Introduction 1

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

KEY POINTS

- The Barometer is the first comprehensive assessment of SRHR by civil society in SADC based on 100 indicators covering sexual and reproductive health; adolescent SRHR; HIV and AIDS; gender-based violence (GBV); harmful practices and sexual diversity.
- In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 SADC member states approved the ground-breaking SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030 and corresponding Score Card to measure progress.
- A gender critique of the SADC SRHR Strategy and score card points to some limitations. For example they make no reference to menstrual health management (MHM).
- A contradiction in the Strategy is the focus on key populations such MSM; sex workers and transgender persons without the requisite focus on decriminalising the conditions in which these populations live.
- Out of the 20 indicators in the SADC SRHR score card, the Barometer only found reliable data on 12 indicators that have been scored for this Barometer. This raises concerns as to how governments will use this instrument.
- Data on Comoros is sparse in many cases and the Alliance is still identifying a partner network. Comoros will be included in the 2020 **#VoiceandChoice** Barometer.
- The 2020 **#VoiceandChoice** Barometer will develop a basket of weights using the 100 indicators identified to rank countries and thematic areas in the attainment of SRHR.
- The **#VoiceandChoice** Barometer should be read together with the *State of Gender Equality in SADC report* which the Alliance will launch annually at the SADC Heads of State summit.

The tenth edition of the SADC Gender Protocol Barometer, published in 2018, put a spotlight on the inter-linked gender justice issues of our time including menstrual health, comprehensive sexual education, teenage pregnancies, safe abortion, maternal health, GBV, HIV and AIDS, and sexual diversity.

In 2019, Gender Links and the Southern African Gender Protocol Alliance (the Alliance) launch the first SADC SRHR **#VoiceandChoice** Barometer. The Barometer is the first comprehensive assessment of SRHR by civil society in SADC based on an assessment of 100 indicators covering sexual and reproductive health; adolescent SRHR; HIV and AIDS; gender-based violence (GBV); harmful practices and sexual diversity.

The SADC SRHR Barometer occurs against the backdrop of several key global and SADC developments including the 25th anniversaries of the International Conference on Population and Development (ICPD) and Beijing Platform for Action as well as the adoption of the SADC Regional Strategy and Scorecard on Sexual and Reproductive Health and Rights (2019 - 2030). The introductory chapter covers the global and SADC context, the SADC Gender Protocol Alliance and Centres of Excellence in Gender and local government ***#VoiceandChoice*** *campaign*, and explains the methodology underpinning the Barometer.

