The Impact of COVID-19 on Adolescents and Young People in the Southern African Development Community Region

June 2021
MIET AFRICA

Established in 1996, MIET AFRICA is a regional organization with its head office in South Africa. Its purpose is to promote the holistic development of children and youth and their associated school communities in the SADC Region by supporting education, as well as health and socioeconomic development where it relates to education. For over twenty years, MIET AFRICA has assisted Ministries of Education to strengthen their education systems so that they are better able to address barriers to learning, all towards securing the right of the region’s children and youth to quality education. Through innovation and strong partnerships, the organization is able to make a significant contribution to sustainable development in the region. It has pioneered many development models and programmes, and its influence extends across Africa and beyond.

The FutureLife-Now! Programme adopts an innovative approach towards providing child and youth-friendly services in support of health, gender, migration, food security, violence, climate change and other challenges facing children and youth, especially the most vulnerable. FutureLife-Now! aims to promote greater self-confidence and hope for the present and future among young people in the SADC Region. A combination of activities that includes strengthened HIV education policies, enhanced CSE, access to youth-friendly HIV/SRHR services facilitated through schools, peer-support groups, targeted programming for boys, and youth driven climate action contribute to the programme’s overall objective of reducing new HIV infections and increasing adherence to ART among children and youth in the SADC Region.

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Any views or opinions presented in this report are solely those of the review team based on analysis of data available to them. These views and opinions do not necessarily represent or reflect the official position of the SADC Secretariat, MIET AFRICA or governments in the SADC Member States under review. The mention of specific departments, institutions, companies, firms or products of certain manufacturers or suppliers does not imply their endorsement or recommendation by the review team, SADC Secretariat, MIET AFRICA or governments of SADC Member States in preference to others of similar nature, not mentioned in this report. Errors and omissions excepted, all references have been duly acknowledged.

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## Abbreviations

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<tr>
<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
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<tr>
<td>ART</td>
<td>Anti-retroviral Treatment</td>
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<td>AU</td>
<td>African Union</td>
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<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
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<td>CSE</td>
<td>Comprehensive Sexuality Education</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<td>ECD</td>
<td>Early Childhood Development</td>
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<td>ESA</td>
<td>East and Southern Africa</td>
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<tr>
<td>FAO</td>
<td>Food and Agricultural Organization</td>
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<td>FGDs</td>
<td>Focus Group Discussions</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GPE</td>
<td>Global Partnership for Education</td>
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<td>HSRC</td>
<td>Human Sciences Resource Council</td>
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<td>ICT</td>
<td>Information and Communications Technology</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bi-sexual, Transgender, Queer or Questioning, and Intersex</td>
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<tr>
<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>SRH[R]</td>
<td>Sexual Reproductive Health [and Rights]</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNCRRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>WFP</td>
<td>World Food Programme</td>
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Preface

The coronavirus outbreak that was declared a global pandemic by the World Health Organization (WHO) in March 2020 has signalled a crisis that is impacting health, education, economies, livelihoods and security in the Eastern and Southern African region. Although the region recorded fewer cases during the first wave compared to other parts of the world, the second wave of outbreaks experienced in Southern African Development Community (SADC) Member States in late 2020 and early 2021 has necessitated the continuation of national lockdowns, school closures and the introduction of austerity measures to address the economic impacts of this global pandemic.

Despite the presence of robust legal and policy frameworks, health systems in SADC Member States are overwhelmed and the education sector is challenged to ensure education continuity, particularly for the most marginalized youth. There is a looming danger and concern that there will be a reversal of progress made over the past 25 years, specifically a clawback on education, sexual reproductive health and rights (SRHR), and protection outcomes outlined in international and human rights commitments.

In 2020, a study was conducted by MIET AFRICA, in partnership with the Human Sciences Research Council (HSRC), on the impact of COVID-19 on young people in the SADC region, with a particular focus on the effects of the pandemic on their education and their sexual and reproductive health. This report provides an analysis of the findings, highlighting the realities facing adolescents and young people in accessing education, SRHR information, support and services. It reviews the impact of the COVID-19 pandemic on protection mechanisms and assesses the extent to which SADC Member States have established normative, institutional and programmatic arrangements to respond to the COVID-19 crisis. Importantly, the report addresses the linkages between the advancement of youth rights and good governance and presents an informed overview of the specific vulnerabilities that deprived and marginalized youth—including girls, youth with disabilities, those living in rural or remote areas and refugee camps, and LGBTQI* youth—face in the crisis.

The findings of the study shed some light on how COVID-19 has led to loss of livelihoods, significant stress on families, increased gender-based violence (GBV), and lack of access to safe spaces and services for youth, particularly girls and young women. Since the outbreak of COVID-19, the six SADC Member States under review† have all recorded higher rates of child, early and forced marriages, early pregnancies and school dropouts. For too many young people in the SADC Region, missing school means that they may never return; and heightened pressures and stress on families mean increased mental health concerns for young people. This is a grim reality that ought to be urgently addressed. There is a clarion call for Member States to continue investing in education by embedding comprehensive sexuality education (CSE) in school curricula, and to put in place the necessary programmatic arrangements to provide SRHR support and services for young people.

However, we cannot effectively establish the necessary investments without listening to young people themselves: their views and perspectives are just as important. We are particularly

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* The evolving terminology includes lesbian, gay, bisexual, transgender, queer or questioning, and intersex.
† Lesotho, Madagascar, Malawi, Namibia, Zambia and Zimbabwe
pleased that this report reflects the views and experiences of 322 young people from the six Member States under review. We thank all the young people who participated in this research for their commitment, bravery and openness. During a very challenging time in their lives, they were willing to give their personal and collective reflections of how the coronavirus pandemic has affected them, and also share their thoughts on how duty bearers can support them to live healthy lives and transition to successful adults.

We are hopeful that this report will catalyse government and stakeholder efforts to ensure that youth in the SADC Region, no matter what their background, are able to access education, information and services to make informed decisions about their health and sexuality, and to have the agency to participate in decision-making processes.

The priority areas for action put forward in this report provide pointers on measures that need to be taken by SADC Member States, CSOs, academia and private sector in an effort to “build back better”. As a road map to recovery, governments should re-affirm their commitments to subscribe to the SADC SRHR Strategy and East and Southern Africa (ESA) SRHR commitments and accelerate the achievements of the Sustainable Development Goals (SDGs), AU Agenda 2063, and AU Agenda 2040—an Africa fit for children. It is a moral and ethical imperative for all stakeholders to address the many challenges facing youth during this time.
CHAPTER 1: Introduction

1.1 Background

Within just a few months, the Coronavirus disease 2019 (COVID-19) pandemic became a global phenomenon, affecting over 200 countries and territories.\(^1\) Despite various efforts by governments around the world to “flatten the curve of infections” and to address the spread of the virus, the pandemic continues to spread, with various countries recording high mortality rates leading to a collapse of national health systems and a ripple impact on the most vulnerable populations. While the containment measures contributed to delaying an immediate health crisis and were aimed at protecting young people and their communities from COVID-19 infections, they have interrupted an already precarious learning and protection context for millions of young people in sub-Saharan Africa. This is especially the case for girls, youth with disabilities, LGBTQI youth and youth living in rural areas, who have traditionally been disproportionately affected by crises impacting the continent.\(^2\)

As is the case with any outbreak of infectious disease, children and young people face multi-dimensional risks, including exposure to the infection and indirect risks to accessing education and healthcare services. This is largely due to government priorities shifting to funding interventions to minimizing contamination, as well as direct risks to the population’s overall care and protection.\(^3\) From the onset of the COVID-19 pandemic, one of the defining messages has been that older persons are more affected, and that young persons have a lower risk of COVID-19 infection. Yet the health and non-health impacts on young people are proving to be significant. The impact the movement restrictions and lockdowns are having on livelihoods and wellbeing of young people in the short term, and the consequences in their lives in the long term, remain major areas of concern and are still being examined.

In response to the COVID-19 outbreak, and based on growing concerns on access to SRHR services for adolescents and young people, MIET AFRICA and the HSRC conducted a study to investigate the impact of COVID-19 on adolescents and young people in the SADC Region. A review of literature on the impact of COVID-19 on children, adolescents and young people, with a particular focus on the impact pandemics have on access to education, health, GBV and SRH, was conducted to inform the analysis and to contextualize the findings of this study. The literature review shows that available research and data on the impact of COVID-19 in the SADC Region is largely focused efforts to contain the health crises in countries.\(^4\) Data from UN Agencies provides some insights as to the challenges encountered by young peoples’ access to education, as well as the increased protection risks and the economic impact COVID-19 outbreak will have on countries’ economies.\(^5\) However, available research provides scanty details on states’ responses for continued access to SRHR services for young people, education continuity for most marginalized, HIV&AIDS treatment and prevention approaches, and the mental health and psychosocial impacts of the pandemic.\(^6\)

The analysis also indicates a very limited involvement of adolescents and young people in research and decision-making processes.\(^7\) Although young people have been engaged in regional webinars to solicit their views on programme response to COVID-19, it is not entirely clear from the available research whether they have been meaningfully engaged in education and health policymaking processes and in generating evidence to inform programmatic action at national levels. As a result, the preliminary literature review shows significant gaps in terms
of understanding the real impact of COVID-19 on young peoples’ lives, which is imperative because young people aged 16 to 35 account for the majority of the population in Africa, and the youth population is projected to grow by at least 42 percent by 2030.8 MIET AFRICA is equally concerned that COVID-19 is disrupting young people’s already tenuous access to HIV and SRHR education, services and products—including CSE, condoms, anti-retroviral treatment (ART) and counselling services in cases of unintended pregnancies or rape. With increased focus on COVID-19 and health provision for infected persons, there is a risk that the policy and programmatic gains on HIV&AIDS and SRHR outcomes will be reversed. In addition, the availability of necessary services and supports may be limited, due to supply-chain disruptions and prioritization of COVID-19 health services.

1.2 Purpose of the research study

FutureLife-Now! and School’s Out are two regional programmes supported by MIET AFRICA and HSRC, respectively. These programmes focus on expanding the access of youth-friendly SRHR services and support to adolescents and young people through and around schools in the SADC Region. In light of the COVID-19 outbreak, and based on growing concerns on access to SRHR services for adolescents and young people, MIET AFRICA and HSRC commissioned this study to investigate the impact of COVID-19 on adolescents and young people in the SADC Region.

The specific purpose of the research study is to generate evidence on how the COVID-19 pandemic has impacted adolescents’ and young people’s access to and realization of their SRHR. The research analyses current strategies in the delivery of teaching and learning, as well as investigating the care and support services provided to adolescents and youth in the SADC Region. It focuses particularly on the effect that the COVID-19 pandemic has had on the SRHR of adolescents and young people and the disruption it has caused to their education, access to basic services and social lives. The information generated will culminate into country-specific findings that can be used by Member States, civil society organizations (CSOs) and other stakeholders to establish appropriate and responsive legal, policy, programmatic and institutional actions for protecting the rights of adolescents and young people.

1.3 Objectives of the research study

The main objective of the study is to provide an analysis of the impact of COVID-19 on adolescents and young people in the SADC Region. Specifically, it aims to:

- Establish evidence on how the COVID-19 pandemic is affecting the lives of young people in the SADC Region, with particular focus on the most marginalized
- Conduct a critical analysis of the effects of COVID-19 on adolescent and young people’s access to SRHR information, services and products, in the light of the school closures and various levels of restrictions on human movement and social interactions
- Map out and analyse children’s and youth’s perspectives and views about their future, physical and mental health, and propose recommendations from young people on how to improve access to learning and health services
• Assess how COVID-19 is changing the way schools and their broader support networks operate, both in the delivery of teaching and learning and of care and support services

• Identify priority areas for action for the Member States under review, and recommend effective ways of teaching and learning, particularly on content that is not prioritized in times of crises

Guided by available qualitative secondary data and primary evidence from the SADC Secretariat, government officials, CSOs and young people themselves, it is expected that the study will enable a greater understanding of the unique circumstance in which adolescents and young people in the region find themselves, and which could assist with appropriate provision of effective care and support throughout the COVID-19 crisis and its aftermath. More pragmatically, the study focuses on identifying successes, challenges and lessons learnt and seeks to generate concrete conclusions and recommendations for action by various stakeholders.

1.4 Scope and guiding framework for analysis

This study was approved by the SADC Secretariat as part of a broader project activity on generating evidence on young people’s access to SRHR under the FutureLife-Now! and School’s Out programmes. It was conducted among programme participants, including learners benefiting from the FutureLife-Now! programme, government officials overseeing the implementation of the programmes at national level, and CSO partners that engage closely with MIET AFRICA in programme implementation in the four Member States.

This research is firmly rooted in the MIET AFRICA approach to considering the voices of youth, amplifying their views and engaging them in a meaningful way to ensure their needs are understood, identified and addressed. MIET AFRICA places a strategic focus on adolescence and youth for several reasons: young people under 24 make up the greatest proportion of the population in the SADC Region. Furthermore, within SADC Member States, nearly seventeen million people are living with HIV and there were 675 000 new infections in 2019. Young people, particularly young women, represent a significant portion of these new infections: across SADC, there were 175 800 new infections among young women (15–24) and 72 400 among young men (15–24) in 2018, which is over a third of all new infections in the region. In Southern Africa, the drivers of the HIV pandemic, early pregnancies and school dropouts among young people are closely linked to SRHR issues, including intergenerational sex, multiple and concurrent sexual partners, GBV, transactional sex or sex work, and limited and/or inconsistent use of condoms. Importantly, during crises such as COVID-19, compared to other sub-groups of the population adolescents face differential risks related to loss of education and access to health including SRH, and are at risk of experiencing violence and of being overlooked in policy formulation.

The research study was conducted in six SADC Member States: five where the FutureLife-Now! and School’s Out programmes are implemented—Lesotho, Malawi, Namibia, Zambia and Zimbabwe—and in Madagascar. The choice of countries is based on the geographical and linguistic representation of SADC Member States (Anglophone and Francophone). A

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* Based on recommendations from the SADC Secretariat, Mozambique was considered for in-depth review but its Ministry of Education and Human Development was unable to accommodate the study at the time of request.
broader literature review on the impact of COVID-19 on adolescents and young people was undertaken for all sixteen Member States.

In pursuance of achieving the above research objectives, the study analysed information from a plethora of sources to gather detailed responses and evidence to the following four research questions.

1. **How is the COVID-19 pandemic affecting young people in the SADC Region, particularly the most marginalized?**

2. **With school closures and various levels of lockdown in most Member States, what are the effects of COVID-19 on adolescents’ and young people's access to SRHR information, services and products, to their physical and mental health, and their feelings about the future?**

3. **How is COVID-19 changing the way schools and their broader support networks operate, both in the delivery of teaching and learning, and in care and support services?**

4. **What are effective ways of teaching and learning, particularly of content that is not prioritized, in times of crisis?**

The imperative to investigate adolescents’ and young people’s wellbeing from a rights-based approach lies at the foundation of this research study. The *United Nations Convention on the Rights of the Child (UNCRC)*, which has been ratified by all the SADC Member States under review, forms the primary guiding framework for the study and the analysis of information gathered. The *African Charter on the Rights and Welfare of the Child (ACRWC)* and the *African Youth Charter*, as principal norm-setting instruments for child and youth rights in Africa, and which have similar comparable rights to those provided in the UNCRC, also contribute to the normative foundations of the study.

The cardinal principles of child rights and other core rights that are most at risk for adolescents and young people in emergency and humanitarian crises include: the best interest of the child, the right to life, survival and development, non-discrimination and participation, the right to food and shelter, the right to health and SRHR services, education, protection from violence, and the right to social security. Other global health and education commitments, including the ESA SRHR commitments and SDG Targets 3.7, 4a, 5.2, 5.6 and 16.2, as well as Global Partnership for Education (GPE) outcomes, were used as a guiding framework for the analysis. Furthermore, the scope and depth of the data collection and analysis was guided by and followed the structure of the SADC COVID-19 response plan, SADC Member States response plans, and governments' education and health strategies, as well as SRHR priorities set out in the Future-Life Now! and School's Out regional programmes. The study on the impact of COVID-19 on adolescents and young people revolves around an in-depth analysis of the extent to which SADC Members States, CSOs, and other relevant stakeholders have upheld the fundamental rights of young people to their protection and welfare.

* Angola, Botswana, Comoros, DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia, Zimbabwe
Analysis of existing government policies, laws, guidelines, programmes and available literature was conducted to:

- Determine how the COVID-19 pandemic is affecting the lives of young people in the SADC Region, with particular focus on the most marginalized in key areas, including the prevalence of GBV and the access youth have to:
  - SRH services and products and other essential services for youth
  - Learning and teaching
  - Safety and protection, water, sanitation and health (WASH)
  - Mental health and psychosocial support (MHPSS)
- Establish the current government response and prevention strategies that have been put in place by SADC Member States, with particular focus on the most marginalized
- Ascertain the effects of COVID-19 on adolescents’ and young people’s access to SRHR information, services and products in light of the school closures and various levels of restrictions on human movement and social interactions
- Map out and analyse children’s and youth’s perspectives and views about their future, physical and mental health, and propose recommendations from young people on how to improve access to learning and health services
- Assess how COVID-19 is changing the way schools and their broader support networks operate, both in the delivery of teaching and learning and care and support services
- Recommend effective ways of teaching and learning, particularly on content that is not prioritized in times of crises

Accordingly, the international, regional and national normative frameworks, together with the FutureLife-Now! and School’s Out programme frameworks, provided the overall conceptual framework within which the study was conducted.
CHAPTER 2: Methodology

This section provides a summary of the study research design and methods.

At the beginning of 2020, the impact that COVID-19 would have on adolescents and young people was completely unknown. The study therefore adopted an exploratory research design. The primary purpose of the exploratory research design is to investigate and map out a problem to stimulate further inquiry into the phenomenon. The choice of an exploratory research design ensured that the study provided preliminary but comprehensive information on the COVID-19 situation, nature, trends and responses to adolescents’ and young people’s health education needs, which can be further examined.

2.1 Sampling, recruitment and data collection methods

The research was designed to obtain a representative sample of respondents engaged or connected to the FutureLife-Now! or School’s Out programmes. Because of the COVID-19 travel restrictions, national lockdowns and school closures in the Member States under review, online and remote data collection methods were employed. The study population was therefore necessarily reduced to respondents with remote access to mobile phones or internet connectivity.

The research can therefore only be considered as representative of FutureLife-Now! and School’s Out programme participants in the countries where the study was being conducted. As the these programmes are not implemented in Madagascar, the choosing of participants was informed by purposive sampling of learners by the Malagasy Ministry of Education, taking into account the geographical location of remote schools, the inclusion of learners with disabilities and the availability of teachers to support the data collection process in the country.

There were only two eligibility criteria for participation in the study:

- Adult respondents (aged 25 and above) were to be strategically linked to the FutureLife-Now! and School’s Out Regional Programmes
- Adolescents and youth people were to be aged 15–24 (in line with FutureLife-Now! programme focus)

Data collection for this study spanned five months (October 2020–February 2021). It was led by the consultant, in collaboration with FutureLife-Now! country managers and country coordinators. Qualitative and quantitative secondary data was obtained through desktop research. As part of the triangulation process, primary data was gathered using structured and semi-structured interview guides for in-depth interviews with key informants and focus group discussions (FGDs) with adolescents and young people.

- In Lesotho and Zimbabwe, the research team conducted a total of six FGDs with adolescents and young people and one FGD each with adults from the Ministries of Education.
  
  In Zimbabwe, because of the proximity of the researcher to adolescents and young people in the country, permission was granted for in-person interviews.

- In Malawi and Zambia, the research team held four FGDs with adolescents and one with Ministry of Education officials in each country.
In Namibia and Madagascar, the research team held a combined FGD in each country with Ministry of Education and Health officials.

The consultant held one FGD each in Malawi, Zambia and Lesotho with a total of fifteen youth peer educators from the FutureLife-Now! Target schools.

A team of male and female youth facilitators from Malawi, Lesotho, Zambia and government officials from Madagascar were trained virtually (using MS Teams and Zoom) on the data collection tools, how to obtain informed consent from young respondents, and how to explain questions that may be difficult for participants to understand. All FGDs with female learners and out-of-school youth were conducted by female enumerators, while those for males were primarily conducted by men (although in some cases there were female enumerators).

