or controversies rather than everyday realities and human experiences. This sensationalism can provoke fear and backlash among those who might not have direct experience with LGBTQI+ individuals, setting back attempts to protect them and their rights.

Media coverage that emphasises conflicts surrounding LGBTQI+ rights, such as efforts to improve legislation affecting the community, also frequently enforces polarised perspectives. With the growth of social media across the region, anti-gender and LGBTQI+ rights actors have become increasingly effective and organised in their social media messaging.

As pro-rights activists promote positive messages and share stories that target stigma and misconceptions, anti-rights movements increasingly depend on social media to spread misinformation about LGBTQI+ individuals or issues, influencing public opinion in negative ways. By perpetuating negative narratives and focusing on conflict, the media can contribute to societal backlash against LGBTQI+ people, making it

crucial for media outlets to approach LGBTQI+ topics with sensitivity, accuracy, and dedication to representation.

In **Malawi**, the LGBTQI+ community faced a backlash following a legal challenge regarding the constitutionality of the country's outdated penal code, which criminalises same-sex relations. According to LGBTQI+ activists, messages from anti-LGBTQI+ protesters, which the media has frequently shared, have intentionally mixed up the distinct issues of LGBTQI+ organisation registration, decriminalisation of same-sex relations, and same-sex marriage. While the court contemplates the decriminalisation of consensual same-sex sexual acts (by repealing section 153 of the Penal Code), some religious groups have deliberately merged these issues in the media to misrepresent the case as one concerning same-sex marriage, aiming to provoke public outrage and further complicate the discourse.[63]

Conversion therapy

Conversion practices are attempts to suppress or alter an individual's sexual orientation, gender identity, or gender expression. These remain prevalent in SADC even though medical experts have long noted they have harmful effects on the lives of LGBTQI+ individuals. The methods used as part of what is also known as "conversion therapy" abuse LGBTQI+ peoples' fundamental human rights.

"Conversion" practices damage people who undergo them and can include beatings, rape and forced isolation, administration of drugs and hormones and religious "ritual cleansings."[64] Major mental health organisations, including the World Health Organisation, have condemned conversion therapy, citing the potential for significant psychological harm and asserting that sexual orientation and gender identity are inherent and not subject to change.

In many places, policymakers have criminalised or restricted conversion therapy, reflecting a growing recognition of the rights of LGBTQI+ individuals and the importance of supporting their mental health and well-being.

While activists have extensively documented conversion practices over the past 50 years in North America and Australia, comprehensive research has yet to be conducted in any African country to characterise the nature and extent of these damaging and degrading practices. In 2022, Outright International produced the first report on so-called conversion therapy in Africa, titled Converting Mindsets, Not Our Identities. It found that these damaging practices occur in many countries and vary in their degrees of physical and psychological harm.

Key cross-cutting findings from the research on conversion practices in Kenya, Nigeria, and South Africa include:

- More than half of the LGBTQI+ respondents from the three countries surveyed indicated that they had undergone some form of conversion practices.
- Conversion practices take various forms. The cross-cutting forms identified in the research include talk therapy, exorcism, drinking herbs, prayer, laying of hands for healing, beatings, and rape or another form of sexual assault.
- Frequently, those who administer it combine several forms of conversion practices to change a person's identity or sexual orientation, either simultaneously or over different periods. As a result, most of the respondents in this survey indicated that they endured more than one form of conversion practice.
- Practices increase in intensity from the moment of discovery, starting with family talks and conversations and escalating to counselling

[63] Ibid.
[64] UNDP, SADC parliamentarians discuss the harms of 'conversion' practices in Africa, 8 May 2023, accessed 10 November 2024.

or prayer, and then to violence, economic coercion, and shunning when other methods do not work.
- Conversion practices perpetuate over a long period and they usually do not end until a victim affirms that they have changed to being heterosexual and/or cisgender.
- Religious leaders, mental health practitioners, and family members represent the main perpetrators of conversion practices, while family members mostly initiate them. However, some LGBTQI+ individuals seek out these practices, likely because of the immense stigma, fear and discrimination they face in homophobic and transphobic communities.
- Conversion practices can harm the physical and mental health of survivors. The research found that many survivors of conversion practices suffer from depression, social anxiety, substance abuse, and thoughts of or attempts of suicide.

Next steps

There is a worrying and growing trend of resistance and backlash to LGBTQI+ rights in the region. Even in countries in which same-sex relationships are legal, public attitudes towards LGBTQI+ people remain mostly negative when compared to the laws and freedoms increasingly afforded to them.

- Activists and allies need new **strategies and tactics** to counter the resistance and backlash. They should start by researching and understanding the opposition actors, their strategies, and their sources of funding.
- **Opposition tracking:** Understand and follow the opposition's tactics and actions to comprehend and respond to the specific challenges and threats to LGBTQI+ rights. This insight can help formulate effective strategies for advocacy and mobilisation.
- Develop counter strategies and communication to **combat misinformation** and negative narratives.
- **Build alliances** with other progressive organisations and movements facing similar challenges. This enhances advocacy and ensures that well-intentioned actions or messaging do not cause unintended negative consequences.
- **Documenting** opposition helps raise awareness within the broader community, including allies outside the region, about the ongoing struggles faced by LGBTQI+ individuals in SADC. This also encourages public support and solidarity.
- Gender and LGBTQI+ activists and organisations must work together in **coordinated campaigns** across the region that challenge discriminatory laws and policies. These initiatives should adopt an intersectional approach, highlighting the diverse experiences within communities. Key objectives should include a clear timeline for the elimination of conversion therapy and the enactment of hate crimes legislation to protect individuals from violence and discrimination.
- **Collaboration with stakeholders** - such as policymakers, educators, and healthcare providers - is a critical tactic for fostering support and driving meaningful change in the legal landscape.

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Notes

Notes

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

GENDER LINKS
FOR EQUALITY AND JUSTICE

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AMPLIFY CHANGE