Global context

ICPD25

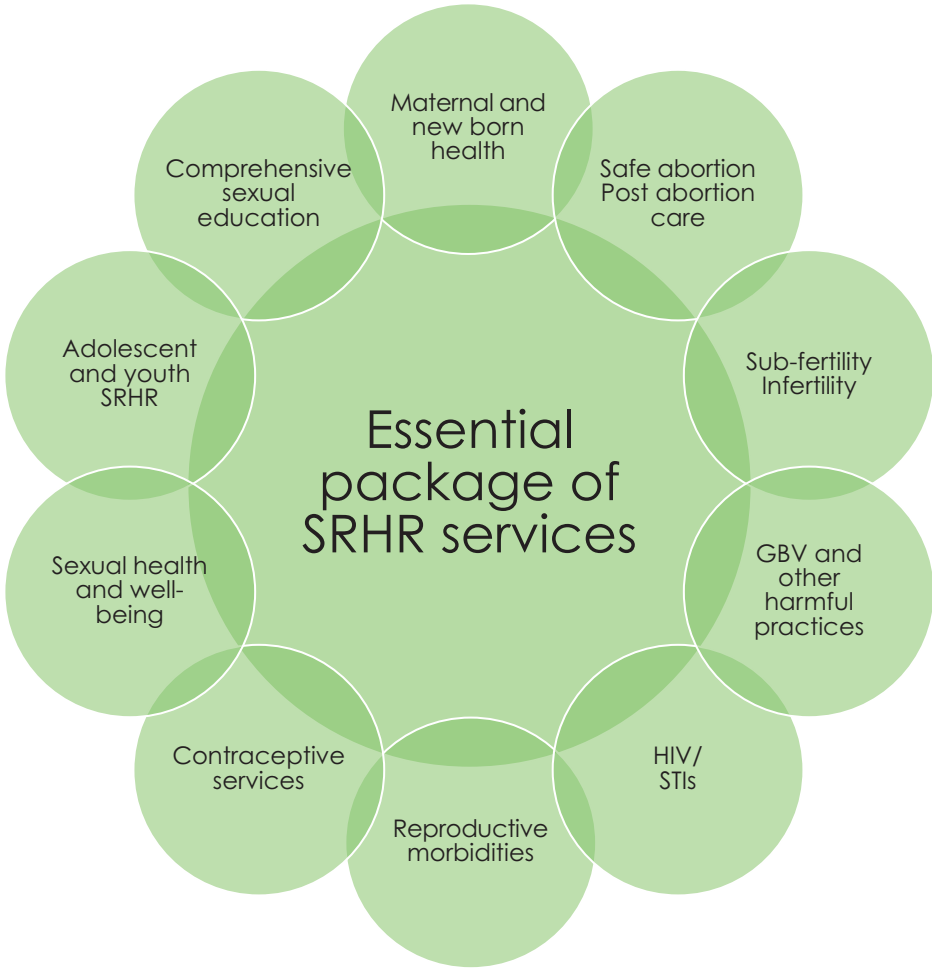
In 1994, 179 governments adopted a landmark Programme of Action (POA) at the International Conference on Population and Development (ICPD) in Cairo to empower women and girls to realise their well-being and full potential.

Implementation of the ICPD POA has varied across the globe. High levels of maternal mortality, gender-based violence and unmet need for contraception, amongst others, persist particularly in Africa. These factors impact on countries achieving their demographic dividend. Burgeoning youth populations across Africa receive low quality education, have inadequate access to health care and remain on the periphery of economic development. The status quo must change if Africa is to achieve the economic growth required to sustain the growing population. The deadline to achieve the Sustainable Development (SDGs) by 2030 adds impetus to the realising the ICPD POA. In November 2019 a high-level Summit in Nairobi, Kenya, will bring governments, civil society organisations, young people and other key stakeholders together to mobilise the political will and financial resources to implement the ICPD POA. The Summit will centre around achieving zero unmet need for family planning information and services, zero preventable maternal deaths, zero sexual and gender-based violence, and harmful practices against women and girls.

The ICPD Summit will cover five themes:

- Universal access to sexual and reproductive health and rights as a part of universal health coverage (UHC).
- Financing required to complete the ICPD Programme of Action, and to sustain the gains made.
- Drawing on demographic diversity to drive economic growth and achieve sustainable development.
- Ending gender-based violence and harmful practices.
- Upholding the right to sexual and reproductive health care in humanitarian and fragile contexts.

Figure 1.1: Essential package of SRHR services



The current Universal Health Care (UHC) package does not include comprehensive SRHR. The United Nations Population Fund (UNFPA), East and Southern Africa, model for the essential package of SRHR services includes ten key areas outlined in Figure 1.1. According to UNFPA East and Southern Africa Region (ESARO):

- Three out of the 10 SRHR elements (contraceptives; care during pregnancy, delivery and post-delivery; and RTIs, STIs and HIV) are partially covered under UHC in many countries.
- Progressively, at least seven SRHR elements (comprehensive inclusion of the above three elements plus Adolescent Sexual and Reproductive Health (ASRHR), safe-abortion and post abortion, reproductive cancer and sub-fertility and infertility) could potentially be made part of the UHC.
- Discussion is needed on how the health sector responds to the remaining three SRHR elements - Comprehensive Sexuality Education (CSE); Sexual Gender Based Violence (SGBV), Female Genital Mutilation (FGM), Child marriage; and, menstrual hygiene management within UHC.