Primary data was also collected through a single online survey for young people (Survey AnyPlace), either completed directly by the young respondents themselves or indirectly via a youth facilitator’s or youth educator’s mobile phone. Research participants were also invited to participate in the study after being sent the survey link by email, text messaging, WhatsApp or other instant messaging platform. They could then complete the online survey in their own time using a device of their choice. The online survey was designed to capture information across multiple sectors or themes: access to information and communications technology (ICT); health and access to SRHR information and services; access to education and learning; protection and mental health; youth participation in decision-making.

The initial research approach envisaged the active engagement of youth in national data collection processes as peer researchers. Peer-to-peer data collection using youth-friendly data capturing approaches would ensure that young people themselves led the process of generating evidence on the differentiated impact of COVID-19 on their lives.

Ethical clearance for the study was obtained from MIET AFRICA’s internal ethical clearance system. This was important for ensuring the protection of MIET AFRICA as a regional organization, as well as the researchers and the participants in the data collection process. All the participants had full knowledge of what was expected of them during the study; each participant signed a consent form. Furthermore, where ethical clearance was required in the Member State, it was obtained.

Other ethical considerations included upholding the confidentiality and the anonymity of the participants to protect their identity during data collection and analysis. The participants were also informed that the participation was voluntary, and they were free to withdraw their participation at any time without recourse or with any disadvantage or prejudice to them.

To enable a youth-led and -informed report, the research sought to engage young people as researchers, by involving them in data collection, analysis and write-up of the report. However, due to the COVID-19 lockdowns and significant delays in obtaining ethical clearance for the engagement of adolescents as young researchers in the countries under review, adolescents and young people participated in the research as respondents only. However, the FutureLife-Now! school-based youth facilitators and peer educators were instrumental in mobilizing learners and led their participation in the online surveys and FGDs.

The data collection process with young people followed the minimum standards for consulting with children and young people developed by the Inter-Agency Working Group on Children’s
Participation. These principles include transparency, honesty, accountability, provision of a child-friendly environment, equality of opportunity and the safety and protection of young participants. The research process considered the requirements to gain informed consent, ensure confidentiality and anonymity, acknowledge the diverse cultures of the research sites, and refrain from presenting any information that may potentially harm participants.

2.2 Respondents’ profile

The findings from this study are derived from information captured from quantitative and qualitative methods with respondents including:

- 82 responses from young people in an online survey targeting youth aged 15–35 across the SADC Region
- 59 adult responses from key informant interviews and FGDs with the SADC Secretariat, UN Agencies, education- and SRH-focused CSOs, and key informant interviews with Ministries of Education and Health officials
- 240 responses from sixteen FGDs held with adolescents and youth aged 15–24 in FutureLife-Now! schools and out-of-school youth in Lesotho, Malawi, Madagascar, Zambia and Zimbabwe

The study sample includes young people with disabilities, young people from key populations, peer educators, youth for whom English is not their first language, out-of-school youth and young people living in rural and informal settlements. The FutureLife-Now! and School’s Out programmes focus on adolescents and young people between the ages of 15 and 24. As guided by the African Union (AU) definition of youth, the report extended the research participants to youth between 25 and 35. The extension was made to include young people from older age brackets as a means to circumventing the challenges the research team met on obtaining national-level ethical clearances for engaging younger people. Youth-led organizations and youth networks engaging young people from the 25–35 age bracket also participated in the data collection process.

**TABLE 1: DATA COLLECTION TOOLS, PARTICIPANT TYPES AND INTERVIEWS CONDUCTED**

<table>
<thead>
<tr>
<th>DATA COLLECTION TOOL</th>
<th>TARGET PARTICIPANTS</th>
<th>RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Online survey</strong></td>
<td>The online survey was supported by trained youth facilitators, or by participants themselves through a link sent to their smartphones. Survey links were circulated to youth networks in the SADC Region through the African Youth and Adolescents Network (AfriYAN).</td>
<td>82 young people</td>
</tr>
<tr>
<td><strong>Key informant interviews</strong></td>
<td>SADC Secretariat, UNFPA and UNESCO ESA Regional Offices SRH, Education and GBV NGO/CSO service providers, at managerial and at community/case manager level</td>
<td>3 adults 29 adults</td>
</tr>
</tbody>
</table>

* Namibia was not included because ethical clearance was not received in time.
### Data Collection Tool

<table>
<thead>
<tr>
<th>DATA COLLECTION TOOL</th>
<th>TARGET PARTICIPANTS</th>
<th>RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGDs</td>
<td>Government officials from Ministries of Education, Health and Children/Youth Affairs</td>
<td>27 adults from 6 FGDs</td>
</tr>
<tr>
<td></td>
<td>Youth peer educators working at community level within FutureLife-Now! schools</td>
<td>15 young people from 3 FGDs</td>
</tr>
<tr>
<td></td>
<td>Learners from targeted FutureLife-Now! schools and out-of-school youth from national-level youth networks</td>
<td>225 young people from 20 FGDs</td>
</tr>
</tbody>
</table>

**Figure 1** and **Figure 2** below illustrate the geographical and gender representation of adult respondents. Key informant interviews and FGDs responses comprised 56% female and 44% male respondents. The majority of responses were received from Madagascar (fourteen), with nine each from Malawi, Zambia and Zimbabwe.

**Figure 1**: Adult respondents by nationality and gender  
*Source: Data collection tools*

The youth participants’ self-reported gender and age is illustrated below:

**Figure 2**: Youth participants by self-reported gender and age  
*Source: Data collection tools*
Participation of youth

Girls and young women comprised 54% of those who took part in the study through online surveys and FGDs. The participation of female youth in the online survey was lower than that of male youth (41% versus 59%), indicating challenges young girls have in accessing mobile phones or ICT tools. However, young women’s participation improved in FGDs, through community mobilization and the identification of female respondents in FutureLife-Now! and School’s Out programme sites.

Of those the young people who participated in the research, 55% were aged 15–18 and 35% were aged 19–25, indicating the importance of the topic to these cohorts (secondary school learners and early tertiary students). The data collection process also included out-of-school youth, who were part of the FGDs and online surveys from Malawi and Zimbabwe. Youth responses from Namibia were low, due to delays in receiving ethical clearance to conduct FGDs in that country.

![Figure 3: Youth respondents by country](image)

Source: Data collection tools

2.3 Data analysis

Following data collection, the raw survey results were downloaded from Survey Anyplace into an Excel file for quantitative analysis. Probability weighting was used to weigh the programme participant sample against the total programme participant population, looking at variables according to gender and age lines, and whenever possible paying attention to the diversity markers of disability, where the young person lived, and whether they were in or out of school. Using a regression analysis performed with the F-Statistic test in STATA, data (FGDs and key informant interviews) were recorded and summarized in written form to identify common themes and codes and to provide more nuance to the findings from the online surveys. A probability value of <0.05 was used to denote statistical significance. The literature review derived from the secondary sources in the SADC Member States was analysed to triangulate the findings further.
The quotes featured in this report (see boxes) were selected following a qualitative analysis of five open-ended survey questions answered by all adolescents and youth respondents. The qualitative analysis employed a conceptual content approach to identify key themes that adolescents and young people reflected on and discussed. All open-ended responses by the young people were examined and coded, irrespective of any divergent perceptions on saturation point. Quotes and case studies reported from the qualitative data analysis are consistent with these key themes or are noted as particularly salient and important to the adolescent or young respondents across the six Member States under review.

2.4 Study limitations

This research was conducted during a challenging time, when COVID-19 social distancing and lockdown restrictions were in force in most SADC Member States. Stakeholders’ working routines were disrupted, affecting scheduling of virtual consultations amid competing priorities. Within such a context, the following limitations were also encountered during the study:

**Ethical clearance to conduct the study in SADC Member States**

SADC does not have a central research ethics committee for regional studies. This meant that MIET AFRICA had to apply for ethical clearance for the participation of young people from medical research institutes or ethics review boards in six Member States. The six Member States had different application criteria, with some of which being cost-prohibitive. Significant delays were experienced during the application processes in some Member States. Despite concerted efforts to complete the ethical clearance processes, clearance could not be obtained for Namibia, thus limiting the quantity and quality of responses.

**Remote collecting of data**

Due to movement restrictions related to COVID-19, except in Zimbabwe all data was collected remotely and was therefore dependent on respondents having access to the internet or to smartphones or other devices enabling remote communication. It is worth acknowledging that accessing respondents via digital means could be a limitation of the research. Children and young people in the most fragile environments or living in extreme poverty may not have access to technology and thus may not be completely represented. In some instances, unreliable internet and network connections affected the quality of the consultations. FGDs with women and girls are the preferred method for rapid assessments on the sensitive subjects of GBV and SRH, and the inability to hold several in-person FGDs in a safe and private location proved challenging.

Furthermore, the data collection period coincided with school examinations and the re-opening of schools after months of lockdown; many young people in the region were pre-occupied with their studies.

**Purposive sampling**

Survey and FGD participants were chosen through purposive sampling, which potentially can bias the results as women and girls who are already connected to a project are more likely to report awareness of services and help-seeking behaviours than persons selected through probability sampling.
More importantly, however, SRH and GBV are sensitive topics in any culture and while the questions were worded carefully in local languages to avoid references to personal experiences of violence, abuse and sexual orientation, shyness is to be expected, and some participants preferred not to speak openly on these topics. It is likewise important to acknowledge that data collection carried out virtually or over the phone brings with it the risk of potentially compromising the confidentiality of respondents who do not have full privacy to speak freely within their homes or school settings due to the presence of other people. This can create trust issues between data collectors who are not known to the respondents, particularly when there is no option of face-to-face meetings to firmly establish rapport before consultations. To mitigate risks to participants, data collectors utilized a clear consent protocol that explained to participants their rights, how the information would be used, and asked for their permission to continue. In addition, participants were reminded of their right to skip questions or to completely terminate the interview.

*Circumscribed youth participation*

The methodology initially included collaboration between adults on the consultation team and learners engaged as peer researchers. Using an intergenerational collaboration approach, the research team had planned to include four adult professionals and 30 young researchers (aged 15–19) who were to interview other young people over social media and messaging platforms. However, due to delays in receiving ethical clearance and lockdown measures, young people were not actively involved as researchers but rather as respondents only.

Collecting data for education indicators amid the crisis is difficult. Teachers may not be able to report attendance in the same way as they do under normal conditions; learners may not have access to the same tools used by the school system to deliver daily lessons and homework, and teachers may not possess the same skills to navigate the different platforms used in education delivery. Furthermore, estimating increases in early pregnancy due to COVID-19 school closures was difficult due to limited data availability, significant under-reporting and the fluid state of school closures. This report estimated the projected number of adolescent learner pregnancy due to COVID-19 school closures from UN secondary data and primary data from government officials.

Notwithstanding the above limitations, the research provides useful and timely information on how COVID-19 has affected the lives of young people on a range of issues. However, the study limitations must be taken into account in the interpretation of its findings.
CHAPTER 3:  Member States’ legislative and policy landscape

Before and during COVID-19

This section examines the existing international, regional and national normative frameworks on young people’s rights. It explores the status of implementation of legal frameworks by analysing financial investments made towards child wellbeing before COVID-19. It also reviews the impact of COVID-19 on the SADC economy and its implications on promotion and protection of young people’s rights, and is followed by an analysis of the initial COVID-19 response actions in the SADC Region by highlighting some promising practices to alleviate major shocks on young people’s access to education, health, livelihoods and protection as a result of the pandemic.

Key findings

- SADC Member States have made notable progress in creating an enabling policy environment for the realization of young people’s rights. Having ratified 75% of international and regional human instruments, the region is yet to achieve full harmonization through revision of discriminatory laws on age of consent and marriage that impede the full realization of rights, particularly for girls.

- The previous years of underinvestment in child-wellbeing are catching up with Member States. Before COVID-19, at least 80% of children were deprived of at least two wellbeing indicators in five Member States. COVID-19 is projected to worsen the situation of young people.

- 84% of the adult respondents believed that Member States were ill-prepared to address the impact of COVID-19.

- Although lockdowns in Africa have been effective at mitigating the spread of COVID-19, they have had severe economic consequences for the most vulnerable.

- The COVID-19 pandemic has shown that countries that have made financial investments in health, education and social protection are better equipped to respond to crises and emergencies.

- The fiscal position for Member States will be affected with fiscal deficits forecasted to widen to 5.7% of gross domestic product (GDP) in 2020, compared to the previous estimate of 3.0%.

- COVID-19 effects could reverse hard-won gains in poverty reduction over the past two decades. The negative economic outlook is projected not only at national levels but its ripple effect on individual households and families was confirmed by 72% of youth respondents.

- Member States need to protect education, health and social protection financing by strengthening domestic revenue mobilization, increasing the share of expenditure for key wellbeing sectors, and ensuring efficiency in the use of public resources.
3.1 Overview of international and regional frameworks on youth

An examination of the main international and regional instruments relating to youth reveals that youth issues have been included in human rights instruments. Before the COVID-19 pandemic, SADC Member States had made formidable progress in signing, acceding and ratifying human rights instruments on children and young people. As indicated in Error! Reference source not found. below, of the twenty applicable human rights instruments, all sixteen Member States have either signed or ratified seven instruments, fifteen have signed or ratified four treaties, and fourteen have ratified four.

Yet despite this marked progress, four human rights instruments have been ratified or signed by fewer that twelve SADC Member States. The Optional Protocol to the UNCRC on a Communication Procedure, which provides legal safeguards for adolescents and young people to submit reports on grave violations of children's and young people's rights to the UN, has not been signed or ratified by any Member State. However, by virtue of it having been ratified, the ACRWC, provides stronger safeguards for children to submit communications on any child-rights violations.

With fifteen instruments out of the twenty receiving near-universal ratification, it is evident that there is some level of political commitment to protect and promote the rights of young people in Southern Africa. The COVID-19 pandemic came at a point in time when Member States were making concerted efforts to implement policy commitments on education, health and protection, with varying degrees of success. Furthermore, in addition to the instruments discussed in Table 2 (see below), Member States have also subscribed to the following policy commitments:

- SDGs
- SADC Protocol on Gender and Development
- ESA Ministerial SRHR Commitments
- UN Conference on the Status of Women Resolution 60/2 on Women, the Girl Child and HIV
- Beijing Platform for Action
- International Conference on Population and Development (ICPD)
- African Union Agenda 2063—the Africa we want
- AU Agenda 2040 for Children-an Africa fit for children
### Table 2: Overview of International and Regional Instruments on Youth Rights

<table>
<thead>
<tr>
<th>International or Regional Instrument</th>
<th># Member States That Have Ratified</th>
<th>Reference</th>
<th>Context in Which Youth are Referenced or Article Applicable for Youth*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The UN Convention on the Rights of the Child (UNCRC)</td>
<td>16</td>
<td>All Articles</td>
<td>A comprehensive instrument giving effect to the rights of young people under 18</td>
</tr>
<tr>
<td>Optional Protocol to the UNCRC on the involvement of children in armed conflict</td>
<td>15</td>
<td>Article 3</td>
<td>Raising of minimum age of recruitment into armed forces for all State Parties to 18 and above</td>
</tr>
<tr>
<td>Optional Protocol to the UNCRC on a Communications Procedure</td>
<td>0</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>International Labour Organization (ILO) Minimum Age Convention, 1973 (No. 138)</td>
<td>16</td>
<td>Articles 3, 5, 6, 7, 8</td>
<td>Admission to any type of employment set at 18 Exemptions of light work done by children and young people in schools or vocational training</td>
</tr>
<tr>
<td>ILO Worst Forms of Child Labour Convention, 1999 (No. 182)</td>
<td>16</td>
<td>Article 7</td>
<td>Protection from forced or compulsory labour</td>
</tr>
<tr>
<td>ILO Protocol of 2014 to the Forced Labour Convention, 2014</td>
<td>6</td>
<td>Preamble, Par 2, Article 2</td>
<td>Forced or compulsory labour and impact on education Access to education on worst forms of labour</td>
</tr>
<tr>
<td>Convention on the Rights of Persons with Disabilities (CRPD)</td>
<td>15</td>
<td>Articles 6, 7, 16, 29, 30</td>
<td>Special protection measures for women and children with disabilities Freedom from exploitation, violence and abuse Participation of young people with disabilities in public and private life</td>
</tr>
</tbody>
</table>

* This refers to specific provisions where youth are mentioned or where provisions are applicable to young people.
<table>
<thead>
<tr>
<th>International or Regional Instrument</th>
<th># Member States That Have Ratified</th>
<th>Reference</th>
<th>Context in Which Youth are Referenced or Article Applicable for Youth*</th>
</tr>
</thead>
</table>
| Convention on the Elimination of All Forms of Discrimination Against Women | 16 | Articles 5, 10, 16 | Girls and young women’s right to access free and compulsory education  
The right of women to freely choose a spouse and to enter into marriage |
| Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment | 14 | Article 16 | Protection from cruel, inhumane and degrading treatment and punishment |
| Hague Convention on Inter-Country Adoption, 1993 | 9 | Article 4 (2), | Due recognition of a child or young person’s views during inter-country adoption procedures |
| Protocol to Prevent, Suppress, and Punish TIP Persons, Especially Women and Children, supplementing the UN Convention against Transnational Organized Crime | 16 | Article 6 | Protection of victims of trafficking |
| International Covenant on Economic, Social and Cultural Rights | 14 | Articles 3, 10, 11, 12, 13 | Equal access to economic, social and cultural rights of women and men  
Right to social protection of children and young people from birth  
Right to an adequate standard of living, highest attainable standard of health  
Right to education |
| African Charter on the Rights and Welfare of the Child (ACRWC) | 16 | All Articles | A comprehensive instrument giving effect to the rights of young people under 18  
Includes specific provisions on the responsibilities of the child in Article 31 |
<p>| African Youth Charter | 15 | All Articles | A comprehensive instrument giving effect to the rights of young people aged 15–35 |</p>
<table>
<thead>
<tr>
<th>INTERNATIONAL OR REGIONAL INSTRUMENT</th>
<th># MEMBER STATES THAT HAVE RATIFIED</th>
<th>CONTEXT IN WHICH YOUTH ARE REFERENCED OR ARTICLE APPLICABLE FOR YOUTH*</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Charter on Human and Peoples’ Rights</td>
<td>16</td>
<td>Articles 16, 17, 18, 29</td>
</tr>
<tr>
<td>Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol)</td>
<td>14</td>
<td>Articles 4, 5, 8, 9, 12, 14, 18, 20</td>
</tr>
<tr>
<td>Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Persons with Disabilities in Africa</td>
<td>2*</td>
<td>Articles 11, 13, 16, 17, 20, 21, 27, 28, 29</td>
</tr>
<tr>
<td>African Charter on Democracy, Elections and Governance, 2007</td>
<td>14</td>
<td>Article 41(1)</td>
</tr>
<tr>
<td>AU Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention), 2009</td>
<td>12</td>
<td>Articles 7, 9, 13</td>
</tr>
</tbody>
</table>

*No SADC Member State has ratified the Optional Protocol to the African Charter on Human and Peoples’ Rights on Persons with Disabilities. However, Angola and South Africa have signed the Optional Protocol.
The review shows the considerable progress made across the SADC Region in adopting laws and policies in line with international and regional standards. However, further examination indicates weak implementation and resourcing by governments, which has been exacerbated by the COVID-19 pandemic.

Prior to COVID-19, the sixteen Member States had promulgated education or health acts or sectoral policies/strategies on SRHR and protection from GBV. Table 3 shows the legal and policy landscape in place in all sixteen Member States before COVID-19.