The preparatory processes towards the ICPD25 is an important opportunity to discuss a comprehensive SRHR package in UHC. The final agreed upon conclusions must include a roadmap towards achieving universal access to SRHR across the globe. Governments, development partners, civil society and health institutions need to work together to achieve SRHR as part of UHC. The time for collective action is now to guarantee universal SRHR for all.

The Nairobi ICPD 25 conference will flow into the 25 year review of the Fourth World Conference for Women in Beijing which took place in 1995, or the Beijing Platform for Action (BPFA) Plus 25

meeting at the Commission on the Status of Women (CSW) in New York in 2020. BPFA +25 calls for revising existing policies to address emerging trends of violence against women and girls such as forced and coerced sterilisation and forced abortion of women living with HIV/AIDs. It also calls for implementing programmes that ensure men's shared responsibility, especially with regard to family planning, HIV and sexual and gender-based violence. Beijing +25 Review (B+25) calls for the review and revise national constitutions and legal systems to systematically remove all discriminatory laws, norms, practices and policies to make the legal framework conform to international and regional instruments on women's human rights. It also calls for building the capacity of the judiciary and law enforcement agencies in gender and women's human rights.

The African context

A variety of African normative frameworks provide for appropriate measures to promote adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas. The frameworks commit to reducing maternal mortality through the establishment and strengthening of existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.

The **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** adopted in July of 2003 in Maputo, Mozambique (the **Maputo Protocol**) covers a wide range of women's rights including political, social, cultural, environmental, economic, civil and health and promises to eliminate discrimination against women. Article 14: Health and Reproductive Health Rights empowers women to control their fertility, decide whether to have children or not and the number thereof, provides the right to choose their preferred contraception, the right to self-protection and to be protected from STI's.

Additionally, women have the right to be informed of their health status and that of their partner and the right to family planning education. Women are further afforded the right to affordable and accessible health services, pre and post- natal as well as for delivery and nutritional services. Finally, women are granted the right to medical abortions in cases of sexual assault, rape, incest, in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child. Article 14; 2C is the only international instrument to provide for safe abortion, although this is limited to cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

Goal three of the **African Union Agenda 2063** aims to increase 2013 levels of Sexual and Reproductive Health (SRHR) Services to women by at least 30%. Goal 3 of the Sustainable Development Goals (SDGs) includes SRHR targets of reducing maternal mortality, child mortality, ending AIDS, tuberculosis, malaria, tropical diseases, hepatitis, and other communicable and water-borne diseases,[1] universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Agenda 2063 provides for equal, affordable and timely access to independent courts and judiciary that deliver justice without fear or favour. All reviewed frameworks provide for constitutional and legislative commitments to commit to gender equality and non-discrimination on the basis of gender. The 2009 AU Gender Policy provides for non-discrimination through its Commitment 2 on legislation and legal protection actions against discrimination, for ensuring gender equality

[1] Sustainable Development Goals

AU Agenda 2063 provides that all harmful social practices (especially female genital mutilation (FGM) and child marriages) will be ended and barriers to quality health and education for women and girls eliminated. All frameworks commit to appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of in particular; the girl child and women. The measures include specific legislature to end harmful practices such as child marriages and female genital mutilation. Some of these practices include but not limited to child marriage and the betrothal of girls and boys for marriage, polygamy, wife inheritance, wife kidnapping, sexual cleansing of widows, FGM and virginity testing.[2]

SADC context

SADC is a region of great political and economic contrasts, underpinned in all 15 countries by patriarchal norms that reflect in high levels of gender inequality, and low SRHR. In 2008, SADC became the first region in the world to adopt a legally binding Protocol on Gender and Development, bringing together African and global commitments to gender equality, updated in line with the Sustainable Development Goals in 2016.

The 2018 SADC Gender Protocol Barometer revealed that contraceptive usage in the region ranges from 5% and 6% in Angola and the DRC to 76% among women in Mauritius. The Barometer reports that only South Africa and Mozambique give women the choice to terminate pregnancy. Unsafe abortion contributes to high rates of maternal mortality across the region. While maternal mortality ratios are declining in other regions, in SADC they increased between 1990 and 2010 mainly as a result of HIV.

Women's lack of voice, choice and control in SRHR reflects in the high rates of GBV and HIV in the region. Violence Against Women Baseline studies conducted by GL in seven SADC countries show lifetime prevalence rates ranging from 25% in Mauritius to 86% in Lesotho. Southern Africa has the highest rates of HIV and AIDS in the world. Sexual violence against women and girls remains one of the major causes of HIV infection. Marital rape is pervasive and contributes to the HIV and AIDS pandemic. For every two people enrolled in HIV treatment, five become newly infected. Women account for 58% of those living with HIV in SADC.

Key SRHR concerns relating to youth include significant percentages of sexually active adolescents below the age of 16; multiple concurrent sexual relations; increasing trends of intergenerational sexual relations; low levels of consistent condom usage during sex; high levels of maternal mortality amongst young mothers; compromised quality of antenatal care to young mothers compared to older mothers; high levels of HIV and AIDS among young people, especially young women, and high levels of GBV. Punitive policies and restrictive laws against vulnerable groups create barriers to their access to SRHR services.

The **Southern African Gender Protocol Alliance** is a "network of networks" that campaigned for the adoption of the SADC Protocol on Gender and Development and its updating in 2016 to align to the SDGs. Attesting to the vital role of civil society in campaigning for gender justice in the region, the SADC Gender Protocol is the only one of the 26 SADC Protocols that have been updated; also the only Protocol that is accompanied by a Monitoring, Evaluation and Results Framework.

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

A key gain in the updated Protocol is the inclusion of SRHR, with cross reference to the Maputo Protocol and principles of the ICPD. Another is 18 as the minimum age of marriage; an issue that became so divisive that Mauritius refused to sign the Protocol and is the only SADC country that has failed to do so. However, only one SADC country (Mozambique) has adopted a stand-alone child marriage laws. Only three SADC countries have water tight laws on child marriages. Evidence such as this, highlighted by the Barometer, has added grist to regional campaigns.

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

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

In November 2018, Ministers of Health and Ministers responsible for HIV and AIDS from the 16 SADC member states approved the ground-breaking **SADC Regional Strategy for Sexual and Reproductive Health and Rights (SRHR) 2019 - 2030** and corresponding Score Card to measure progress. The Strategy provides a framework for the member states to fast-track SRHR in the region. It will support the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015-2020 of a shared future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom, social justice, peace and security for its peoples.[3]

The SADC SRHR Strategy builds on the Sexual and Reproductive Health Strategy 2006 - 2015. The current strategy moves from a service focus to a rights-based approach. This illustrates an important shift to recognising people's human rights as the centre of development and achieving higher levels of well-being in SADC. Ministers approved the first ever SADC **multi-sectoral score card** to measure progress in achieving implementation of the strategy and the SGDs.[4]

Celebrating the approval of the SADC SRHR Strategy in Namibia, 2018. Photo:Gender Links

[3] The SADC SRHR Strategy, 2019 - 2030
[4] https://esaro.unfpa.org/en/news/groundbreaking-regional-strategy-sexual-and-reproductive-health-gets-ministerial-approval

Key targets

The key targets of the strategy are:

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

Gender critique of the SADC SRHR Strategy

Colleen Lowe Morna, GL Chief Executive Officer, highlighting the need for affordable sanitary ware in Tanzania. Photo: Tarisai Nyamweda

GL conducted a gender analysis of the strategy and found strong gender provisions. The SADC SRHR Strategy is an important milestone for the region and includes several gender aware provisions. These include legal unrestricted abortion; access to contraception without third party consent; tracking new HIV infections amongst females between 15 - 24 and the use of condoms by women and girls during the last high-risk sex and the number of women receiving the recommended dosage of human papillomavirus (HPV) vaccine.