**TABLE 3: LEGISLATIVE AND POLICY LANDSCAPE IN THE SADC REGION**

<table>
<thead>
<tr>
<th>MEMBER STATE</th>
<th>EDUCATION LEGISLATIVE &amp; POLICY FRAMEWORK</th>
<th>HEALTH AND SRHR LEGISLATIVE &amp; POLICY FRAMEWORK</th>
<th>PROTECTION LEGISLATIVE &amp; POLICY FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>• Education Law 13/01</td>
<td>• The National Strategy on Comprehensive Healthcare for Adolescents and Youth, Family Planning and Reproductive Health</td>
<td>• Law 25/11 against domestic violence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Basic Law of the National Health System</td>
<td>• National Gender Policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• General Regulations of Health Clinics in the National Health Service</td>
<td>• National Youth Plan (2005)</td>
</tr>
<tr>
<td>Botswana</td>
<td>• Education Act 1967</td>
<td>• Public Health Act</td>
<td>• Children’s Act (1981)</td>
</tr>
<tr>
<td></td>
<td>• Outline Act on the Education System</td>
<td></td>
<td>• National Policy for the Protection of Children</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Law to Combat Child Labour and Trafficking</td>
</tr>
<tr>
<td></td>
<td>• National Education Act (2014)</td>
<td></td>
<td>• Family Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• National strategy to combat GBV (2009)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• National Policy of Gender Integration, Family Promotion and Child Protection (2008)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• National Action Plan to end marriage of children, 2017–2021</td>
</tr>
</tbody>
</table>
## Impact of COVID-19 on Adolescents and Young People in the SADC Region

<table>
<thead>
<tr>
<th>Member State</th>
<th>Education Legislative &amp; Policy Framework</th>
<th>Health and SRHR Legislative &amp; Policy Framework</th>
<th>Protection Legislative &amp; Policy Framework</th>
</tr>
</thead>
</table>
| Eswatini     | • Education Act (1981)  
              • Teaching Services Act (1982)  
              • Teaching Service Regulations (1983) | • National Health Policy (2007)  
              • National Health Sector Strategic Plan (2015)  
              • Essential Healthcare Package (2010)  
              • National Gender Policy (2010)  
              • National Strategy and Action Plan to End Violence (2017)  
              • National Youth Policy (2020)  
              • Child Protection and Welfare Act (2012) |
| Lesotho      | • Education Act (2010)  
              • Education Sector Plan (2016–2026)  
              • National Health Strategic Plan (2017–2022)  
              • Domestic Violence Bill  
              • Sexual Offences Act (2003)  
              • Children’s Protection and Welfare Act (2011)  
              • National Youth Policy (2008) |
              • Decree No. 2009–1147 on inclusive education | • Law concerning HIV and AIDS (2005)  
              • Integrated Strategic Plan for Family Planning and Contraceptive Security (2016–2020)  
              • Madagascar National Policy on Community Health (2009)  
              • Law on General Rules Governing Reproductive Health and Family Planning  
              • Law on the rights and Protection of Children (2007)  
              • Law on Marriage (2007) |
| Malawi       | • Education Act (2013)  
              • Public Health Act (1948)  
              • Child Care, Protection and Justice Act (2010)  
              • Prevention of Domestic Violence Act (2006)  
              • National Youth Policy (2018) |
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<tr>
<th>Member State</th>
<th>Education Legislative &amp; Policy Framework</th>
<th>Health and SRHR Legislative &amp; Policy Framework</th>
<th>Protection Legislative &amp; Policy Framework</th>
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</table>
| Mauritius    | • Education Regulations (1957)  
• Education Amendment Act (2011) | • Public Health Act (2009)  
• National Health Sector Strategy (2017–2022)  
• Protection from Domestic Violence Amendment Act (2016)  
• National Gender Policy Framework  
• National Youth Policy (2016) |
| Mozambique   | • National System of Education Act (1992)  
• Integrated Package of Services for Youth (2010)  
• National Family Planning, and Contraceptives Strategy (2010)  
• Domestic Violence Act (2009)  
• National Plan of Action for Adolescent and Youth Development (1998-2001)  
• Law on Decriminalisation of Abortion (2019)  
• National Policy on Youth and Implementation Strategy (2016) |
| Namibia      | • Education Act (2001)  
• Basic Education Act (2020)  
• Sector Policy on Inclusive Education (2013)  
• National Policy for Reproductive Health (2001)  
• Combating of Rape Act (2010)  
• Child Care and Protection Act (2015)  
• Children’s Status Act (2005)  
• National Gender Policy (2010–2020)  
• National Youth Policy (2006) |
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<th>HEALTH AND SRHR LEGISLATIVE &amp; POLICY FRAMEWORK</th>
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<td>• National Gender Policy (2014)</td>
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Governments’ commitments to protecting and promoting the rights of youth are reflected in some positive trends towards setting in place dedicated SRHR strategies. Of the sixteen SADC Member States, fourteen have standalone policies and guidelines on SRHR, while twelve give adolescents’ access to SRHR services in education and health systems.  

All Member States have an education act or policy focusing on increasing primary and secondary-school enrolment, while thirteen have standalone GBV policies, and fifteen have comprehensive policies on HIV&AIDS. Regarding protection, eleven Member States have legislation or policies on sexual and GBV, and fourteen have anti-trafficking legislation. Comprehensive children’s acts exist in twelve Member States, while eleven have dedicated youth policies.

The analysis shows that in the SADC Region, there are areas with strong legislative and policy frameworks such as SRHR, GBV and HIV&AIDS prevention, while for a certain cluster of youth, rights legislation and policies remain inconsistent with international standards. For example, the region is yet to record progress in the universal revision of laws on the minimum age of marriage to 18. The DRC, Seychelles and Tanzania have a discriminatory minimum age of marriage set at 15 for girls and 18 for boys. Across Member States, the contradictions in legal provisions relating to the minimum age of sexual consent contribute to the poor SRHR outcomes for adolescents.  

While in most Member States the legal age of consent is 16 for both boys and girls, in Mozambique and Seychelles it is 18, while in Namibia and Madagascar it is 14. Angola, the DRC and Tanzania apply different ages of sexual consent for boys and girls: 18 for boys, while girls are legally able to consent to sex at 16, 14 and 15 respectively. Such gender distinctions perpetuate harmful practices that negatively affect the girl child and suggest cultural acceptance for young adolescent girls to be partnered with older males, whether consensual or not.

In line with UN and AU instruments on health and gender equality, the SADC Strategy on SRHR (2019–2030) urges Member States to review and adjust their legal frameworks to provide an enabling environment for adolescents and young people to access SRHR. The strategy states that the legal age for marriage should be set at 18 for both males and females, it also stresses that Member States should take into account the evolving capacity of adolescents and young adults when reviewing the legal frameworks on the age of consent for sex, which should be set at 16.

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* Angola and the DRC do not have specific SRHR policies.
Member States are encouraged to remove age restrictions on the right to access services—including contraceptives, HIV testing and information—so that all adolescents can “access youth-friendly integrated SRHR services, including HIV services (testing, counselling and accessing treatment.”

As part of harmonization and implementation efforts, all sixteen Member States have in place institutional arrangements, including ministries responsible for Health, Education, Gender, Youth and Social Development Affairs. These ministries have specific departments and governmental agencies aimed at the provision of education, health and social protection of adolescents and young people. However, despite the presence of such institutional structures at national level, inter-ministerial coordination for improved outcomes for children and youth remains a challenge, which is coupled with limited budget allocation to address education, health (including SRHR), social protection and protection needs of adolescents and young people.

3.2 SADC economic outlook

Negative economic growth trends exacerbating vulnerability

The COVID-19 pandemic is far more than a health crisis. It is affecting societies and economies at their core. While the impact of the pandemic will vary from country to country, it will most likely increase poverty and inequalities, particularly among young women, girls, youth with disabilities and those from families living in lower-income quintiles. In Africa, Southern Africa is the region that was hardest hit by the pandemic, with an economic contraction of 7.0% in 2020, while the African Development Bank estimates that about 39 million sub-Saharan Africans could fall into extreme poverty in 2021 if appropriate support is not provided, with disproportionate effects on the most vulnerable. Government revenues are expected to fall drastically due to the disruption of economic activity, which is coupled with elevated government expenditures amid historical debt burdens. The fiscal position for SADC Member States will be worsened, with fiscal deficits forecasted to widen to 5.7% of GDP in 2020 compared to the previous 2020 estimate of 3%.

The economic contraction reflects macroeconomic impacts arising from the sharp decline in output growth among the region’s key trading partners (including China), the fall in commodity prices and reduced tourism in Member States (particularly Botswana, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania and Zimbabwe), as well as the effects of other austerity measures to contain the coronavirus pandemic.

**Box 1: Dr Lamboly Mbukumbeko—SADC Secretariat**

“Like the rest of the world, SADC Member States health-systems were not prepared for a pandemic of such magnitude. When the COVID-19 was declared a public emergency, only two laboratories in [the] SADC Region had COVID-19 testing capacity. As weeks progressed other countries accelerated mass testing. As governments and SADC, we need to reflect on how to better prepare for potential crises as part of efforts to building resilient health systems in the region.”

The ban on international travel and cross-border closures will have negative consequences for not only the tourism sector and cargo flows but also cross-border traders—formal and informal. Informal cross-border trade is a significant feature of regional trade and international mobility in Southern Africa. It generates substantial income and employment in the region,
allowing vulnerable populations to access goods and services that are key for their economic and social recovery—thereby playing a critical role in poverty alleviation, food security and household livelihoods. Demographically, women and youth constitute a significant proportion of informal cross-border traders in the SADC Region, and thus the border closures will disproportionately affect them.

As of December 2020, per capita GDP had declined by at least 10% in Botswana, DRC, Eswatini, Malawi, Seychelles, Zimbabwe, with declines of 5.8%, 4.9% and 3.3% for Namibia, Zambia and Mozambique respectively. In 2020, revenue falls for key exporters of fuels in the region such as Angola (-4.5%), and DRC (-2.3%) were recorded. In Angola, the crisis has added to existing vulnerabilities, where real GDP is now projected to shrink for a fifth consecutive year. Other resource-intensive economies are estimated to have contracted by 4.7% in 2020 because of a drop in metal and mineral prices due to lower demand, Botswana (-8.9%) and South Africa (-8.2%) were the hardest hit in the SADC Region.

Furthermore, debt levels for SADC Member States are projected to increase beyond the regional threshold of 60% of GDP to 69.8% in 2020, thereby exacerbating the unsustainable debt burden, which impedes prioritization to much-needed health, education, infrastructure and social safety net expenditures.

The pandemic’s impacts have reversed hard-won gains in poverty reduction and inclusive growth. COVID-19 is estimated to have increased the proportion of people living on less than US$1.90 per day by 2.3 percentage points in 2020 and by 2.9 percentage points in 2021, leading to “extreme poverty rates” of 34.5% in 2020 and 34.4% in 2021. Most of the people falling into extreme poverty are those with lower levels of education and fewer assets, those in vulnerable employment and informal jobs, low-skilled workers, and those already in precarious situations (such as households affected by locust invasions or drought). These population groups in Southern Africa are significantly exposed because they often work in contact-intensive sectors, such as retail services, or in labour-intensive manufacturing activities with fewer opportunities to socially distance or work from home. The increased poverty rates are recorded at a time when SDG implementation, which should be gaining momentum during this decade, will slow down, thereby putting many Member States off target. Furthermore, reduction in social protection programmes means more vulnerabilities. Significant job losses, particularly in the informal sector where job protection is weaker and levels of inequalities—already very high in Southern Africa—will continue to increase.

The negative economic outlook is projected not only at macro-level (national level) but is being experienced at family level, as confirmed by 62% of youth respondents. COVID-19 will push more children into poverty or increase the depth of poverty experienced by children already living below the poverty line. Lockdown and quarantine measures to contain the pandemic are affecting families’ ability to sustain their livelihoods and make ends meet. Findings indicate that COVID-19 has threatened households’ livelihood, access to markets and food security. Many young people reported that either one or both of their parents [caregivers] had lost their only source of income due to the lockdowns, therefore reducing household income. Young people in Lesotho, Malawi and Zimbabwe highlighted that due to loss of household income some families could only have one meal a day. Among the youth respondents who reported

*In this report, “caregivers” include parents, other members of the family, guardians or other adults who provide daily care to the learner.
having trouble paying for essential items due to income loss caused by COVID-19, 71% reported that they are struggling to buy food and essential household items.

Families are struggling to pay for children’s essential needs. As a result of income loss, caregivers in the SADC Region are struggling to cater for essential needs (such as food, healthcare and rent), which also impacts children and other members of the household.

**Figure 4: Reported loss of household income since start of pandemic (Youth responses)**

The findings indicate that COVID-19 has threatened livelihoods, access to markets and food security for those surveyed. This complements a Food and Agricultural Organization (FAO) and World Food Programme (WFP) report warning that hunger threatens to soar to devastating levels in Member States such as DRC, Mozambique and Zimbabwe in the coming months. In addition to the loss of income and livelihoods, the report confirms that the COVID-19 pandemic has exacerbated barriers to food access. More than half (52%) of respondents said that food is too expensive, while market closures were mentioned as a barrier by 10% of young respondents.

**Box 2: Young female (16)—Zimbabwe**

“My mother works at the local market. Since the first lockdown in March 2020, she can no longer sell her produce. Before the lockdown, we managed to eat two meals a day—breakfast and supper. However, because my mother does not have money right now, we are now having one meal a day. Sometimes I feel hungry in the afternoon, and when I open the fridge to look for something to eat she shouts at me.”

The economic recovery for both households and governments will be a long road in SADC Member States. However, the focus for governments and other actors should be to build resilience to ensure young people do not further lose out on access to education, health, including SRHR, and to protection from violence, abuse and exploitation. More importantly, reaching the most marginalized and deprived is a critical focus for adolescents and youth rights and building back better from the COVID-19 pandemic.
3.3 Financing of child wellbeing before COVID-19

The wellbeing of adolescents and young people is an essential indicator of a country’s vitality, its prospects of economic growth and human development. It also means that a country is making progress towards meeting the SDG targets. According to the United Nations Children’s Fund (UNICEF), if children are doing well, chances are high that parents and caretakers are doing well, and the economy is also doing well. Such a positive scenario also means that the human capital base is strengthened, which can drive future productivity, innovation and economic growth, while creating opportunities for individuals to improve their lives and the lives of their families.

Before COVID-19, there was slow economic growth and incremental progress towards poverty reduction in SADC, although with noticeable disparities between Member States. However, due to COVID-19, SADC is experiencing a dual public health and economic crisis that is overwhelming healthcare systems, destroying livelihoods, disrupting education and slowing the region’s growth prospects for years to come. The region is also witnessing simultaneous threats on child-wellbeing outcomes as a result of the economic downturn caused by COVID-19, but more so due to historical underinvestment in key sectors affecting children and young people. The current crisis could therefore erase years of development gains made in the region.

Sub-Saharan countries such as Zambia, DRC, Mozambique and Tanzania recorded low performances in child wellbeing and human capital indices, as reported in the 2018 and 2020 African Reports on Child Wellbeing conducted by the African Child Policy Forum. Approximately 40% of children did not have access to clean water or adequate nutrition, while close to two out of every three children did not have access to basic sanitation and had no hope of acquiring even basic skills from school; close to half were living in households that could not meet minimum consumption needs. The Sub-Saharan Africa Child Wellbeing Report indicates that at least 80% of children were deprived in at least two wellbeing indicators in five SADC Member States—Angola, Comoros, the DRC, Eswatini and Tanzania. Before COVID-19, monetary poverty affected numerous children in the region, thereby contributing to the high incidence of wellbeing deprivation. Figure 5 illustrates the multi-dimensional and monetary poverty for children between the ages of 0 and 17 in SADC Member States, before the COVID-19 pandemic; the DRC and Eswatini, for example, have high rates of children who are considered both multi-dimensionally and monetarily poor. Sub-Saharan Africa has both the highest rates in the world for both children living in extreme poverty, at just under 45.8%, and the largest share of the world’s extremely poor children, at 65.8%.

* Health, nutrition and education were three of the most widespread deprivations experienced by adolescents and young people.
Overall, child wellbeing indicators in the SADC Region are closely related to efficient and equitable budget allocation and spending in key sectors such as education, health, nutrition, water, sanitation, social protection and child protection. The level and quality of investments in young people through these critical social sectors broadly indicate systemic implementation of regional and international human rights commitments made by a Member State. Governments’ budgetary commitments to young people are measured by examining the proportion of financial resources (from either foreign or domestic sources) devoted to sectors and programmes benefiting young people relative to national income. Such measurements show the extent to which governments are using the maximum available resources to improve the situation of young people.

Investing in young people’s wellbeing is not only right in principle but also right in practice: it has significant pay-offs in terms of economic growth and social stability. Investments in education and health develop human capital and can lead to greater productivity—a critical component of stronger economies. There are indirect impacts on economic growth too because adolescents’ education contributes to a country’s productivity. Focusing resources on the most marginalized young people can also contribute to reducing inequality and foster greater social cohesion.

While national contexts are diverse, international and regional benchmarks are crucial reference points for promoting development. The Addis Ababa Action Agenda encourages states to set nationally appropriate spending targets for education. The Incheon Declaration recommends an allocation of at least 4% to 6% of GDP to education and/or that governments allocate at least 15% to 20% of public expenditure to education. The most recent data on education budgets revealed that Botswana, Eswatini, Lesotho, Mozambique and South Africa spent relatively higher percentages of their GDP towards education (average of 9%); on the
other hand, Comoros, DRC Madagascar spent less than 3% of government expenditure on education.

While many African governments do allocate a substantial share of available resources to education, the amount spent relative to the size of the learner population remains low. The average amount spent per learner in Africa is only US$533 for primary and US$925 for secondary school. With an already precarious education financing trajectory, COVID-19 has exacerbated education financing and equity in spending for the most vulnerable youth.

Figure 6 shows that before COVID-19, sub-Saharan African governments spent only 2% on pre-primary education, with 37% on primary education, and a significant 37% on secondary education, with the remainder directed towards higher education and tertiary education. Southern African countries can close significant gaps in education and training if they prioritize universal foundational skills by improving literacy, numeracy, socio-emotional skills, and life skills of children and young people. UNESCO, GPE and United Nations Development Programme (UNDP) confirm that investments in lower levels of education financing improve transition and retention rates. The gaps in investments in the early years are compounded by the low quality of schooling in basic education, as revealed by teacher absenteeism and deficiencies in subject knowledge. Effective teaching—the most critical determinant of learning—is lacking in many Member States in the region. This strategy requires focusing on investments in the early years and inputs that matter most for education quality, specifically investing in effective teaching, not merely hiring more teachers or erecting more buildings.

![Figure 6: Percentage of Total Education Expenditure by Level](image)

*Source: Author’s Analysis of UNESCO Institute for Statistics for information on enrolment, student progression on education financing, World Bank data on education Financing & GPE data on education sector financing*
In addition to education financing, funding for social protection is an effective investment approach towards improving wellbeing, thereby realizing the rights of adolescents and young people. Social protection programmes, such as cash transfers, play a pivotal role in preventing multiple deprivations. UNICEF, ILO and Save the Children International note that social protection has added benefits of increasing household purchasing power, improving food expenditure and supporting school enrolment and retention. They can further contribute to addressing the underlying economic causes of violence, exploitation and abuse. They have also proved to be effective response measures that reduce GBV so that young women can increase their decision-making power and support women and girls to forge stronger social support networks.

A review of the existing legal and policy landscape shows that all sixteen SADC Member States had a policy framework on social protection prior to COVID-19, and with support from development partners each country was rolling out a social protection scheme. However, despite the numerous social protection schemes in place to cushion young people from risks and shocks, when the COVID-19 pandemic hit, Member States were unable to meet the social protection needs of the most vulnerable youth.

Social protection coverage before COVID-19 was low, with few families benefiting from the various social protection schemes before the crisis. This indicates that strong safety nets have been a persistent fiscal challenge in the region. Before the COVID-19 pandemic, Angola, Mauritius, Namibia, Seychelles, South Africa and Tanzania spent between 6 to 10% on social protection, while very little investment (as low as 0.7% of GDP) was made by Comoros, Madagascar, Malawi and Zambia on social protection (Figure 7).
As signatories to the ACRWC and UNCRC, SADC Member States are obliged to ensure young people enjoy the highest standard of healthcare. Fulfilling these obligations requires significant public spending on healthcare, in line with the Abuja Health Financing targets of 15% of annual budget allocations towards the health sector. Figure 8 below shows that Zimbabwe and Madagascar have successfully met these health expenditure targets set in 2001, while Botswana and South Africa are on track to achieving the target. However, in the DRC, Comoros and Mozambique, expenditure is less than 5% of their national spending towards health.

The average health expenditure rate for the region stands at 9.6%, indicating fragile financing systems that are unable to adequately respond to a global health pandemic such as COVID-19. Inadequate health financing during COVID-19 will set back the treatment and control of diseases such as TB, HIV&AIDS and malaria in the Southern Africa region, which carries the highest burdens of these diseases.
States with strong and resilient health and education systems are better equipped to respond to crises. The COVID-19 pandemic has made it glaringly clear that there are significant gaps that exist in health and education systems in the SADC Region. The pressure exerted on health systems during the pandemic has exposed a lack of preparedness and capacity in many Member States, which has direct and indirect consequences for young people. This was confirmed by 84% of adult respondents, who believed most Member States were ill-prepared to address the effects of COVID-19, financially and programmatically. The pre-COVID-19 investment trends in SADC heavily underlines the need to invest more in health and education infrastructure and to improve social protection coverage. Historic underinvestment in key wellbeing sectors weakens a state’s ability to respond to a pandemic of this magnitude.

3.4 Initial responses to COVID-19

**SADC COVID-19 measures**

At the initial time of writing (February 2021), eleven months had passed since COVID-19 was first detected on the continent in March 2020. The rate of infection remains on a high scale in several Member States, with 1.8 million reported cases. According to the African Centre for Diseases Control, Southern Africa currently records the highest case load on the continent; South Africa carried the highest burden of infections (83%) with 1.5 million cases, followed by
Zambia (73 467 cases or 4% of infections), Mozambique (53 527 cases or 3% of infections) and Namibia accounting for 36 680 cases, or 2% of the infections.

Figure 9 shows the reported number of COVID-19 cases in SADC Member States at 19 February 2021.

The situation necessitated an urgent need for SADC Member States to institute restrictive measures aimed at containing COVID-19. In response to the rising concerns about the rapid spread of the virus, Member States took preventive measures as soon as COVID-19 cases were reported by instituting various stringent measures. These measures included: public health measures set out in national COVID-19 response strategies/policies; monetary and fiscal measures; restrictions on travel and human movement; trade measures; school and workplace closures; restrictions on private gatherings. As illustrated in Figure 10 below, between March and September 2020, ten Member States had imposed either full or partial lockdowns on the movements and activities of their citizens. South Africa went on full lockdown on 26 March 2020; Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, Zambia and Zimbabwe soon followed. In Malawi, the government’s directive to institute a lockdown was blocked by the public through a court judgement: citizens opposed a full lockdown due to serious concerns about the negative impact it would have on livelihoods in a country where the poorest population is employed largely by the informal sector, and where there were no government economic stimulus efforts to provide adequate safety nets to protect the poor.

Various Member States, including Lesotho, Namibia, Seychelles and South Africa, instituted restrictions on international travel.
The lockdowns were effective at mitigating the spread of COVID-19 in the region. However, as confirmed COVID-19 cases increased, Member States tightened the lockdown measures. On average, it took a month for most SADC Member States to achieve full lockdown.

The African Development Bank’s regression analyses of COVID-19 infections and the stringency of lockdowns and other covariates (such as social distancing measures, public information campaigns on personal hygiene, improved water, sanitation facilities, increased testing and contact tracing) revealed that the stringent lockdowns reduced COVID-19 infections, with the effects of lockdowns being evident 30 days after implementation. However, despite being effective in reducing the rate of infections, African countries such as Botswana, the DRC, Namibia and Zimbabwe that instituted strict lockdown measures recorded sharper economic contractions in 2020. Lockdowns can have serious economic consequences because they disrupt economic activities, livelihoods, and movement. In the Southern African context, the marginal impact of imposing more stringent lockdown measures was generally low because they were difficult to enforce. For informal sector workers, staying home means potentially losing their jobs and livelihoods, leading to the dilemma of choosing between suffering from hunger at home and going to work, thereby risking exposure to the coronavirus.

The pandemic will therefore have long-term implications for human capital development. Millions of learners have already lost a full year of learning, with poor communities disproportionately affected. Disruptions in routine essential healthcare services—such as malaria prevention and treatment, vaccinations, and maternal and child health services—have resulted in a secondary health crisis. Furthermore, a disproportionately high rate of pandemic-induced job loss and livelihood damage among women will degrade human capital through lower investment in children’s and young people’s health, nutrition, and education. Unless
there are effective remediation policies, adolescents’ and young people’s lives will be significantly affected.

Building resilience and accelerating recovery through economic stimulus policies

**Box 4: Male Learner (16)—Zambia**

“We have been locked down for almost two months now. Our government was very wise to let us stay at home. My father and older sister are no longer employed due to corona, and there are a lot more people in the same situation in my community that need money to feed their families. We need help from the government and other organisations.”

The pandemic has exposed the economic vulnerabilities of many African countries. Now the pandemic appears to be abating due to accelerated vaccination campaigns, the focus of governments should be to reopen economies safely, accelerate recovery and reduce economic vulnerabilities particularly for the most vulnerable (children, youth, women, those with disabilities and the poor).

SADC Member States have introduced economic stimulus packages in response to COVID-19, as illustrated below.

**Table 4: National COVID-19 recovery strategies**

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<th>Member State</th>
<th>Monetary Stimulus</th>
<th>Social Protection Expansion</th>
<th>Business Stimulus</th>
<th>Health Systems Strengthening</th>
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**Source:** ILO & UNECA Socio-Economic Impact of COVID-19 in Southern Africa (2021)

The fiscal stimulus measures, though varying in extent and intensity, have included increased spending in the health sector, the establishment of relief funds and wage subsidies; monetary
measures have included interest rate cuts, loan deferrals and restructuring, adjustment of reserve requirements and the reduction in discount rates and liquidity requirements—all designed to lower the cost of borrowing. For example, Botswana established a BWP2 billion (US$190 million) fund to support industry; South Africa announced a ZAR500 billion (US$26 billion) package for businesses in distress; Zambia introduced a ZMW10 billion (US$445 million) fiscal stimulus package for industry; Zimbabwe announced a ZWL$18 billion package to support business (US$50 million). The packages are in addition to many other strategies employed to support economic revival. Three Member States—Mauritius, Namibia and South Africa—developed systematic and diversified COVID-19 recovery plans with coordinated strategies focusing on health system strengthening, public awareness, provision of social protection schemes and stimulus for businesses.

Box 5: Case Study—South Africa (COVID-19 Relief Measures)

President Ramaphosa Announces COVID-19 Economic and Social Relief Measures (21 April 2020)

South Africa imposed restrictions on social mobility and interaction, with a five-week stringent national lockdown between 27 March and 1 May [2020], followed by a risk-adjusted, five-phased reopening of the economy. Inevitably, such stringent measures would have a significant impact on losses to individuals and households. The pandemic-related shocks to employment, working hours, and earnings among low-wage and vulnerable workers exacerbated the already high levels of poverty and inequality in South Africa.

On 21 April 2020, the President, Cyril Ramaphosa, presented the government’s Economic Reconstruction and Recovery Plan to restore the South African economy following the devastation caused by the COVID-19 pandemic. The announced stimulus package, amounting to US$26 billion (10% of GDP), would provide additional health support, assistance to municipalities for the provision of basic services, wage protection through the Unemployment Insurance Fund, further income support through the tax system, financial support for small and informal businesses, and—the largest component—the credit guarantee scheme.

Notably, 10% of the stimulus package, or US$3.2 billion, was allocated to social assistance, including an expansion of cash transfers or social grants including the child support grant and a new, special COVID-19 Social Relief, reaching thirteen million children and eight million caregivers. The stimulus package has surpassed global standards and the reach in terms of support to the poor and vulnerable has been impressive. As South Africa continues to focus on COVID-19 recovery in 2021, social protection programmes for young people at risk of losing out on education, health and protection must continue to target adolescents and young people.

Source: Bhurat & Kholer’s Lockdown Economics in South Africa: Social Assistance and the Ramaphosa Stimulus Package

3.5 Recommendations

Despite the presence of comprehensive legal and policy frameworks on children and youth rights, before the COVID-19 pandemic the SADC region was already facing formidable challenges in fulfilling education, health and social protection commitments. Due to historic under investments in youth sectors, the ramifications of the COVID-19 pandemic have undoubtedly been catastrophic as Member States grapple with disease containment and
education continuity, while ensuring that citizens are not worse off economically and socially. When factoring in the compounding effects from COVID-19, alongside the high levels of pre-existing vulnerabilities, there is no question that young people are being impacted by increased levels of multi-dimensional poverty, lack of quality education and restrictions on access to healthcare, including SRHR. To build resilience for young people in the region, governments are called to re-think their financing priorities to ensure the promotion of the protection of young people’s rights in line with international standards.

National government authorities and the international community need to protect the provision of education, health and social protection for adolescents and young people by:

- Urgently undertaking legal and policy reform on existing discriminatory laws of sexual consent and marriage that limit the full protection of children and youth
- Prioritizing public investment in children and youth by creating more fiscal space for child and youth focussed sectors, including education, health, social protection and child protection

Where there is fiscal opportunity or access to liquidity, policymakers should continue monetary support until the expected economic recovery has fully materialized. Once recovery has been achieved, governments should commit to a credible fiscal consolidation path to restore debt and fiscal sustainability post-COVID-19.

- Designing social protection schemes and policies that enable such packages to respond quickly to the urgent needs of children and young people and effectively address future shocks

SADC governments should institute governance reforms to enhance the efficiency of public spending and to block leakages to ensure social protection schemes reach their intended targets. Good governance remains paramount for an effective response to the crisis. Member States must implement governance reforms to rebuild and strengthen trust in public institutions.

- Accelerating the digitalization of services including health and education to reduce disruptions in social services provisions through investments in digital infrastructure and to facilitate the rollout of e-learning and e-commerce platforms for business and other economic activities to continue

African policy makers therefore must turn the COVID-19 crises into opportunities by focusing on improving access to education and strengthening healthcare and social protection systems.
CHAPTER 4: Impact on Adolescents’ Access to Education

This section examines the impact of the COVID-19 pandemic on access to education for adolescents as a critical wellbeing indicator. It starts by assessing the projected impact of school closures on education outcomes in the SADC Region, the teaching and learning approach implemented to ensure learning continuity during the pandemic, and the socioeconomic inequalities brought about because of the crisis. It concludes with recommendations to address the education concerns identified during this pandemic.

Key findings

- The school closures have impacted 127 million learners in Eastern and Southern Africa.
- One million girls in sub-Saharan Africa are at risk of not returning to school because of falling pregnant. COVID-19 has brought challenges for young people leading to an increase in early pregnancies by as much as 65% in SADC Member States.
- The weeks of school closures in SADC mean learning will decline and dropouts will increase, especially among the most disadvantaged. The projected school dropouts could wipe out gains made in reducing the number of out-of-school young people by 25% since 2012.
- For the most vulnerable young people, including those with disabilities and those living in poor or marginalized communities, education is lifesaving. Beyond the classroom, schools are spaces of support, providing young people with nutrition through school meals, as well as critical psychosocial and SRHR support for their wellbeing and healthy development.
- CSE provided in schools is a critical support and service for adolescents and young people. Governments and CSOs should invest in innovative, digitally-based and remote SRH information and services for adolescents and young people.
- Bridging the digital divide is crucial for SADC’s development. The limited access to mobile phones and internet connectivity is widening the education gap, particularly for girls living in rural and remote areas. Governments should improve e-governance by investing in modern ICT infrastructure and supporting the education sector to use blended approaches to teaching and learning to suit learner needs.
- As the COVID-19 curve of infection flattens, governments are called upon to urgently and safely open schools, focusing on equity-based access to education to ensure that SADC is truly building back better by leaving no one behind.

4.1 Impact of school closures on young people

The effects of the COVID-19 pandemic and related school closures on education provision, learning and wellbeing are severe for most children. The pandemic has caused an unprecedented disruption of education systems globally, affecting the lives of more than 1.5 billion learners and their families. As part of stringent measures to protect young people from contracting and spreading the virus, all SADC Member States instituted partial or full school
and tertiary institution closures. The school closures impacted 127 million learners in Eastern and Southern Africa. When considering the low levels of education of most caregivers in the region and the limited resources to support home-based learning, the study review shows that learning completely stopped for most young people, at least for some period. Even in instances where the disruptions were short-term in Member States such as Madagascar and Seychelles (see Table 5, below), learning gaps will still have severe, lifelong consequences for youth. School interruptions even for weeks can have a significant impact on future income-earning potential. Even more worrying is that many learners will end up as permanent dropouts, adding to the 100 million young people who were already out of school before the pandemic. There is a growing concern that if learners are not properly supported, some may never return to school. This would further worsen pre-existing disparities, thereby reversing progress on SDG 4.

In 2020, the World Bank identified three possible scenarios for the loss of learning that could result from prolonged school closures. These included a reduction in average learning levels for learners, a widening of the distribution of learning achievements due to highly unequal effects of the pandemic, and a significant increase of learners with very low levels of achievement, due in part to massive dropouts. Almost all (92%) the interviewed Ministry of Education officials from Lesotho, Madagascar, Malawi, Namibia, Zambia and Zimbabwe confirmed these scenarios at national level. They emphasized that more learners may fall below the basic average scores necessary for foundational learning skills (literacy and numeracy). The prolonged school closures (more than five months) were likely to lead to learners falling far behind, heightening the risks of primary and secondary school dropouts even when schools eventually fully re-open across the region.

**Box 6: Author’s overall analysis of data collected**

An entire generation’s education has been impacted by the COVID-19 pandemic, with some moving to distance learning as schools remain closed and others receiving no formal education at all. The impact of this will last far longer than the duration of the pandemic. Four in five government education respondents in Lesotho, Madagascar, Malawi, Zambia and Zimbabwe believe that children in their countries have learnt little or nothing since schools closed, and millions face never returning to school once they reopen.

Almost all SADC Member States closed schools for a protracted period because of COVID-19. During the 2020 academic year, schools were closed for more than a hundred days, an estimated full semester’s worth of education for children in the region. The school closures obviously meant physical learning and teaching was not possible.

As illustrated in Table 5, Schools closed for at least 31–40 weeks in four Member States—Comoros, Eswatini, Lesotho and Mozambique. The DRC, Namibia and Zimbabwe closed schools for 21–30 weeks; Botswana, Madagascar, South Africa, Tanzania and Zambia closed them for 11–20 weeks. At the extremes, Malawi, Mauritius and Seychelles closed schools for the shortest periods (less than ten weeks), while Angola closed schools for the longest—more than 40 weeks.

Schools and tertiary institutions were closed for a minimum of 60 days in fourteen of the sixteen SADC Member States. UNESCO figures project that two-thirds of an academic year...
was lost on average globally due to COVID-19 school closures. Because of the school closures in the SADC Region, learners cumulatively lost an average of 66% of their academic year since the onset of the pandemic (2020).

Even though schools were closed, the education sector in most Member States tried to mitigate the loss of physically learning by instituting virtual or hybrid classes for learners; however, most learners could not fully access learning through these platforms, and most learners did not go back to school in 2020. During the period June to December, Lesotho, South Africa, Zambia and Zimbabwe started re-opening schools, prioritizing external national examination classes. However, due to spikes in new infections, by January 2021 these four Member States re-instituted school closures, thereby increasing the weeks spent away from school and exacerbating the lack of education delivery that was already under threat. Decisions to open school were primarily informed by the level at which the curve of COVID-19 infections appeared to be flattening, and the readiness of the education sector to provide safe learning.

Almost all learners interviewed and surveyed (98%) who were attending school before COVID-19 reported that their schools were completely closed (i.e. not open for either in-person or remote learning). Only 2% reported that their school was open for in-person attendance.

### Table 5: Duration of Partial and Full School Closures in SADC Region (weeks)

<table>
<thead>
<tr>
<th>Duration of School Closures</th>
<th>Member State</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1–10 weeks</td>
<td>Malawi; Mauritius; Seychelles</td>
</tr>
<tr>
<td>11–20 weeks</td>
<td>Botswana; Madagascar; South Africa; Tanzania; Zambia</td>
</tr>
<tr>
<td>21–30 weeks</td>
<td>DRC; Namibia; Zimbabwe</td>
</tr>
<tr>
<td>31–40 weeks</td>
<td>Comoros; Eswatini; Lesotho; Mozambique</td>
</tr>
<tr>
<td>41+ weeks</td>
<td>Angola</td>
</tr>
</tbody>
</table>

Beyond the number of weeks that schools were closed, it is also important to understand how much learning was lost. The protracted school closures will adversely affect educational outcomes such as test scores, test score-adjusted years of schooling, and transition and dropout rates. While the full impact of the school closures on learning may not be known for several years, UNICEF predicts that a combination of school closures and the loss of family livelihoods caused by the pandemic will have immediate adverse effects on children’s and young people’s attainment of foundational skills, resulting in an average learning loss of 0.3–0.9 quality-adjusted years of schooling. This will reduce learning achievements that learners typically gain during their lifetime from 7.9 to between 7.0 and 7.6 years.

The loss in learning outcomes is expected to be worse for girls, learners in poorer communities and young people with disabilities, thereby exacerbating gender and income inequality in learning. Identifying the prevalence and scale of such learning loss is key to designing preventive and corrective educational remedial interventions. As learners finally return to school across the region, there is an urgent need to use school-based assessments to assess
learners to inform remediation efforts combined with ongoing adaptation of school instruction to children’s learning levels.

**Box 7: Male Learner (17)—Malawi**

“Really COVID-19 has disrupted plans for my future. I was supposed to write Malawi Examination Board in July 2020 but it has been scheduled to September 2020. Some are even saying that these dates will change again. I really do not know if I will write my national exams and move to the next stage. Access to education is really harder now.”

4.2 Approaches to continuing education during school closures

As a first step towards mitigating the potential negative effects of the COVID-19 school closures on learning, SADC Member States chose diverse policy responses to provide remote teaching and learning through various approaches.

Online learning platforms were the most commonly-used delivery channel utilized to support teachers, learners and their families. Both youth respondents (82%) and adult respondents (76%) confirmed that government and CSOs provided some learners with computers or tablets as well as internet access, or have organized teaching through television, phones, radio, instructional packages and resources (textbooks, notes, worksheets and printouts). However, the concern raised was that not all learners had the same access to digital learning resources.

As shown in Figure 11 below, in SADC Member States certain learning modalities have been used more than others, depending on education level. Although online platforms were used for teaching and learning, in areas with limited connectivity, governments used more traditional distance learning modalities, often including a mix of television and radio programming and the distribution of printed materials. The quality of these remote education modalities to maintain education outcomes have not yet been fully assessed. Most respondents (67% of adult and 82% of youth respondents) highlighted that it was very likely that remote learning was of a lower quality than face-to-face instruction, confirming the global concern that limited equity-based remote learning could further widen the gap between those who have resources, skills, abilities and adequate support to devote to distance education and those who do not.
For certain education levels, distance-learning came with distinct challenges. In the early childhood development (ECD) sub-sector, for example, Lesotho, South Africa, Zambia and Zimbabwe were able to put in place virtual kindergarten for children aged 3–6. However, several government respondents (45%) reported that these online ECD classes were usually provided by private learning institutions and were riddled with challenges in terms of keeping very young learners engaged, thereby worsening educational inequalities and accessibility to early learning for low-income households. The respondents emphasized that radio and TV learning programmes were preferred options for lower grades (pre-primary and primary) and for learners living in remote areas who could not afford online lessons. In their opinion, these learning modalities offered greater national learner coverage. However, these still had limitations as they were either not regularly scheduled, or many learners in Lesotho, Malawi, Zambia and Zimbabwe did not have access to the radios and TV.

For higher learning institutions, online and paper-based learning were mostly used across the region. Ministry of Education officials interviewed were also concerned about relying exclusively on online strategies that may reach only learners from better-off families. While no remote learning technology can completely replace the classroom learning experience, some have features that allow them to better emulate classroom settings. TV and radio usually require programmes to be pre-recorded, which makes live, interactive lessons impossible. In contrast, digital technology such as the internet, personal computers, tablets and mobile phones may be more suitable for emulating classroom-like interaction—yet they are often not accessible for girls, youth from poor families, those living in rural or remote areas and learners with disabilities.

Language is an important barrier to inclusive education for diverse learner groups, mainly for those from an immigrant background and some indigenous or rural communities. Language is an essential component of educational instruction that guarantees not only improved educational outcomes, but also the wellbeing, sense of belonging and self-worth of these learner groups. Many learners in SADC Member States, especially the youngest and those from minority groups, are not fluent in the language of instruction (usually English).
school closures, some Member States (Angola, Lesotho, Madagascar, Mauritius, South Africa and Zambia) have included a language component in their policy response to foster the inclusion of these vulnerable groups. Focusing on language enhances the accessibility and quality of information and learning materials. Consideration of languages helps to avoid perpetuating existing educational gaps by leaving no one behind. In particular, it can foster the engagement and the sense of belonging of some vulnerable learner groups and their families who may feel left out by the immediate responses to the pandemic.

SADC Member States have also worked on communicating information in different languages on health and education concerning COVID-19. Though less common (only 21%), some Member States implemented initiatives aimed at providing online multi-lingual learning resources to reach the learners who may face language barriers in education. However, learners from indigenous communities in Mauritius, Zambia and Zimbabwe were forced to access the content they could not understand. Learners in these contexts have fewer options for education both online and at home, with only a few of them having access to computers, a stable internet connection, the means to pay for educational language tools, and other resources needed for them to learn in a language they understand. In the survey, 45% of the youth respondents identified with this problem. Learners explained it was very difficult to find online learning resources in local languages, and had to resort to English which was not their first language. They revealed that it was difficult for them to effectively grasp subject concepts in a different language of instruction.