However, there are a few critical gaps. For example the strategy and score card make no reference to menstrual health management (MHM). Some of the key MHM issues that impact women and girls are:

- Lack of support from teachers (who are frequently male).
- Teasing by peers when accidental menstrual soiling of clothes occurs.
- Poor familial support.
- Limited economic resources to purchase supplies.
- Inadequate water and sanitation facilities at school and work places.
- Menstrual cramps, pain, and discomfort.
- Lengthy travel to and from school and work places, which increases the likelihood of leaks or stains.[5]
- There needs to be a strategy to address educating of men and boys in menstruation.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5482567/

The Strategy prioritises the SRHR needs of key populations. These include men having sex with men (MSM); people in prisons; people who use drugs; sex workers and transgender people. Young people will be a key population in every category. The strategy however does not mention strategies to address the specific SRHR needs of the key populations such as gender reassignment for transgender persons.

A contradiction in the strategy is the focus on key populations such MSM; sex workers and transgender persons without the requisite focus on decriminalising the conditions in which these populations live. Sex work is illegal in 14 SADC countries. MSM and transgender people are but part of a larger LGBTIQ community that is largely invisible in the strategy. Homosexuality is criminalsed in ten SADC countries. The key populations are linked to those who are deemed to be most vulnerable to HIV and AIDS. SRHR must address the needs of a broader group of people. For example, there is no mention of strategies to address the serious SRHR issues facing child brides. Moving forward, measuring progress must be disaggregated by different key populations and vulnerable groups.

The **#VoiceandChoice** campaign

Voice + Choice
Action and results for SRHR in SADC

Despite energetic advocacy campaigns, levels of GBV and HIV in SADC remain at alarming levels. In 2018 GL, local government and SADC Gender Protocol Alliance focal points from 15 SADC countries met to discuss how to move forward more effectively. The meeting identified the following key lessons:

- Sporadic initiatives such as the Sixteen Days of No Violence Against Women were not adequate. There is need for sustained year-long action. Something GL has been advocating for since 2010 under the banner *16 Days for life*.
- GBV prevention must be a subset of a basket of interventions to realise SADC citizens well-being. Ultimately the goal is to provide a holistic strategy that will address Sexual and Reproductive Health Rights (SRHR). These include rights-based issues such as age of consent for various matters and the challenges adolescents face in schools when they pregnant and violence in schools as well as the provision of effective services.
- In line with the ideology that ultimately women and men change their circumstances by exercising their agency, GL works with 1500 survivors of violence in ten SADC countries to increase their agency and economic power as a way of securing their futures.

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

The objectives of the **#VoiceandChoice** campaign are to:

- Ensure that SADC citizens including key populations have access to an essential package of SRHR services and that these are included into Universal Health Care strategies.
- Contribute towards positive policy change that will ensure equal access to good quality SRHR across SADC.
- Contribute towards the attainment of SRHR concerns in regional, continental and global development instruments including amongst others the SADC Protocol on Gender and Development and SGDs.

- Foster a culture of inclusivity through embracing key populations and other vulnerable groups.
- Hold governments accountable on investment in health through ongoing monitoring, lobbying and advocacy.
- Use multi-media platforms to raise awareness of effective SRHR to key populations, women and adolescents.
- Create a strong network of SRHR advocates through the SADC Protocol Alliance SRHR cluster.
- Build a body of knowledge on good SRHR practices through national **#VoiceandChoice** summits.

Figure 1.2: Stages in the **#VoiceandChoice** campaign

The **Audit of SRHR Laws and Policies in SADC** provides a picture of a region with a diverse landscape. In areas such as gender-based violence (GBV) and HIV and AIDS there are strong legislative and policy frameworks. GBV, however, remains at crisis levels. There is need to step back in order to move forward. Current strategies are not working and urgent prevention strategies are needed.

HIV and AIDS policies are woefully out of date and review and updating to take into account new strategies such as the 90:90:90 and new areas such as HPV and increasing new infections amongst young women between ages 15 and 49.

In other areas such as safe abortion, sex work, decriminalising homosexuality and child marriages there has been little movement in the policy and legislative arena.

Teenage pregnancies and menstrual health are inextricably linked to comprehensive sexuality education (CSE). Most SADC countries provide CSE. The question remains as to how effective the content and delivery is in the classroom. This also impacts on the SRH services young people know about and can access. The menstrual health discourse revolves around the provision and removal of value added tax (VAT) on sanitary ware. These are important considerations. The discourse must include strategies to provide water and sanitation to all schools.