The logistical challenges related to continuity of learning through distance teaching and learning modalities during prolonged closures are substantial. The protracted COVID-19 school closures threaten the implementation of the academic calendar, the sitting of national examinations and the assessment of distance learning.

4.3 Clicking but not learning

Challenges experienced by learners

Government, schools and learners across the SADC Region showed flexibility and some level of commitment to continue teaching and learning during the school closures, although not all learners could access education consistently. Interviewed learners (59% male, 78% female) shared a common concern that even when remote learning was made available, learners were not consistently attending classes (see Figure 12, below). Learners also reported learning significantly less since the COVID-19 pandemic. Less than 5% of those interviewed felt they were learning as much as they were when attending physical school, although 8% thought that remotely, they were learning a lot more; more than eight in ten (81%) felt they were learning a little, while 6% self-reported learning nothing at all.

When asked why they were not accessing lessons regularly, learners in Lesotho, Madagascar, Malawi, Zambia and Zimbabwe provided varied responses. Most learners in Zimbabwe (80%), Malawi (72%) and Lesotho (65%) reported the following as common challenges to class attendance: high data prices for attending regularly; low to no internet connectivity; lack of caregiver support with homework and communication with teachers on difficult concepts; keeping up with the revised remote learning timetables. The youth respondents’ self-reporting confirmed that learners in Member States with long-duration school closures and that also have low rates of internet connectivity, are most at risk of missing out on learning opportunities
that use internet-based technologies, putting them at severe risk of falling behind with their education.48

During the FGD discussions, learners also reported the following as reasons for not attending remote classes: competing home priorities, particularly increased household chores and support to younger siblings; limited home supervision; personal challenges with self-directed learning, grasping and retention of previously learnt topics in various subjects. They also highlighted teacher absence (due to poor internet connectivity and teacher strikes) as other challenges to learning.

![Figure 12: Young people’s access to remote learning during COVID-19](image)

Although most interviewed learners were able to access some lessons, 69% of government officials in the Member States under review reported concerns related to communication with students and their effective participation in class. They reported significant difficulties in accessing all learners at any given teaching period and challenges in addressing learners concerns after they submitted their assignments and workbooks.

Before COVID-19, the traditional face-to-face pedagogical approach enabled teachers to provide feedback, engage in asynchronous instruction, monitor learners’ progress and gauge their level of understanding. Teachers could provide support where needed through remedial classes and more hands-on support to learners. Most adult respondents (72%) reported that maintaining positive discipline and holding learners accountable for missed homework or incomplete schoolwork proved almost impossible during school closures, and nearly one-third (31%) of education officials stated that teachers in their countries were reporting concerns on providing instruction within the context of remote learning for technical subjects such as Mathematics, Physics, Chemistry and Biology.

Teachers in all the Member States reviewed were required to teach during school closures, and most reported that there were no changes to teacher salaries or benefits. In Zimbabwe, teachers went on strike during the school closures, thereby exacerbating the time of teaching lost.
The government officials highlighted that the provision of learning within the home setting was not always easy as they faced challenges reaching caregivers of struggling learners. In poorly resourced families and some rural areas, even adults in the household who had a mobile phone usually did not have a smartphone, making it difficult to engage consistently with learners using online platforms. But even where smart mobile devices were available, due to low literacy levels, caregivers were unable to fully support their children to utilize ICT applications such as Google Classroom and Zoom. Adult respondents (89%) also confirmed that during the lockdown period caregivers were struggling to meet the teaching support demands at home while pursuing their livelihoods.

Despite significant internet coverage growth in Africa, Southern Africa still faces challenges in improving ICT coverage. According to the International Telecommunication Union statistical dataset (2017), a large portion of SADC residents (74%) still do not have access to the internet, even with the presence of mobile broadband. Most of SADC’s citizens who are not connected to the internet reside in rural areas. At the national level, the internet penetration rates vary widely between Member States—from as low as 1% in the DRC, 10% in Malawi and 40% in Seychelles. The highest rates are in Mauritius and South Africa at 56.5% and
53.2% respectively. Unsurprisingly, these two Member States have the most digitized internet networks and infrastructure.56

The major obstacle in the path of rapid internet growth is the lack of telecommunication infrastructure and exorbitant internet prices. There are few internet service providers per internet users because leased lines are costly, and the burden of costs are often borne by the users through high data prices. While internet use continues to spread, digital divides persist both in access to and use of technologies; this has important implications in the region for the use of digital technologies in education.

Increased digitalization of schooling is likely to widen inequalities thereby intensifying the existing disparities in learning outcomes along socioeconomic and geographic (urban–rural) lines. In most Southern African countries, the majority of the population with internet access is from richer socioeconomic and urban households that can afford private school education, thereby giving children from such backgrounds a learning advantage over their public school counterparts. Learners from poorer socioeconomic backgrounds tend to have limited access to internet connectivity, computers, mobile phones, functional ICT skills and active caregiver support in learning. Moreover, they dwell in rural areas where indigenous languages are dominant and this limits the uptake of ICT-based learning, which is often not provided in local languages. These perceptions were confirmed by young respondents from Zimbabwe (73%), Zambia (69%), Madagascar (62%), Lesotho (60%) and Malawi (60%).

Learners in Zimbabwe reported that to participate effectively in a full-day online class timetable, a learner would require 1.2 gigabytes of data, costing approximately US$13. The situation was similar in Malawi, where learners reported exorbitant prices and weak connectivity and were therefore unable to log into Zoom and Skype lessons effectively. For many learners in the region living on less than $1.91 per day, the costs are far too high to ensure continued learning during COVID-19. The projected estimates are that two out of five learners will miss out on remote learning due to lack of access to the internet and ICT devices.

Learners were asked if they had regular internet access to support distance learning during COVID-19 school closures. The analysis revealed that 51% of female youth respondents and 42% of male youth sometimes had regular internet access. The main digital-specific challenges reported were having access to stable connectivity, electricity and/or devices, having consistent mobile-phone credit and having internet data. Of those interviewed, 37% of the learner respondents reported that the main challenge with learning online was the affordability of phone credit and internet data; 27% reported that access to digital devices was the main challenge they faced, while 24% reporting that electricity was their main challenge. Only 2% reported other issues as challenges for remote learning.

The qualitative responses also showed nuanced differences in learners’ ability to access learning based on the quality of their internet connections, their digital skills/experience and the availability of learning support through a teacher or caregiver. Learners who “sometimes”
had access to the internet were still hindered from learning effectively because of poor internet connectivity, and those who “always” had internet access could not fully participate without an adequate understanding of how the digital learning platforms work.

Figure 14: Internet access for distance learning during school closures (young people’s responses)

The study also examined the types of digital tools that learners had access to aid with their remote learning. As shown in Figure 15 below, 49% of youth respondents had access to a mobile phone to access notes, online classes and to communicate with teachers and peers when possible. This indicates that mobile phones have great potential for connecting learners to information from their teachers and with their peers, yet many learners live in remote locations that are not served by mobile networks.

Given that mobile smartphones were a preferred device in all Member States under review, it is not surprising that poor network connection and an insufficient number of devices to go around the family were reported by 72% of girls and boys as barriers to remote education. Most learners revealed that they depended on their caregivers’ mobile devices to access learning. In most cases, caregivers were not at home during the day when most learning occurred, meaning learners lost out on lessons. In instances where caregivers were home, the learners reported that they had limited time to catch up on subject guidance as caregivers often used the mobile device at the same time. Interestingly, 25% of survey and FGD youth respondents reported that they had no access to a device during the pandemic, corroborating existing literature on the digital divide where disadvantaged populations in the region have limited access to technological devices.

Learners also reflected on the type of learning resources they needed to learn the way they desired while at home. Learners living in high-density suburbs, those living in remote areas and those with special needs were more likely to report that they needed digital tools to access remote learning during the pandemic. Overall, 53% of youth respondents reported that they needed internet-enabled mobile phones, 59% needed access to stable internet and 49% reported that they needed laptops. Only 7% reported they had all they needed (analysed as “I have all I need to learn the way I want”).
The gender-digital divide is pronounced in the SADC Region. Overall, women are 50% less likely to use the internet than men. Boys are 1.5 times more likely to own a phone than girls in low and middle-income countries, and they are 1.8 times more likely to own a smartphone that can access the internet. Even where smartphones and internet are available, the cost associated with using internet data is prohibitively high for many girls; the girls interviewed in the study in Lesotho (37%), Zimbabwe (55%) and Malawi (62%) reported having no access to internet at least three out of the five days of online learning instruction. Female learners highlighted that they relied on their school notes/handouts or their friends who had regular internet access at home.

Gender gaps in education could be a result of girls being unable to participate in online learning due to taking on additional domestic chores, family care and income-generating activities to support the family. Youth respondents from rural areas in Malawi and Zimbabwe confirmed the additional burden of care in addition to not having access to internet and mobile phones to effectively access education. Over and above girls falling behind in their education and experiencing higher dropout rates, school closures can lead to negative effects that go beyond the direct loss of education for girls. Being out of school significantly reduces girls’ social networks, their interaction and support from peers and staff, access to SRH and to safe space, leading to early marriages and early pregnancies.

**Box 10: Female Learner (16)—Lesotho**

“I like Science and Maths because when I finish school I want to be a gynaecologist. Since the lockdown, I am becoming afraid that I will not be able to achieve my dream. I live in the mountain areas and sometimes internet is poor. I miss out on Maths and Science classes when I am at home. When I get the notes, it is so difficult for me to read alone without the teachers’ help. COVID-19 must end so I can see my teachers who help me understand Maths and Science.”

When teachers deliver remote instruction, their capacity to communicate with learners and their families is conditional on them having home internet access. Teachers whose learners had stable and regular access to the internet at home were more likely to have higher
proportions of learners completing assignments and to be in regular communication with a higher proportion of learners' families. The analysis suggests that access to the internet is an important factor for contact with learners and families, irrespective of other characteristics of the learner population within a school. Some youth respondents (22% female and 8% male) reported that they did not have internet at home or access to a device to support learning. Of the adult respondents who reported not having internet access at home, 42% of education officials confirmed that they depended largely on mobile phones to deliver teaching. Education government officials from Lesotho, Malawi, Namibia and Zimbabwe stated that less than half of their learners were able to submit homework, workbooks and school tasks on time, with learners often citing connectivity challenges as the reason for non-submission.

Digital literacy for learners and teachers is increasingly recognized as an indispensable element of children's right to education. The transitional phase from face-to-face classroom learning to remote online learning posed various challenges for teachers as well. Many were not prepared for the transition to online learning, further widening the digital divide as they were not able to teach effectively. Many officials from education ministries (65%) pointed out that not all teachers have specific educational qualifications and experience using ICT. Across the different contexts, the school disruptions showed teachers' anxiety in dealing with online learning applications (Zoom, Skype, MS Teams or Google Classrooms). CSOs that were interviewed reiterated that teachers, particularly those living in rural areas, struggled in the first two months of transition to online learning due to issues with access to the internet, limited digital teaching skills and limited government support for in-service training, as well as data support, as they taught from home.

Caregivers' support to their children is a critical pillar for improving educational outcomes for adolescents and young people. The research examined adult responses to the question on whether caregivers were supporting their children's remote learning. The findings revealed that government officials were mostly convinced that caregivers were making efforts to provide dedicated support to their children during the lockdown (see Figure 16, below). This contrasted sharply with the perceptions of the CSOs from the Member States under review that were interviewed: they thought that caregivers provided very little support to learners. They attributed the limited caregiver involvement in teaching and learning mainly to caregivers' additional burdens due to work-from-home measures, loss of income, limited knowledge of the subject matter or lack of experience or technical savviness in using digital platforms and mobile application to support children's online and remote learning.

Discussions with CSO and government respondents also revealed that, unsurprisingly, children whose caregivers had low to no literacy and numeracy skills were most likely to face difficulties at home in terms of caregiver support. The analysis indicates that caregivers who had attained above secondary education were more likely to support their children's remote learning, thereby improving learning outcomes. Beyond educational levels, the qualitative responses showed that caregivers' ability (or inability) to afford an internet connection, multiple or sufficient ICT devices, constant electricity and private tuition or home tutors, influenced how well they could support their children's learning during the pandemic. This was further corroborated by 56% of young respondents who reported not having any school help from caregivers, making it difficult for them to grasp certain subject concepts. Learners in Madagascar, Malawi and Zimbabwe mentioned that some caregivers had paid for extra
lessons to bridge the learning gap—although not all caregivers could afford extra lessons for their children.

**Figure 16: Caregivers’ Support for Young People’s Remote Learning during Lockdown (CSO and Government Respondents’ Views)**

These gaps mean that children from better-off families are not only getting a higher quantity of home learning, they also have access to potentially higher-quality support from schools and from their caregivers. In addition, the activities that children from better-off families are doing may require less caregiver support because they involve a more active engagement with teachers and tutors. It is almost certain that these factors will coalesce to widen an already prominent attainment gap between children from poorer and better-off backgrounds in Southern Africa. Unless there is a concerted effort to help children from poorly resourced communities once schools reopen, these wider gaps may well become permanent.

**Box 11: Dr Ando Rakotoharinivo—Madagascar Ministry of National Education**

“The government of Madagascar has been providing online classes in Madagascar. Parents and caregivers where possible are providing additional support to their children through private home lessons. The home lessons are paid privately by parents. Unfortunately, not all parents can afford private tutors, meaning that some children are left behind in subject catch-up efforts during lockdown.”

The blended approach to learning during the COVID-19 has shown that the most powerful and positive impact on education is the digital transformation of the educational sector. The agility of many academic institutions and governments to move learning modules online quickly and to dedicated mass media channels is admirable. But the current transition to e-learning, with its strong emphasis on partnerships with private companies, risks overlooking the barriers encountered by the most disadvantaged learners, especially in poor countries. To be addressed, it will require a heightened sense of vigilance and supervision by education ministries, complemented by oversight provided by the international community. This coordination and partnerships will be all the more important in times to come, as the looming economic crisis will surely push many countries to reduce their deficits by privatizing
education. The privatization of education, if it continues beyond the current crisis, can potentially lead to a decline in the quality and accessibility of public education, jeopardizing the accomplishment of SDG 4 (access to quality education for all). In the months and years to come, it is therefore imperative that public actors in the education sector ensure that all learners, especially the most disadvantaged, have access to affordable and quality education, no matter what channels that education is delivered through. To combat this loss of learning, SADC Member States must adapt to the contexts in their countries, while schools must take into account the situation of each learner.

Member States need not only to address the immediate impact of COVID-19 on education but also build up the longer-term resilience of education systems. The continuity of learning (including distance learning options such as e-learning and radio broadcasts of academic content, and access to essential services for all children) remains essential in the event of school closures. With the growing use of low-cost ICT, integration of innovative digital technologies in education (for example, e-learning, tele- and video-conferencing, virtual learning, and virtual libraries) will provide an avenue to enrich conventional methods of teaching at all levels and could enhance learner learning. Member States must harness this momentum to work quicker and harder to achieve digital inclusion in the region. States such as Mauritius, Mozambique, South Africa and Zambia are already working with tele-communication companies on zero-rate agreements to facilitate downloading of learning materials via smartphones, and also encourage the use of social networks (for example, WhatsApp or SMS) for communication of learning, especially for the most remote areas.
BOX 12: CASE STUDY—ZAMBIA (PUBLIC–PRIVATE PARTNERSHIPS)
EXAMS COUNCIL OF ZAMBIA PARTNERS WITH ZAMTEL TO BRING SMART REVISION PLATFORM FOR EXAMINATION SITTING LEARNERS

The Zambia Telecommunication Company (Zamtel) and the Exams Council of Zambia have partnered to support learners with free access to education in simplified ways on electronic devices, including via SMS.

Smart Revision is a platform offering quick and reliable means to revise and get ready for those attempting to sit for Examinations Council of Zambia (ECZ) final examinations in Grades 7, 9 and 12. The portal provides digitized past examination papers with revision tips and suggested answers. Smart Revision is currently web-based and can be accessed through any mobile network by members of the public wishing to subscribe and access the content. This product is part of the digital transformation being championed by Zamtel.

Access to the platform is zero-rated using the Zamtel network and subscription to access the content for anyone with a Zamtel SIM card can easily be made via ZamPay or talk time by clicking on the “Subscribe” tab. Members of the public with a SIM card other than that of Zamtel and wishing to access Smart Revision content can also subscribe free for you. However, users need to note that other mobile network carriers may charge other access fees.

Innovative solutions should encourage the use of real-time (live) teaching sessions and cheaper offline methods to ensure all learners are able to access education. The Ministry of Education, ECZ, and Zamtel will continue to partner to support the recording of lectures and uploading on Learner Management Systems (LMS) and engaging students for discussions, questions and answer sessions through forums on the LMS and WhatsApp platforms.

Source: Smart Revision

4.5 Missing more than a classroom

Limited access to schools as protective environments

The region-wide school closures have affected learners in ways beyond the absence or remoteness of learning. They also disrupt social relationships and networks, school-based provision of other services (such as food, medicines, and SRH interventions), and emotional and wellbeing pathways. These may include opportunities to maintain and benefit from friendships, relationships with teachers who may be role models, as well as emotional supporters in addition to their educative function, and pathways for care and attention in case of elevated need. Schools also provide an access point for other services—such as food and nutrition services, interventions for SRH for adolescents, and emotional wellbeing initiatives such as bullying prevention.

Before the COVID-19 pandemic school closures, schools provided frontline support to learners, providing them with important psychosocial, nutrition and protection support. The school closures now mean that learners from vulnerable backgrounds (particularly girls, learners with disabilities and those from very poor families) are likely not to receive the support and services they need, such as school meals, life skills and CSE, counselling from teachers and social support from their peers. In the absence of these critical supports that keep school-going youth in school healthy and safe, the gap between learners that experience additional
barriers and those who do not, will widen. Closures can also have considerable effects on learners’ sense of belonging and their feelings of self-worth, which are critical elements for education inclusion.

For adolescents and youth, connecting is key to their sense of belonging and overall wellbeing. Long-term confinement and isolation from educational spaces will erode the social support networks young people build with each other. Beyond accessing education, learners are missing out on the social interaction they had with their fellow learners and teachers, which are essential to their wellbeing, protection, development and social-emotional skills. Such social support also enables them to be change agents and empowers them to make healthy decisions. Being abruptly drawn away from friends, teachers and the normality they rely on, children have suffered emotionally and psychologically. Furthermore, they miss out on the opportunity to learn essential life skills, such as how to manage emotions, cope with stress, build healthy relationships and resolve conflict without violence. While young people are generally very connected digitally, many do not have regular and affordable internet access and may fall behind on social interactions as learning and participation shifts to online platforms.

Most learner respondents—Lesotho (61%), Malawi (55%), Zambia (70%) and Zimbabwe (69%)—reported they were missing their friends. Of note, female respondents reported this aspect of school closure more often than male respondents, as they find their peers sources of great strength and support on personal issues such as menstrual health, relationships and sex, as well as school subjects. Females believed it was difficult to discuss such topics with caregivers and relatives (such as aunties and siblings) during the lockdown period. The FGD discussions revealed that girls found it more difficult than their male peers to connect and keep in touch with their peers and friends regularly. Most caregivers did not allow girls to leave the home unaccompanied, and the risks of COVID-19 infections further limited physical access to friends as girls were confined to homes. In contrast, boys found it easier to navigate lockdown restrictions and were more easily able to have social and face-to-face interactions with their peers and friends. They also revealed that leaving home for errands or defying lockdown and curfew restrictions by running away from police enabled them to meet with their peers to discuss and share personal issues affecting them.