The audit provides an overview of SRHR policies in the SADC region. Some policies, such as Namibia 2001, are very old and some, while very recent, are regressive such as in Madagascar where abortion is outlawed under any circumstances. A strong policy framework that guides SRHR in all countries is a necessary foundation. Every country must lobby and advocate for changes to improve SRHR for citizens and particularly for key populations including amongst others youth, sex workers and LGBTI communities. The findings of the Audit informed the development of the indicators for the SADC SRHR Barometer and are integrated into the individual chapters.

Key campaigns: Over the period from August 2018 to July 2019 and Alliance and local government partners developed SRHR campaigns eight thematic areas including menstrual health; maternal health; comprehensive sexual education (CSE) and services; teenage pregnancy, safe abortion; HIV and AIDS; child marriage; GBV and sexual diversity.

Table 1.1: Overview of **#VoiceandChoice** SRHR campaigns in SADC

Country	Menstrual health		Maternal health		CSE and services		Teenage pregnancy		Safe abortion		HIV and AIDS		Child marriage		GBV		Sexual Diversity		N	L
	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L	N	L		
Angola	1		1								1								**3**	**0**
Botswana					1	15			1	15							1		**2**	**30**
DRC							1						1						**2**	**0**
Eswatini	1	4							1			4	1			4	1		**3**	**12**
Lesotho	1	5								1		5		5	1				**2**	**16**
Madagascar	1	10				10			1				1						**3**	**20**
Malawi			1						1				1						**3**	**0**
Mauritius																1	1		**0**	**1**
Mozambique		10												10					**0**	**20**
Namibia	1	1		3	1	1			1			2					1		**3**	**7**
Seychelles									1						1		1		**3**	**0**
South Africa		3		4						3			1		1	3			**2**	**13**
Tanzania	1		1																**2**	**0**
Zambia	1	5	1	5		5			1				1						**4**	**15**
Zimbabwe	1	10	1	10		10							1	10					**3**	**40**
TOTAL	**8**	**48**	**5**	**22**	**2**	**41**	**1**	**0**	**7**	**19**	**1**	**11**	**7**	**25**	**3**	**8**	**5**	**0**	***40***	***174***

N=National; L=Local

Source: Gender Links.

Partners developed 40 national and 174 local government SRHR campaigns. In addition, GL worked with 95 councils across ten countries to update their SRHR plans. The highest number of campaigns at national (eight) and local level (48) are on menstrual health. GBV also features prominently at national level.

Six countries and 16 local councils are implementing safe abortion campaigns where safe abortion is not available on demand. CSE is a priority in 41 local councils. It is noteworthy that 22 and 25 councils are implementing maternal health and child marriage campaigns respectively. Local level action will strengthen responses to these issues.

GL worked with 75 civil society organisations, including 39 youth and five LGBTI organisations, in 15 SADC countries to roll out the *#Voiceand Choice* campaign. The Campaign included 439 youth champions affiliated or working directly with local government councils. The youth champions include junior councilors, youth group leaders, local arts or drama group members, civil society representatives and students. Youth champions led advocacy on SRHR through community dramas.

GL and Alliance partners leveraged off social media platforms to increase knowledge and reach of SRHR information. Through the use of social media platforms including Facebook and Twitter content on SRHR reached many users and sparked conversation. To amplify its social media campaigns GL and Alliance partners initiated the **#VoiceandChoice** hashtag. The Campaign which generated content through sharing of news, events and messages related to SRHR.

SRHR workshop at a local council in Eswatini. Photo: Thandokuhle Dlamini

As part of its long standing "gender equality in and though the media" campaign GL trained **media practitioners** in 15 countries on SRHR reporting. Journalists produced innovative stories that were published on the GL website and disseminated through social media. A total of 103 media articles have been produced across the nine thematic areas. The stories are carried in the countries' media.