Schools are social structures for support, but more so for girls, who find movement restrictions during crises and emergencies more challenging than do boys.
FIGURE 17: YOUNG PEOPLE’S EXPERIENCE RE LOSS OF SOCIAL INTERACTIONS DUE TO SCHOOL CLOSURES

Many young people in the SADC Region who depended on school-based feeding and nutrition programmes are missing out on a daily meal or more, necessary for good nutrition. COVID-19 will drive widespread food insecurity in the region, thereby increasing the number of food-insecure people in SADC Region from 41.2 million in 2020 to 45 million people in 2021. The increase is due to the loss of income for the poorest families, who were in lockdown for most of 2020. Children and young people from such families are losing out on school meals, as school closures have disrupted the normal distribution channels through which school meal programmes operate, leaving many vulnerable young people without a vital source of food. In Eswatini, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe, this nutrition loss was impacting more than 50% of younger learners, with South Africa recording the highest number of young people going without a school meal during the country’s national lockdown (see Figure 18, below). For many HIV&AIDS positive learners on ART, these meals were important to support them with ART adherence. Two interviewed learners (one each in Zimbabwe and Lesotho) disclosed that due to their health status, the school meals were critical for them, and without these important meals, their caregivers had the financial burden of providing an additional daily meal to keep them healthy.
Both adult (71%) and youth (52%) respondents stated that cases of economic and sexual exploitation for food had increased in rural and high-density or informal settlements. The findings confirm that hunger can exacerbate violence, abuse and exploitation, particularly for young girls, who may end up resorting to providing sex for food during the lockdown period and COVID-19 recovery phase. There is evidence that school feeding programmes decrease child labour, especially for girls and those receiving take-home-rations. This is especially important now when rising poverty may increase pressures on child labour, which may keep children out of school in the long run. In addition, hunger and education deprivation are also highly correlated.

As governments in the SADC Region prepare for schools re-opening, national back-to-school campaigns and re-enrolment drives should include school feeding programmes. These programmes may be a critical part of a strategy to encourage children to go back to school and keeping them enrolled after the COVID-19 pandemic. Besides their role in keeping children in school and being a direct nutrition and health intervention, school feeding programmes are an entry point for introducing other safety nets to address chronic vulnerabilities in underserved or at-risk populations. While reopening schools is a priority, governments should take all possible measures to reopen and revive school feeding programmes safely, following WASH and social distancing protocols.

Schools are more than a place for academic teaching and learning. School closures have also removed a protective environment, resulting in increased sexual, physical and emotional abuse of children and young people when they are out of school for prolonged periods. Most youth respondents (78% female and 63% male) indicated that school closures had increased the vulnerability of girls and young women to child marriage and early pregnancy, and they also noted that GBV was on the increase. While school absenteeism of girls is 33% higher than before COVID-19, boys in Malawi, Zambia and Zimbabwe are also dropping out as they

Notes: (i) SADC Member States that do not have data or where school meals were being provided by November 2020 are not shown; (ii) The age range of children that benefit from the school meal programmes captured in the database was unavailable, so the 5–17 population was used as a proxy to estimate the relative size of children affected across countries. Eswatini is the exception, which covers the 5–19 population, therefore showing slightly higher numbers.
have moved to support themselves or their family in activities such as gold panning, livestock herding or trade. The school disruptions have also caused health concerns, particularly limited access to SRH and psychosocial services since education institutions also serve as platforms for prevention, diagnosis, counselling and support for learners. As a result, vulnerable groups are experiencing both a loss of education and a lack of support for their health and emotional needs as an important element of their wellbeing.

4.6 Provision of CSE during school closures

Learners access important CSE and SRHR information and services within or through the school setting. Before the COVID-19 outbreak, twelve SADC Member States were providing some form of Life Skills and CSE within school, and also providing important linkages to youth-friendly SRHR services in health facilities. Such support services are critical for young people due to the high prevalence of HIV&AIDS in the Region. Although HIV treatment programmes have expanded rapidly within the region, SADC remains particularly affected by the HIV epidemic. Nine Member States (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe) have the highest HIV prevalence in the world, with HIV resulting in the single sharpest reversal in human development in the region. The region also continues to experience high rates of preventable maternal mortality, early pregnancy and GBV.

The transmission of HIV persists because of misunderstandings about how it is transmitted or can be prevented. Infections also rise in this region due to high levels of stigma that still exist. CSE is therefore a key part of the solution to ending HIV&AIDS, as well as reducing unintended pregnancy, as it supports young people to make healthy decisions about their sexuality and their futures.

Also critical in the learning process are discussions on issues of gender-based and intimate-partner violence. CSE is often provided through peer-to-peer support within school. As schools transitioned to remote learning during lockdown, most education facilities in Malawi, Namibia, Zambia and Zimbabwe de-prioritized the teaching of Life Skills, CSE and Physical Education, leaving young people with no access to SRHR information, services and important linkages to health facilities. Although social distancing, lockdowns and quarantine hinder the delivery of CSE in person, digital platforms and tools offer opportunities for reaching young people and have the potential to provide innovative and interactive ways to engage them.

Most learner respondents (78%) reported that before the lockdowns schools provided them with CSE. However, adolescents and young people pointed out that as schools transitioned to online learning, teachers were not scheduling CSE sessions, leading to young people depending on their peers or the internet for SRHR information. As healthcare facilities were pre-occupied with COVID-19 treatment and response, learners faced challenges receiving the necessary supports at schools and clinics. Asked which particular challenges they face, 58% of female and 42% of male learners cited fear of catching the COVID-19 virus in clinics, receiving poor and judgemental treatment from untrained healthcare providers who they did not know, and prohibitive costs of accessing SRHR support and services. Many respondents in Malawi, Lesotho, Zambia and Zimbabwe indicated that before the lockdowns social workers and nurses worked closely with teachers and peer educators to give learners health talks at
their schools. Learners were known by specially trained nurses in communities. Also, because learners accessed services in uniform, they were treated with respect.

![Bar chart showing challenges in accessing SRH services](chart.png)

**Figure 19: Young People’s Challenges in Accessing SRH Services during COVID-19 (Youth Responses)**

Because of the roving nature of medical duties of healthcare workers in facilities during the COVID-19 lockdowns, learners from Lesotho, Malawi, Zambia and Zimbabwe reported that efforts to receive SRHR support and care from known and trained nurses were difficult, as they might go to clinics when such workers were off duty or deployed to another department of the clinic. During the lockdown period, learners on average made two attempts to access SRH information and services at a linked healthcare facility. Most learners (74%) confirmed that after two failed attempts to get the needed help in clinics, they resorted to purchasing condoms in supermarkets or pharmacies, or to accessing sexuality information either online or through peers. But not all had disposable money to purchase condoms or other forms of contraceptives, and most learner respondents indicated that this raised the fear of an increase in early and unplanned pregnancies, as well as sexually transmitted infections (STIs).

Over one-third of interviewed learners (35%) mentioned that for the LGBTQI youth there were added risks of feeling isolated and unsupported in terms of accessing SRH support and services. Learner respondents mentioned that the LGBTQI learners were most likely to suffer psychological stress due to limited support usually provided in school settings. In the absence of physical and safe spaces in the learning institutions that also respect the confidentiality, diversity and needs of these learners, especially when engaging with counsellors, the affected learners find themselves in a deep dilemma. Furthermore, the appointed guidance and counselling teachers who usually depend on school-based face-to-face support for LGBTQI learners faced difficulties in communicating and supporting them.

The FGDs with youth showed that young people appreciated the school-based Life Skills Education and CSE learning instructions as they supported them with improved healthcare linkages. However, the lockdowns gave young people a greater appreciation of the privacy and anonymity that digital CSE provided them when accessing information about their sexual health. They noted that in some instances online CSE sources provided them diversity of information available that is not influenced by teachers’ beliefs on morality and sexuality. For younger adolescents (15–17), there is an expressed preference for written information over
having face-to-face conversations about their bodies, sex and relationships; their discomfort in asking others is likely to lead them online. As they grow older, it seems that many young people also appreciate offline interactions, noting that they may be more verifiable. Most young respondents (73%) across all age groups reported being positively influenced by the content they access online and felt that it had a positive effect on their sexual behaviour and decision-making. Digital sexuality education can therefore be made more accessible and effective by reaching many young people at the same time across large geographical areas. It can also support marginalized, left behind populations of young people—such as out-of-school pregnant youth and those with disabilities—who may otherwise be excluded from mainstream CSE and SRHR programmes.

**Box 13: The benefits of CSE (UNFPA)**

- Improves young people's knowledge and shapes positive attitudes related to behaviours
- Delays initiation of sexual intercourse & reduces risk-taking
- Reduces number of sexual partners and frequency of sexual activity, contributing to reduced infections
- Increases use of condoms and contraception
- Increases communication with caregivers about sexuality, rights awareness and self-efficacy
- Contributes to gender-equitable attitudes, confidence and self-identity

Digital sexuality education may potentially also deliver CSE with increased fidelity, since the content is fixed and not dependent on a facilitator’s willingness to present it, and it can be interactive for the learners while letting them engage more actively with their learning at their own pace. While not a “silver bullet” on its own, digital CSE complements face-to-face CSE and, during this COVID-19 pandemic period, is an especially important supplement to face-to-face CSE in and outside school settings.

But to maximize effectiveness, digital platforms and tools and other out-of-school CSE resources need to form part of broader efforts to promote SRH, including the provision of SRH services and commodities. Teachers in should also advocate with school administrators on the added benefits of continuing CSE delivery throughout the pandemic as part of the essential learning package, through both formal and non-formal education.

The online environment is, however, not free of challenges regarding providing young people with correct SRHR information and their protection. Many young people do not have adequate levels of sexual health literacy, nor the ICT and media literacy to enable them to gain access to, understand, and use correct information in ways that protect their health and wellbeing. Health literacy is critical to empowerment. It includes the timely recognition of the need for health or other services, the ability to seek advice and care, including making appointments, and the ability to navigate complicated health systems. Besides, being highly digitally connected and in the absence of adequate skills to critically assess health-related information, young people might lack accurate knowledge regarding their health and disease in general, and the pandemic in particular, and have a greater chance of being exposed to misleading or inaccurate information. Lack of life-saving information in accessible formats (such as easy-to-read materials, videos with closed captioning and sign language, or materials in Braille) puts
young people with disabilities at higher risk of losing out on critical CSE and SRHR information and services.

Due to information overload from various organizations, interest groups with different priorities and areas of focus, adolescents who rely solely on digital CSE may be at risk of receiving uninformed advice or false facts, or they may use unproven approaches to make decisions about their sexual choices and behaviour. In addition, increased unsupervised online activity puts young people, particularly girls, at heightened risk of online violence and abuse. Spending more time online was reported by UNICEF to increase the likelihood that children encounter online predators who groomed young people for sexual exploitation. A lack of in-person interaction may lead to online risk-taking behaviour (including sharing self-generated sexualized content with peers), which may expose children to extortion, harassment, humiliation or depression and thoughts of suicide. This aspect of digital CSE was confirmed by 56% of young respondents who reported having a peer or friend share an inappropriate picture on WhatsApp during the lockdown period.

Cyberbullying is also a major concern, particularly for girls, children with disabilities and those who are perceived as different or at greater risk of spreading COVID-19.

### Box 14: Case study—Lesotho, Malawi, Zambia and Zimbabwe (Radio programming)

**FutureLife-Now! Radio Programming bridges the gap in CSE education**

In April 2020, MIET AFRICA realized that school closures, travel restrictions and other challenges linked to the COVID-19 pandemic were making it impossible to continue its CSE based FutureLife-Now! programmes in Lesotho, Malawi, Zambia and Zimbabwe as they were originally planned. It also realized that the pandemic was creating a major challenge for Member States: that is, how to get practical, accessible and factually accurate information about coping with COVID-19 out to the public.

One solution was to use radio, with linked SMS messaging, to reach schools and other audiences across each of the countries. It soon became clear that radio had the power to engage audiences across the countries by reaching marginalized communities that often lack access to critical information, and engaged listeners in active discussion around issues they were grappling with.

In partnership with the government ministries in the four Member States, three radio programmes were launched. Youth Talk engages youth panellists and audiences in lively discussion around critical issues such as sexuality, peer pressure and responsible decision-making. Family Talk stimulates often unprecedented discussions between young people and caregivers around the same issues, while the Our Changing Climate: Our Time to Act! creates awareness of the impact of climate change on listeners' daily lives.

MIET AFRICA’s programmes have built a strong, new brand and a loyal, excited listenership that is actively engaged in important SRHR and climate change discussions throughout the four Member States—showing the impact radio has.

Source: MIET AFRICA’s Talking the Talk

### 4.7 Rise in early pregnancies in SADC

A looming threat to education
Schools can offer young people a protective environment from exposure to multiple forms of abuse, including sexual violence leading to increased pregnancies and child marriage. Young people who would normally use schools as places of support and care are now at risk of not accessing needed SRHR services (family planning, condoms, etc). Besides, many young females were forced to spend lockdown periods with sexual perpetrators, heightening the risks of falling pregnant. The lockdowns have also resulted in girls spending more time with men and boys than they would if they were in school, leading to a greater likelihood of them engaging in risky sexual behaviour and increasing the risk of sexual violence and exploitation. Moreover, ongoing school closures and limited access to age-responsive SRH information and services are contributing to an increase in incidents of early pregnancies. World Vision estimates that as many as one million girls across sub-Saharan Africa may be blocked from returning to school due to pregnancies that occurred during COVID-19 school closures.

The GPE posits that the COVID-19 pandemic is threatening girls’ education as never before. School closures and limited access to SRH services increase vulnerability to child marriage, early pregnancy and GBV, all of which significantly decrease the likelihood of girls continuing their education.62 Furthermore, before lockdown, schools in the SADC Region were able to track school absenteeism consistently and report girls who were absent or at risk of abuse or early pregnancy to police, education boards, or community-based protection mechanisms, which is not currently possible.

Even before the crisis, girls and young women faced considerable challenges in accessing essential SRH information and services. But since March 2020, the estimates project that one million girls in Southern Africa will not return to school because of early pregnancies and child marriages. The research shows that most early pregnancies recorded during the COVID-19 pandemic are unintended and largely linked to poverty, sexual violence, and limited school-based CSE and psychosocial support services, as well as the de-prioritization of SRHR services. The risks of complications related to pregnancies and childbirth—coupled with a regressive return to school laws for pregnant girls and adolescent mothers in some Member States—will have devastating consequences for the affected groups.

Adult (71%) and young (85%) respondents shared similar concerns on the glaring numbers of early pregnancies and child marriages emerging in Member States, including Malawi, Namibia, Zambia and Zimbabwe. As schools reopen in phases in most Member States, the impact of the lockdown and school closures on adolescent girls is becoming clear. Early reports from interviewed peer educators, youth facilitators and Ministry of Education officials indicated that in some rural and remote areas as many as half of the girls in exam classes were pregnant, married or not returning to school for other reasons, such as work, or loss of confidence in the school system due to the length of time classes were missed. One out of five youth respondents were aware of at least one pregnant girl (under 18) or a young mother (under 24) who had given birth during the past six months. Three out of five youth knew of a peer, relative, neighbour or acquaintance who was married off before the age of 18 in the past three months, or who had moved to another village, town or country (mostly to South Africa) due to child marriage. Figure 20, below, depicts responses from young people and adult respondents on the drivers of early pregnancies and child marriages in the Member States reviewed.
While most adult respondents (61%) expected children to return to school, there is a strong cause for concern in relation to marginalized children. Pregnant girls, girls with disabilities and boys engaged in child labour were least likely to return to school. Most learner respondents (72%) were hoping to return to normal classes after the lockdowns, but 25% were unsure they would return to school due to the length of school closures, while 3% reported not returning to school due to loss of family income to pay for school fees, pregnancies or having to work to contribute to family income.

![Figure 20: Drivers of Early Pregnancies and Child Marriages during COVID-19 (Youth and Adult Responses)](image)

This figure confirms the plethora of literature that highlights that poverty and lack of access to education and SRHR services are drivers and consequences of child marriage and early pregnancy. What was important to note in the responses provided was that at least 80% of young people needed critical SRHR support and services, and in their opinion, the unmet SRHR needs, either in the school environment or at health facilities, were key drivers of increased cases of early pregnancies.

Poverty was also a major reason for increased pregnancies. Before the pandemic, girls from poorer households and adolescent girls living with caregivers with lower levels of formal education were at higher risk of child marriage in Malawi, Mozambique, Zambia and Zimbabwe. With the triple threat of the worsening economic crisis, persistent droughts and the pandemic, more girls are finding themselves in these higher-risk groups. Families, and adolescent girls themselves, have reduced income-generating opportunities due to the COVID-19 lockdown, which has compounded their economic instability. Consequentially, without life skills support or peer education, loss of social contact, limited access to support systems and structures for making positive and healthy decisions, young girls are engaging in transactional sex even during lockdown.

Adolescents falling pregnant in the COVID-19 pandemic may be at increased risk of adverse maternal and neonatal outcomes due to disruption of maternity care. Antenatal surveillance is reduced or absent, and maternity units for labour and delivery are operating sub-optimally.
Long-lasting consequences of obstructed labour and delayed intervention include *urogenital fistulae*, which dramatically alter the course of life for many women in poor communities. Socioeconomic consequences of early pregnancies include rejection by families, seeking high-risk jobs for survival (including turning to commercial sex work) and unstable families headed by children. Returning to education after early pregnancies is uncommon in the developing world; this is complicated by the prevailing harsh economic conditions in most of sub-Saharan Africa. The young mothers, who may be rejected by the fathers of their children, often have to seek child employment, and in countries with high unemployment rates, this is usually high-risk informal employment, which exposes them to further sexual exploitation. Without adequate social insurance and support, a vicious cycle may erupt with repeated unintended conceptions, unsafe terminations, HIV, STIs and reduced life expectancy.

**Box 15: Mrs Selma Gwede—Namibia Ministry of Education and Culture**

“The rising numbers of teenage pregnancies in Namibia are showing us that our homes are not safe for our young ones. As we open schools, teachers will have to grapple with the high school dropout and loss of potential of their students. As a government we need to prioritise the urgent and safe re-opening of schools to ensure we do not lose a generation of young Namibians.”

As a result of the high early pregnancy rates, the SADC Region is increasingly confronted by how to address and facilitate the continued learning of pregnant teens and young mothers in school. Because education has proved to be one of the most cost-effective strategies to promote development and economic growth in the region, governments, NGOs and other stakeholders are tasked with supporting the safe return of girls. A lost education is catastrophic to young mothers, their children and their communities. Studies have shown that educated mothers tend to have healthier, better-nourished babies and that their children are more likely to attend school, thus helping break the vicious cycle of poverty. It is therefore imperative to create an enabling environment for the return of girls to school.

Back-to-school policies for support of pregnant girls and young mothers vary across the region—from outright expulsion of pregnant girls to strategies that support the continued education of adolescent mothers. However, social norms, care burden, shame and guilt and various practices typically still result in pregnancy being the end to a girl’s education. In Tanzania, school expulsion due to pregnancy dates back to law from the 1960s, with a 2002 Education Regulation used to expel pregnant learners under “offences against morality.” In 2017, the Tanzanian president recommitted the country to this practice, and despite global and regional advocacy and political pressure to revise this policy position, girls cannot go back to school after falling pregnant. The Mozambican Ministry of Education recently revoked its hard-line 2003 guidance that ordered all pregnant schoolgirls to attend night classes and banned them from day classes. Similarly in Zimbabwe, the Education Act was amended in August 2020, making it illegal to ban pregnant girls and young mothers from attending school.
Despite these progressive legislative and policy amendments, additional supportive strategies in communities and schools are required to guarantee girls’ rights to stay in school during pregnancy and to return after they give birth. In response to these recommendations, 57% of young respondents felt that addressing social norms, learner and teacher discrimination and communities’ perception about early pregnancy and promiscuity were important to create an enabling environment for the continued education of pregnant girls and re-entry of adolescent mothers into schools. Youth respondents also recommended that young mothers and their babies be supported at home as they pursued their studies. A youth facilitator in Malawi noted that organizations such as World Vision are currently working with the Ministry of Education to run a back-to-schools campaign with the support of the community and village committees, mother groups and religious leaders. This combined effort will help to bring back to school all learners who have dropped out of school during the pandemic for various reasons.64
4.8 Truly building back better

Post-COVID-19 teaching and learning

The COVID-19 pandemic has brought to the fore the importance of equitable education for adolescents and young people in Southern Africa. The pandemic threatens hard-won gains, especially in narrowing education gaps between girls and boys. The transition to remote learning due to school closures presents challenges to connectivity and access to equitable learning. In particular, girls often have fewer technical skills and less access to the internet, which may ultimately prevent them from acquiring the skills and know-how needed for the labour market.

The findings of this study show that schools are essential for children’s learning, health, safety and wellbeing. For the most vulnerable children, school closures have deprived them of their one nutritious meal a day; children living in violent or dysfunctional family settings who rely on school to provide a safe, nurturing environment have also been cut off from these safe environments. In many SADC Member States, schools also play an essential role in immunization and SRH support. As schools reopen, governments must nurture the development and wellbeing of every learner when they return to the classroom, with comprehensive services including remedial learning, health and nutrition, and mental health, CSE and protection measures.
As Member States brace themselves to address the impacts of the COVID-19 well into the recovery phase, priorities should focus on advancing equity and quality in access to education to ensure learning is not significantly held back below the SDG 4 targets. Given the nature of the crisis, all Member States need to lend support to the most vulnerable children to keep them from being further marginalized and to ensure that they remain engaged in learning. Equity and inclusion in learning needs should be a key objective and priority in the COVID-19 response. As we enter the second year of the COVID-19 pandemic, effort should be spared to keep schools open safely and to prioritize acceleration of remedial learning particularly for the most vulnerable. Children cannot afford another year of school closures without the necessary support and services.

Central to building back better there must be a conscious recognition that existing education systems are already inequitable, excluding girls and children with disabilities, those from disadvantaged and the most-excluded communities, as well as LGBTQI individuals. COVID-19 could exacerbate these existing inequalities, or it could be used as a pivotal turning point where a gender and inclusion “lens” is applied to all aspects of education (including planning, budgeting expenditure and curriculum development) to advance equality and inclusion in access, retention and achievement at all education levels.

Recommendations

As part of truly building back better, governments, UN agencies, NGOs, academia and the private sector must work together to:

- **Ensure continued learning, including CSE, during school closures**

  Governments in SADC should reduce the impact of school closures and education disruption by urgently rolling out youth-friendly, age-appropriate distance education methods such as television, radio, or online learning, as well as printed learning materials where there is no connectivity.

  Member States should ensure all children and adolescents have access to accurate, rights-based, and age-appropriate information about their SRHR through mandatory CSE, including by distance learning. The distance education approaches should include Life Skills Education and CSE as a priority and should be aimed at minimizing the risks related to exclusion and helping young people to recognize and mitigate the risks of HIV&AIDS infections and GBV, as well as early pregnancies and child marriages.

  Blended approaches to learning—focusing on reaching young people with disabilities, and those who do not have English as their first language—should be prioritized. Where possible, duty bearers should work with NGOs to increase access to online learning devices such as mobile phones, laptops and tablets to schools and learners.

  Innovative approaches that have been implemented to reduce high school dropouts during the COVID-19 pandemic (such as radio CSE programming, take-home rations, cash transfer programmes, and public-private partnership for digitized solutions) should be encouraged and replicated across the region. Member States should leverage the pre-existing enabling environment and engage with academic institutions, as well as communities, to encourage the continuation of learning for pregnant girls and the re-entry of adolescent mothers.
In addition, Member States should prioritize the assessing of learning loss and monitoring progress when learners return to school, and the provision of remedial education to help learners catch up.

- **Plan for urgent, inclusive and safe re-opening of schools**

  As the curve of infections flattens in the region, governments need to prioritize the safe and swift return to school to minimize further disruption to young people’s lives.

  Member States should follow the UN Framework for Re-Opening of Schools. The focus should be on addressing learning losses (particularly for the most vulnerable groups), reducing further dropouts and providing the necessary care, supports and services for young people. Where policy decisions are made on opening schools, the necessary school WASH infrastructure and social-distancing measures should be put in place.

  When select schools have been identified for reopening, six key dimensions should be used to assess their state of readiness, and which should also inform planning: policy; financing; safe operations; inclusive learning; reaching the most marginalized; supporting the wellbeing and protection of young people.

  Member States must reintroduce school feeding programmes, with the option of community sites becoming key distribution points that are accompanied by screening for COVID-19 symptoms, follow-up, and monitoring of children from affected households. Therapeutic nutrition ought to be provided to children who are malnourished or receiving ART.

- **Remove barriers to internet connectivity in Africa through subsidized or zero-cost arrangements**

  The COVID-19 pandemic brought a deeper appreciation of the digital divide and related equity gaps that exist in Africa, and more specifically in the Southern African region. Connectivity and access to mobile phone require urgent attention. Governments and development partners need to work together to remove technological barriers by investing in digital infrastructure and lowering data prices.

  Bridging the digital divide will also require greater investment in digital literacy for marginalized populations. At the same time, relying strongly on technology will not on its own bring effective learning for all children, especially the most marginalized. “Low-tech” and “no-tech” approaches should be prioritized for those who have limited access to technology. Member States must plan to ensure adolescents and young people from the poorest households will not be left behind.

- **Provide support to teachers**

  Teachers have had to rapidly innovate their approaches to teaching to facilitate quality distance learning for learners, with or without the use of digital technologies. They played a key role in communicating measures that prevent the spread of the virus, ensuring that young persons are safe and supported. However, the added demands on teachers created by the hybrid teaching approach mean that they require additional technological skills to support effective learning. Technology alone cannot guarantee good learning outcomes.
In-service and teacher education should therefore prioritize training teachers on ICT skills, making sure that they have the necessary assessment and pedagogical skills to meet learners at their level and to implement the accelerated curricula and differentiated learning strategies likely to emerge when schools open. Teachers will require professional development support to assess how much learning was lost during school closures. Academic institutions, in collaboration with Ministries of Education, should support the provision of appropriate remuneration to teachers, as well as psychosocial and emotional support, particularly during the school-opening period when they are most likely to address the issue of high school dropouts.

- **Fully finance education**
  
  The COVID-19 crisis threatens to further strain the funding of education financing, which was already largely underfunded even before the pandemic. Efforts are now needed to ensure that education budgets are not only protected from potential cuts but also increased to facilitate the needed adaptations and full recovery of education systems. Now more than ever, governments need to meet internationally-agreed benchmarks of spending 15–20% of national budgets or 4–6% of GDP on education, while expanding their tax revenue bases. Education must be prioritized as part of donors’ global COVID-19 responses.

  Too often education funds fail to reach the schools in the most disadvantaged communities. Unless there is independent scrutiny, funds are misused or go astray. COVID-19 is already placing extra strains on budgets and on oversight systems to ensure they are transparently and effectively utilized. Civil society actors can play a crucial role in tracking budgets, making sure that monies allocated arrive and decisions are made transparently at the appropriate level. Strengthening civil society voices—and the political environment for those voices to be heard—is essential. Post-COVID, there needs to be a revolution in public accountability of education systems both at local level and at national level—a public-public partnership so that public systems facilitate and respond to public engagement.

- **Invest in early-warning systems**
  
  These are important first steps to prevent a spike in school dropouts. With more learners at risk of dropping out after schools open, governments will have to design well-targeted interventions that address the underlying socioeconomic, academic, and socio-emotional problems leading to dropout.

  Dropping out of school is a gradual process, and learners at risk of dropping out often exhibit tell-tale signs they do. Member States are encouraged to include early warning systems in education assessment and support educators to use these to inform dedicated support to the most vulnerable learners.

- **Create a collaborative approach with caregivers**
  
  Caregivers play an important role in their children’s education. The COVID-19 recovery plans will need to support caregivers in providing the necessary care, guidance and support to learners, when they are at home and when they return to school.
CHAPTER 5: Impact on Adolescents’ Access to Healthcare and SRH

The COVID-19 pandemic has led to reduced access to healthcare for non-COVID-related health issues. Children and adolescents are generally at low risk of COVID-19 infection, and if they become infected it is likely to be mild. Even if younger populations are less directly susceptible to COVID-19 infection and illness, the strain on the health system caused by this pandemic causes considerable threats to children’s and adolescents’ health and wellbeing.

Understanding the impact of lockdowns on young people’s access to healthcare and health-seeking behaviour is important to finding solutions to healthcare service disruptions, and to ensure that in COVID-19 recovery plans healthcare systems can respond to both communicable, non-communicable and chronic illnesses.

This chapter explores how COVID-19 has affected access to basic healthcare for young people and the impacts of limited accessibility including restrictions on movement, and the closure or repurposing of health facilities. It analyses health-seeking behaviours of young people in accessing important SRHR services and the impact of the pandemic on their mental health and psychosocial wellbeing. Actionable prevention, care, and health promotion initiatives are then proposed to mitigate the negative effects of the pandemic on young’s people health.

Key findings

- 92% of young respondents reported their access to general healthcare and routine healthcare was affected.

- Mental health and psychological wellbeing are a grave concern in the region: 74% of youth reported feelings of loneliness, distance and suicide attempts due to loss of income, limited prospects for employment and months of confinement.

- Drug and substance abuse and cyberbullying in on the increase due to lockdowns.

- Three out of five learners lost access to important SRHR services.

- Routine measles and other immunizations are lagging far behind, with the risk of young people getting secondary diseases. At least fourteen million children in sub-Saharan Africa will miss out on routine immunization: 60% live of these children live in the SADC Region.

- SRHR supply chains were disrupted. Stock-outs on ART, condoms and other contraceptives will increase disease burdens (including higher risks of HIV infections and unintended pregnancies) in the SADC Region.

- Linking education with SRHR support has proved a useful model. The “youth corners” or spaces for young people at healthcare support provide an enabling environment for seeking SRH support and services.
5.1 Access to healthcare before COVID-19

Prior to COVID-19, SADC Member States were making concerted efforts to achieve universal health coverage.

Access to basic immunizations against potentially-deadly childhood illnesses such as measles, polio and diphtheria had improved markedly over the past ten years. On average, 62% of children in Southern Africa have received basic vaccinations, with universal coverage recorded in Member States such as Seychelles and South Africa. On the other hand, Member States such as Angola had sub-optimal rates of immunization for vaccinable diseases (such as, measles and polio) before the COVID-19 pandemic. The WHO 2018 estimates indicate that Angola, together with Ethiopia, accounted for 45% of all infants in the ESA region under-vaccinated for diphtheria, tetanus and pertussis.

Preventive maternal and childcare services, including immunization, maternal health and antenatal care, were mostly available for free in public sector hospitals in Botswana, Eswatini, Lesotho, and Mauritius. Healthcare workers in the Member States under review (Lesotho, Madagascar, Malawi, Zambia and Zimbabwe) were accelerating demand creation for routine HIV&AIDS testing, treatment and care, as well as TB treatment and support. Elective surgeries could be provided at most private hospitals at a charge. However, despite this progress, healthcare in most African countries is not free at the point of use. Therefore, the burden of out-of-pocket payments, which is highest for the poor, may result in an increase in deaths of children and young people from non-COVID-19 related causes.

As highlighted in Chapter 3, recent and historical investment in primary healthcare for universal health coverage provides a critical foundation for adapting to the COVID-19 health crises. A well-organized and -prepared healthcare system can maintain equitable access to high-quality essential health services throughout an emergency, thereby limiting direct mortality and avoiding indirect mortality. Health-system resilience is therefore a critical determinant for positive health outcomes for adolescents and young people.

While health facilities remained opened as part of critical social services, 89% of adult respondents and 92% of young respondents revealed that COVID-19 treatment and care took priority and that healthcare had been impacted. As illustrated in Figure 21 below, of the youth respondents interviewed, 78% reported that before COVID-19 they were accessing essential healthcare services through walk-ins into healthcare facilities, while 32% reported that they accessed healthcare through youth-friendly centres and 15% through mobile centres; only 7% had not accessed a healthcare facility before. The findings confirm that before COVID-19 young people were able to access healthcare facilities, with varying degrees of access to quality healthcare. FGD discussions with young people revealed that after lockdown measures were put in place, the situation changed. Due to fear of catching the virus, young people were now relying on home remedies, for minor ailments, or mobile health services.

* Defined as “the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganise if conditions require it.”
IMPACT OF COVID-19 ON ADOLESCENTS AND YOUNG PEOPLE IN THE SADC REGION

Figure 21: Young people’s access to healthcare facilities before COVID-19 (Youth responses)

Many health systems in the SADC Region have been unable to maintain routine service delivery (mostly physical walk-ins) in addition to managing a relatively limited COVID-19 case-load. As demands on systems have surged and with healthcare workers themselves becoming infected by the virus, healthcare workers have had to adapt to provide the best possible care to populations in challenging circumstances. Children and young people have also been affected by the disruptions in healthcare systems.

Box 18: Female learner (19)—Zambia

“I am so worried. The healthcare system is so fragile due to COVID-19. You have to pray you do not get sick during this time.”

5.2 Disruption of essential healthcare services

The COVID-19 pandemic has had significant impact on access to healthcare, medicines and medical supplies at both individual and household levels. During COVID-19, disruptions to essential healthcare services (including services for communicable and non-communicable diseases, for mental health, for reproductive, maternal, new-born, child and adolescent health, and for nutrition) were reported in all SADC Member States. Emergency services were the least disrupted.

The reasons for disrupted healthcare services vary in each Member State. However, analysis of available research showed that generally services were disrupted due to overwhelmed healthcare systems, medicine stock-outs and the prioritization of the COVID-19 response. Even in instances when normal healthcare services were still offered, young people were unable to access them because of reluctance to leave home for fear of being exposed to COVID-19 (43%); restrictions on movement due to government-mandated lockdowns (35%); transport interruptions (7%). Many health workers were also unavailable because of restrictions on travel or re-deployment to COVID-19 response duties, as well as a lack of protective equipment.

Youth respondents also mentioned that loss of income led to economic hardships, meaning that healthcare access was de-prioritized at family level. Most adult respondents (89%)
interviewed also confirmed that their households’ access to healthcare had been affected by the COVID-19 pandemic. Respondents in Lesotho, Malawi, Namibia, Zambia and Zimbabwe reported cases of declining access and utilization of essential services including preventive, curative and rehabilitation services. Out-patient care was also drastically reduced in these Member States, with an average drop rate of 38%.71

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<th>Reason</th>
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<tr>
<td>Services not provided/unavailable</td>
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<tr>
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<td>7%</td>
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<td>Lockdown restrictions</td>
<td>35%</td>
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<tr>
<td>Fear of COVID-19 infections at healthcare facilities</td>
<td>43%</td>
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**Figure 22: Reasons for interrupted access to healthcare by young people during COVID-19 (Youth responses)**

There was a 45% decrease in the number of young people tested for HIV in 2020 (April–October) compared to the same period in 2019.72 At the health-system level, there are concerns that we may soon see shortages of medications, such as contraceptives, anti-retroviral drugs for HIV&AIDS and antibiotics to treat STIs, due to disruptions in supply chains caused by the lockdown—all of which could have life-threatening consequences and reverse recent gains made on these health outcomes. Recently-modelled projections indicate that a six-month disruption of ART could lead to an additional 465 000 AIDS-related deaths in the ESA Region in the next twelve months.73 The findings in the available literature was confirmed during FGDs with health sector NGOs, government ministries and youth. Access to healthcare was significantly impacted in families with an adolescent or young person living with a chronic illness such as HIV&AIDS or a disability. Adult respondents (61%) and young respondents (55%) confirmed that caregivers were likely to report these young people falling sick during the lockdown period, unlike families without a child with a chronic health condition. Respondents indicated that families had not been able to provide regular health and rehabilitation services to their children with a chronic health condition or disability since the outbreak of COVID-19, due to the de-prioritization of rehabilitation services, stock-outs of important chronic medication and failure to access doctors and nurses required for routine care and support.

As Member States in the region implement COVID-19-related public health control measures, there is a need to allocate multi-month prescriptions and refills to young people to reduce the frequency of visits to clinical settings and maintain access to HIV&AIDS prevention services, including condoms and pre-exposure prophylaxis. This will ensure that young patients have enough treatment during stay-at-home orders and limit unnecessary visits to healthcare facilities, thereby reducing the risk of exposure to COVID-19.
The stay-at-home orders that have been implemented to contain the spread of the virus have disrupted vaccination campaigns and immunization activities, which increases the risk of children contracting other infectious diseases. Measles and polio immunization campaigns have been delayed in six SADC Member States, leaving many children unvaccinated and at risk of contracting other infectious diseases. In Zimbabwe, the proportion of districts reporting at least 80% of routine immunizations declined from 90% in December 2019 to less than 60% at the end of June 2020, while there was a 45% decline in the number of women’s fourth antenatal care visits for the April to July period for 2020 compared to 2019. Moreover, women and girls are finding it difficult to gain access to accurate information about COVID-19 due to low access to technology in comparison to men.

In Malawi, a phone survey carried out during May and June 2020 found that 10% of households that needed medical treatment were unable to access it, while in Mozambique as of August 2020, 37 of 130 health facilities in Cabo Delgado Province were closed, which left more than seven hundred thousand persons without access, while cholera and vaccination campaigns had also been suspended. Of concern too is that 45% of the adult respondents from Ministries of Health highlighted that costs for basic healthcare services had increased during COVID-19. In Member States such as Namibia, stock-outs of condoms were reported due to supply chain disruptions.

The WHO confirmed that essential health services were affected across the board. The most frequently disrupted services included routine immunization services—outreach services (70%) and facility-based services (61%); non-communicable disease diagnosis and treatment (69%); family planning and contraception (68%); treatment for mental health disorders (61%); antenatal care (56%); cancer diagnosis and treatment (55%).

Box 19: Male youth facilitator (23)—Malawi

“People in rural areas do not have masks, soaps and running water. Organisations and governments need to help communities like ours at least with boreholes so we get running water.”

Adolescents and young people were asked about the health and hygiene needs they wanted adults (governments and NGOs, for example) to address. In general, the respondents said they wanted adults to take COVID-19 seriously and to follow health and social distancing guidelines. Interestingly, responses from young people living in urban areas and those interviewed living in remote, rural or high-density areas differed. Young respondents in urban areas prioritized having sufficient money to buy food, medical supplies and other household needs, while youth in remote areas focused on the provision of adequate WASH materials to curb the COVID-19 pandemic. Figure 23 illustrates that young people felt they required masks, sanitisers or soap, water, food and sanitary products to stay healthy during the COVID-19 pandemic, yet 72% reported they did not have these essential items.
5.3 Member States’ health response to COVID-19

The response of SADC Member States to the pandemic was, by and large, quick and decisive. In addition to the national health policies and strategies in place before COVID-19, all Member States defined essential health services that were to be maintained during the pandemic through national COVID-19 health response strategy documents.

Government policies concerning service delivery platforms were focused on life-saving treatment for COVID-19 and other emergency care, while healthcare provision through mobile clinics and community-based care was suspended or de-prioritized. In the Southern Africa region, limiting access to selected services or in selected areas of the country was more common than full suspension of services, particularly for outpatient services. In addition to policy strategies on maintaining healthcare provisions, Botswana, Lesotho, Madagascar, Mauritius and South Africa allocated additional funds for health sector strengthening to address the looming threat to loss of lives due to COVID-19 infection.

Almost all SADC Member States had implemented at least one approach to overcome disruptions owing to the COVID-19 pandemic. In Eswatini, Lesotho, Malawi, South Africa, Zambia and Zimbabwe, triaging was common at healthcare facilities to identify healthcare priorities. Other frequently reported approaches included telemedicine deployment to replace in-person consultations (Angola, Mauritius, Namibia, Seychelles and South Africa), task shifting and/or role delegation (all Member States), and adjustments to the supply chain and/or dispensing of medicines. Botswana, Eswatini, Malawi, Mozambique, South Africa, Zambia and Zimbabwe implemented community outreach to provide information on service disruptions and to redirect patients to alternative healthcare facilities.
By September 2020, eleven of the sixteen SADC Member States* had intensified COVID-19 treatment by rolling out training on COVID-19 treatment, testing and care, strengthening laboratory testing capacities, and procuring and distributing testing kids. However, none of the Member States removed user fees: this has implications for access to essential health services, particularly for poor communities and those that have lost income during the lockdown period.

**Box 20: Female youth (22)—Zimbabwe**

“My sister broke her leg in September 2020. In my town there is only one x-ray machine at the local district hospital. We tried to take my sister to the local hospital for about five times, but the nurses kept telling us the x-ray was not working and that due to COVID-19 there were no doctors to see her. She was in so much pain. My parents had to take her to a nearby town—Bulawayo which is about 120km to get medical care. They paid US$125 for her treatment. It is so expensive.”

As at March 2021, Botswana, Eswatini, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Zambia and Zimbabwe were rolling out government-led COVID-19 immunization programmes—a move set to contribute to significant protection of the population in the region by achieving herd immunity. However, effective coordination among government health departments and community health workers should be prioritized as part of efforts to engage communities in the increased uptake of immunizations. SADC governments have introduced COVID-19 healthcare strategies that provide frameworks for strategic and well-coordinated national actions to counter COVID-19 vaccine misinformation and to create demand for COVID-19 vaccination. As the months proceed, Members States will need to prioritize equity in the distribution of vaccines to rural communities, those with disabilities and citizens working in informal sectors, who form part of the largest workforce in the region.