In 2019 GL and Alliance partners will host 15 national **#VoiceandChoice Summits** to share good SRHR practices. The 2020 SRHR Barometer will include an analysis of the case studies and highlight ways of working on SRHR that works.

An example of the momentum that is developing in the region on SRHR is the progress on decriminalising sexual diversity, one of the most contentious SRHR issues in the region. In 2015, only three SADC countries had decriminalised homosexuality - South Africa, DRC and Mozambique. South Africa is the only country in the world whose Constitution recognises sexual orientation. Since then Seychelles and most recently Angola have decriminalised homosexuality. A new generation of young people, and especially young women, is leading the march for **#VoiceandChoice** in the region.

Methodology

For ten years the Alliance has produced the Southern African Gender Protocol Barometer, tracking performance of the 15 SADC countries against the provisions of the 2008 SADC Protocol on Gender and Development, updated in 2016. The **2019 #VoiceandChoice Barometer** takes a radical departure from the past in that:

- It will focus on a specific cross cutting SRHR theme .
- It will measure progress against several relevant instruments, not just the SADC Gender Protocol. These include the SDGs, ICPD, the Maputo Protocol, and the SADC SRHR strategy.

The Alliance will, in addition to the Barometer, publish a shorter sister publication, **State of Gender Equality in SADC Report** based on the SADC Gender and Development Index; the Citizen Score Card; the Protocol knowledge quiz; the Gender Progress Attitudes Score and the Gender Responsive Assessment (GRA) of Constitutions and Laws. These traditional monitoring and evaluation tools administered by Alliance network provide a wealth of data on how governments are performing overall in the attainment of gender equality. Other traditional chapters of the Barometer, such as Economic Justice, Governance and Climate Change will be published as E books and coincide with key dates or events linked to these chapters. For example, by the end of this year five elections will have taken place in SADC (South Africa, Namibia, Botswana, Madagascar, and Mozambique). The Governance chapter will be published in early 2020.

Structure of the SRHR Barometer

Table 1.2: Breakdown of the SRHR Barometer

Chapters	Relation to previous Barometer Chapters
1. Introduction	
2. Sexual and reproductive health	Health
3. Adolescent SRHR	Education
4. Safe abortion	Constitutional and legal Rights
5. HIV and AIDS	HIV and AIDS
6. Gender-based violence	Gender-based violence
7. Harmful practices	Constitutional and legal rights
8. Sexual Diversity	New

Table 1.2 maps the eight chapters of the SRHR Barometer in relation to the original Barometer. The 2019 SADC SRHR Barometer introduces a new chapter on Sexual Diversity. The chapter measures 15 indicators relating to the status of LGBTI communities.

Normative frameworks

The regional, African and global frameworks mapped against each chapter include:

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

The GL and the Alliance comprehensive **review of SRHR laws and policies** in 15 SADC countries provided in-depth information on policy and legislative frameworks; responses; services and prevention strategies in the different areas. These are integrated into the different chapters.

Each chapter begins with a table of key indicators

Developing indicators - quantitative measures

Each chapter begins with a table of key indicators for which data could be reliably obtained across the 15 countries. The three primary sources of these indicators are:

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

Table 1.3: Classification of indicators

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

Table 1.3 shows that:

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

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

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

Qualitative data

Two sources of qualitative data have been used:

- **Case studies:** GL put out a call for Alliance partners to share Most Significant Result (MSR). Evidence is also being gathered through the case studies presented at the #Voiceand Choice SADC Protocol@Work summits (in progress at the time of writing).
- **Media articles:** From the journalists trained in 15 countries on coverage of SRHR.

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

Limitations

- Comoros became a full member of SADC at the 38th Summit of Heads of State and Government on August 2018 in Windhoek Namibia. Data on Comoros is sparse in many cases and the Alliance is still identifying a partner network. Comoros will be included in the 2020 #Voice andChoice Barometer.
- The 2019 **#VoiceandChoice** Barometer is an "out of the box" version of previous Barometers. Departing from previous norms and practices with limited human and financial resources is a risk, but one we considered worth taking to provide the necessary evidence base for our advocacy work.