Although the policy decisions and lockdown measures have been instrumental in reducing infections, health infrastructure in most SADC Member States could not fully support critical care for severe COVID-19 cases. Accessibility to hospitals has been a challenge, or almost impossible. South Africa, a country with one of the best health systems in Africa, has less than one thousand Intensive Care Unit (ICU) beds for the country’s 56 million people, while the DRC has as few as five ICU beds in one hospital. To keep beds for the most severe cases, “supportive care” is standard for COVID-19 treatment. This means ventilator support is provided only if a patient develops respiratory distress. The shortage of ventilators has already been experienced by most Member States (including Malawi, South Africa, Zambia and Zimbabwe) that are extremely affected by this pandemic. One of the main reasons for the shortage is related to the global supply chain. Due to the worldwide spread of infection, the exports of medical equipment, including ventilators, has been interrupted. Simply put, African countries’ health systems cannot contain the pandemic given the increasing infection rates.

Poor testing capacity has also hampered case identification, quarantine and contact tracing efforts. The WHO advocates for effective community surveillance through increasing testing. However, most countries in the Southern African region have inadequate surveillance and

* Angola, Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Namibia, South Africa, Zambia and Zimbabwe
laboratory capacity to perform testing, coupled with limited fiscal support to acquire testing or build the diagnostic capacity necessary to decentralize testing, and are dependent on donor aid for testing kits. Testing and vaccines have not been universally accepted, with Tanzanian authorities, for example, dismissing the validity of WHO-recommended testing platforms and test kits. Furthermore, personal protective equipment (PPE) for health workers is in short supply, which in Zimbabwe resulted in a nationwide strike of doctors and nurses.

As the COVID-19 case-load and associated pressure on the health system decrease, many services that were suspended will need to be restored. In many settings, the temporary suspension of services will lead to a backlog of people needing care. Interrupted preventive programmes, including screening, are likely to require catch-up campaigns, for example for missed vaccinations. The suspension of surgical services is also likely to create a substantial backlog in most systems, with some procedures that were initially deemed elective becoming progressively more urgent. Given the health workforce requirements, the necessity for close contact and the associated material resource needs (including operating theatres and extensive PPE), restoration of operative services post COVID-19 will require a coordinated and well-planned strategy within Member States.

5.4 Adolescents’ access to SRH and services

Adolescent SRH services are critical for girls and young women and men. During crises and emergencies, disruptions to critical SRHR services may lead to unintended pregnancies, STIs (including HIV&AIDS) and increased health risks for young people.

The provision of SRHR services was disrupted in Lesotho, Malawi, Zambia and Zimbabwe. Projections from UNFPA note that, if the average lockdown (or COVID-19-related disruptions) continues for six months, an increase in unintended pregnancies, GBV cases and child marriages could occur. It also estimates that by March 2021 twelve million women may have been unable to access family planning services as a result of the COVID-19 pandemic, with disruption of supplies and services lasting an average of 3.6 months. The COVID-19 crisis therefore threatens to shrink the already limited access to SRH services for adolescents and young people. The restrictive laws and policies—concerning sexuality and consent, caregiver or partner control, limited knowledge, distance to healthcare facilities, cost, lack of confidentiality and service provider bias—existing in most countries limit adolescents’ autonomy and prevent them from accessing and receiving the SRHR information and services they need. These barriers to access SRH have been compounded by COVID-19.

Air and border travel restrictions have increased stock-outs of key SRHR products, which has been exacerbated by factory closures in countries such as China and India. The socioeconomic implications of the pandemic have made SRH services increasingly unaffordable, and movement restrictions have made it more difficult for adolescents and young people to access services discreetly. Women and girls in rural areas face additional barriers to accessing services.

Indications of reduced access to SRHR services during COVID-19 are emerging. Interviews conducted found that girls’ use of health centres for SRHR services had considerably decreased. This is especially true in rural areas, where the distance to the nearest healthcare facility is long. Many girls interviewed (58%) explained that they are refraining from accessing SRHR healthcare of their own volition due to fear of judgemental treatment at clinics. This is
particularly challenging for adolescent girls, and girls with disabilities, who had limited access to SRHR and GBV response services even before the lockdown. Girls from Lesotho, Zambia and Zimbabwe (41%) reported that even when they needed access to SRHR services, they decided to stay home as they feared harassment from police enforcing stay-at-home orders during their travel to health centres.

When asked if adolescents and young people were accessing SRHR services before COVID-19 lockdown, 64% of the surveyed youth and 72% of FGD youth respondents confirmed that they had been, by walking into healthcare facilities (61%), accessing youth-friendly corners or centres (41%) or through mobile health services (15%). However, regular access was affected by the lockdowns instituted.

Young learners felt that the youth-friendly corners that were linked to their schools offered an enabling environment for receiving dedicated support by a known nurse or healthcare worker. However, the school linkages to healthcare services have been disrupted, and young people found themselves having to navigate the healthcare system on their own without the support of trusted and trained adults in the school and health system. The respondents mentioned that their sources of information on contraception and STIs were hindered by limited access to healthcare facilities and health workers. They expressed concern that the COVID-19 lockdowns sometimes created an inhospitable atmosphere for discussions on such sensitive subjects with caregivers.

Youth FGD respondents (59%) reported having less information on how they can access SRH services during the lockdown than they had had before. Figure 24, below, presents the percentage of respondents in each of the demographic groups surveyed who reported knowing where to access SRHR support and service before and during the lockdown, and shows that knowledge about accessing SRH services since the lockdown has declined for each age cohort. Generally, the older research participants had more knowledge than the younger demographic groups. The data makes it clear that younger teens across all the six Member States reviewed require more youth-friendly information on SRH services during the pandemic.

For those that do have information on where to obtain SRH services during COVID-19, youth-friendly corners, community hospitals and the internet were mentioned as sources of information, as was information passed on through WhatsApp chats. But 42% of girls under 18 interviewed reported not having information on how to access SRH during the lockdown. This points to a need for continued targeting of girls and their families to inform them of available services.
Adolescent girls in FGDs were embarrassed to speak openly about access to SRH services. Many mentioned NGOs as being supportive in them accessing such information through their SRH programmes provided at youth-friendly corners and healthcare facilities. This suggests that NGOs providing targeted SRH information sessions for adolescents may be a preferred way for girls to obtain information about a subject that they link with shame or embarrassment.

Many girls and boys also report having used virtual SRH and GBV services (see Figure 25, below), particularly those linked to schools or known to their peers, though a greater percentage of young women from 19–25 (52%) had accessed a virtual SRHR service than had adolescent girls 15–19 (38%) or young women 25–35 (10%).

Adolescent girls (Lesotho, Malawi, Zambia and Zimbabwe) who had received virtual SRHR information and services generally regarded these well and said the service made them feel better and supported in decisions about having sex. However, in key informant interviews, 71% of adult service providers opined that virtual services are not a true replacement for in-person services.

Adolescent girls and boys also reported that SRHR radio and TV programmes sponsored by NGOs were providing them with important information, with 51% of female and 66% male respondents reporting that they had tuned in to at least two SRHR radio programmes during the 2020 national lockdowns.

* Possible reasons are that virtual services were not as accessible to adolescent girls from younger age groups, mainly because of limited access to personal mobile devices and data.
CSE is an important strategy to address the barriers to SRHR provision for school-going youth. School-based CSE links adolescents and young people to health centres, community-based protection and care mechanisms. But because of the school-closures, learners could not access CSE and Life Skills Education, as the subjects were not included in virtual learning packages or in reading packs and notes. This left young learners without accesses to CSE and SRHR programmes linked to health facilities, communities and school.

Young people generally (89%) felt that the models of linking schools to SRHR support and services were good. However, adult respondents (63%) expressed concerns that more conservative governments that have been opposed to CSE may seek to use the crisis to curtail significant gains on SRH made through the education sector, for example, by limiting the content in CSE curricula or removing it from education programmes altogether. This was noted mostly by CSO respondents who raised the importance of continued advocacy with SADC governments to renew the ESA SRHR commitments and create an enabling environment for its implementation.

CSE must also be included in distance learning packages and consideration made for those who do not have access to digital resources.
The respondents (53% adults and 75% youth) were generally concerned that the curtailing of services and difficulty accessing critical condoms, contraceptives, HIV&AIDS treatment may lead to more unplanned pregnancies, complicated births or HIV&AIDS infections. Young learners felt that accessing condoms, HIV&AIDS treatment and contraceptives had been easier before the COVID-19 pandemic. In the FGDs, 65% of girls reported shortages of menstrual health and hygiene products, a sharp rise in prices of sanitary pads and tampons, and lack of access to basic information and services about menstrual hygiene management. Although Member States such as Malawi and Zimbabwe had removed VAT from sanitary pads, many girls in those Member States, and in Lesotho, were still struggling with managing their menstrual cycles due to high prices of menstrual kits.

Many young women and girls confirmed being pre-occupied with staying safe from COVID-19 and they had de-prioritized the uptake of contraceptives. For male youth respondents, access to free condoms was also a challenge, noting that they resorted to buying condoms with pocket money in supermarkets as they could not get them at local clinics because of long queues.

Young respondents also reflected on the additional challenges LGBTQI youth were facing in accessing healthcare and SRHR. The qualitative analysis of FGD discussions with young people showed that even in the absence of the pandemic, LGBTQI individuals face challenges in accessing healthcare due to stigma and discrimination, and in contexts where they are criminalized, face threats to their security and lives. Some LGBTQI people have greater health vulnerability. The fact that access to SRHR and trans-specific healthcare has been compromised, particularly during the pandemic, and that access to mental health support is limited, creates multiple challenges for these young people. Access to ART, hormones (and other transition-related and gender-affirming care and medication) and SRH services remains critical for the wellbeing of LGBTQI people. Young people agreed that the peers of LGBTQI people should support them with information about where they can access the services they need.
Box 22: Case Study—Botswana (CSE)
Advancing CSE by Linking Schools, Community Leaders and Health Workers Supporting Young People

The Gender Sector of the Botswana Council of Non-Governmental Organisations (BOCONGO) collaborated with UNESCO on this CSE campaign. Through a partnership with the Ministry of Basic Education, it led to training of teachers and health workers (nurses) on the CSE manual to integrate CSE into the school curriculum. Using UNESCO’s Parent-Child Communication manual, the Ministry is also working with caregivers to bring them on board to address SRHR.

Another partnership, between the Botswana Ministry of Health and the Botswana Council of Churches, aims to train healthcare workers, faith-based organizations and religious leaders on SRHR, while UNPFA and UNESCO work on prevention of early and unplanned pregnancy among young people. This includes supporting line ministries to ensure young people have access to SRHR services and information, and to ensure policies are aligned to global standards.

Source: Global Financial Facility & Reproductive Health Supplies Coalition (2020)

5.5 A generation in need of care
Youth MHPSS

COVID-19 has undeniably affected adolescents’ and young people’s emotional and mental wellbeing. Restrictions on freedom of movement, limits to physical social contact, and quarantine with unsupportive or abusive family members, can negatively impact their health and wellbeing. Loss of contacts and socialization with extended families and friends can also bring feelings of loneliness and isolation, and the virus itself is also a cause for anxiety.

Because of the lockdown measures, young people have limited access to positive coping mechanisms that they would normally turn to in times of crises, including social initiatives, community-based services, formal or non-formal education, sports, other types of physical activity and recreational services. Isolated from their support systems, young people may turn to negative coping mechanisms such as alcohol and drug abuse, self-harm, or harmful sexual behaviours. The need for adolescent and youth-sensitive MHPSS services and counselling will increase as the pandemic progresses. The COVID-19 pandemic itself has triggered significant stress and worry among young people, with a heightened fear of contracting the virus, losing a loved one or infecting someone else.

The consequences of stay-at-home orders are likely to be exacerbated in low-resource countries, such as those in the SADC Region, where financial capacity to support young people with MHPSS is limited. Stress that is triggered by homebound orders can weaken the immune systems of growing children and increase their susceptibility to infections. Young active people who are forced into sedentary lifestyles are at higher risk of developing non-communicable chronic illnesses such as diabetes, and hypertension, which are already a growing concern in the SADC Region. In addition, because young people living with HIV and LGBTQI persons are more vulnerable to mental illness, especially depression, and coping with a public health emergency such as COVID-19 might compound pre-existing psychological distress. Restrictions on movement imposed by lockdowns has made it difficult for young people living in the SADC Region to access comprehensive MHPSS services where these are available, whether in healthcare facilities, the school set-up or in communities.
MHPSS is not a well-discussed issue in most communities in Africa, and young people experiencing overwhelming feelings of loneliness, loss of hope and suicidal thoughts may not receive the necessary emotional care and support they require from their family members or community leaders. Mental health issues have been on the rise during the COVID-19 pandemic because of economic pressures on families. Unemployment rates remain high, with young people being disproportionately affected. Most of the employed young people in the region rely on the informal sector for income.

Overall, the data collected from young people’s survey and FGD discussions suggest that, while some young people have demonstrated resilience, a significant cohort of adolescents and young people appear to be suffering mental distress related to the COVID-19 crisis. Almost three in four youth respondents (74%) reported feeling more worried than before the outbreak, and two in three (62%) reported being less happy. Children reported being less hopeful (47%), feeling sadder (59%) and less safe (53%). As the confinement period and weeks of school closure increased, so did young people’s reported negative feelings. For young people, the negative feelings increased from 52% for Weeks 1–4 to 76% in Weeks 11–12 of school closures.

About 45% of young people reported that they were sleeping less than before the COVID-19 virus outbreak, while 39% highlighted that in the first six weeks of the lockdown they experienced headaches and stomach aches because of anxiety and stress. Around 60% reported being more bored than before, and approximately 25% felt that they had less of their own space and time than before. Surprisingly, children surveyed in Malawi, Lesotho and Zimbabwe reported spending 50% less time on relaxation than before the outbreak. The reasons cited were increased household chores and burden of care of siblings. At the time of data collection, these three Member States were in the rainy and planting season, and young respondents mentioned that they were expected to help at home with younger siblings, with domestic work and/or in the fields. However, this did not affect them equally: 61% of the female youth respondents reported that they had more chores to do, compared to only 47% of the boys (see Figure 26, below).

Among FGD respondents, 62% reported that they were noticing increased cases of drug and alcohol abuse, with two out of three participants confirming that they knew one friend taking harmful substances such as marijuana, nyoape,* codeine or sniffing glue. Girls in Malawi, Zambia and Zimbabwe expressed concern that there were many stories in the media (radios and newspapers) about ritual killings of children by young adults in their late 20s, and of suicides in their communities.

These results confirm research that the mental health of young adults is now of serious concern in Africa. Exposure to violence, the huge burden of domestic and care work, and the inability to negotiate and be heard within the family are among factors that contribute to young people’s poor mental health. Exposure to multiple forms of violence, for example, increases the likelihood of girls experiencing mental illness by two to seven times when compared with those who have never experienced violence.90

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* Also known as whoonga or wonga, a form of black tar heroin
In keeping with the restrictions put in place by the government, respondents unsurprisingly reported significant changes in their daily lives. Most of the female and male young people responding to the surveys reported their lives to have changed at least somewhat. Interestingly, young men 19–25 were most likely to report that their daily lives had not changed much since the pandemic, followed by the cohort 26–35 (81%). This may be due to the higher likelihood of older male young people having the flexibility of working outside of the home and not being confined for long periods. Young adolescent’s girls (15–18) missed social interactions with friends but found the home setting enabled them to have more time with their caregivers and siblings. Some said they had learnt a new skill which they would not have but for the long lockdown periods. The older female youth (19–25) expressed similar concerns that life had changed for them as they could not visit friends or go to recreational places freely. Some reported using the time to strengthen their belief systems (praying and reading), as well as in other forms of reading and supporting their caregivers.

In contrast to the negative effects reported from lockdowns and other COVID-19-related measures, there have also been a range of positive experiences associated with the situation. These include having more time for play or to pursue hobbies, building better family relationships, spending more time outdoors, having a better community spirit or being more open to speaking to neighbours, and learning new skills. A substantial number of children and young people have also engaged in positive actions, such as sending encouraging messages to others or making a video to make someone smile.

When asked about what made them happy during the lockdown, 65% of male and 72% female respondents reported that they felt happy spending time and connecting with caregivers who would usually have been occupied with their work and careers. The young people felt that their caregivers were getting to know them better as they spent time together. They also noted improved relationships with their caregivers. Strikingly, although most learners had felt happy about reconnecting with family, 31% of youth respondents noted that this was not the same for everyone as some were stuck at home with abusive or unsupportive caregivers, or they were staying alone as their caregivers had migrated to other countries leaving them with no caregiver support and love. Furthermore, some young people expressed fears that included testing positive for COVID-19, a family member or friend testing positive, or losing a loved one. They said the numbers of people dying daily scared them. As the weeks progressed, they were increasingly distressed by the numbers of those in their communities who they knew who...
were getting infected and were dying. They were also worried by their caregivers not going to work, and by the loss of the family income. Another concern was the loss to their education and not knowing when they would write their national exams.

![Figure 26: Young people feeling more worried and less safe over lockdowns (Youth responses)](image)

The FGD results revealed young people’s resilience during a difficult time of uncertainty. When asked how they are passing the time, respondents across age and gender groups indicated that they had been watching television, reading novels, staying connected and chatting with family and friends, helping their younger siblings or learning a new skill (see Figure 27, below). Watching television is popular among all groups, while girls are more likely to spend time reading or writing than boys are. Adolescent boys reported being more involved in sports at home or walking. Interestingly, only 45% of adolescent girls reported staying connected with and chatting with friends as a common pastime in comparison to 72% of boys, which may be linked to adolescent girls being less likely to have access to a mobile phone. Adolescent girls participating in FGDs also reported spending time in personal development such as studying (including studying for final high school exams), as well as learning new languages.

While lockdown has created positive experiences, many aspects have been immensely challenging for young people. Restrictions on freedom and, in particular, not being able to see friends and family were identified as the most difficult aspect of lockdown. The resulting feelings of loneliness and isolation can have a profound impact on mental health and wellbeing. Young people feel cut off from the support mechanisms that had previously helped them to cope, have their voices heard, exercise their rights and feel safe, happy, and protected. Lockdown has exacerbated existing issues, such as feelings of powerlessness and...
the inability to move forward or change aspects of their lives. This has in turn impacted profoundly on mental health and feelings of wellbeing.

![Bar chart showing activities for coping with COVID-19 lockdowns for males and females.](chart.png)

**Figure 27: What young people are doing to cope with COVID-19 lockdowns (Youth responses)**

The pandemic has also caused major disruptions to family relations and structures, exerting widespread impacts on pregnancy, childhood and parenting. For pregnant women, reduced access to antenatal care or fear of getting infected in health facilities, and the uncertainty and anxiety over the pandemic, are leaving many of the disadvantaged isolated from support structures and skilled healthcare personnel.

Caregivers are feeling strained in multiple ways from the pandemic, and this can spill over into childcare. For them, lockdowns and unemployment due to retrenchments and salary cuts are increasing levels of anxiety and depression. School closures have also added to their burden of childcare and provision of nutrition to replace school feeding programmes. In addition, when schools and kindergartens remain closed even as lockdowns ease and economies open up to a degree, the childcare implications can be profound. In South Africa, Zambia and Zimbabwe for example, domestic workers have had to return to work as the lockdown eased earlier this year (2021) but without the safety net of crèches and schools—which remained closed—to care for their own children. Caregivers are thus confronted with dilemma of working to receive an income against leaving their children in situations of suboptimal care and lacking adequate educational stimulation and support. Caregivers working as essential service providers are also experiencing considerable stress, which in turn could impair their ability to undertake childcare and household activities.
The short- and long-term implications of the crisis on mental health are largely unknown. A better understanding of the impact on mental health is necessary for more targeted response strategies. While most resources are channelled to addressing physical needs caused by COVID-19, there is a risk that investment in mental health services is often overlooked. The disruption of the delivery of SRH services and information also affects young people. The need for mental health services and counselling is paramount, as many people, including young people, are facing high levels of anxiety and stress-related to COVID-19. Young people are also affected by closures of non-formal education opportunities, depriving them of social engagement with their peers and teachers. Prolonged periods of closures and movement restrictions may lead to additional emotional unrest and anxieties.

5.6 Health systems strengthening

Health systems in the Southern African region face challenges due to the increasing demand for care of people with COVID-19, compounded by other critical essential healthcare needs. Though the COVID-19 restrictions and healthcare measures introduced were necessary, they may have direct and indirect implications for specific populations including adolescents and youth. The choice of intervention to support adolescents’ healthcare needs should depend on the specific challenges faced: e-health interventions could be effective for adolescents able to access and use them; community-based interventions, working with adolescents and their caregivers, could serve as an effective response for adolescents living with disabilities or for severe cases of mental health disorders. The need for home visits or other in-person contact should be assessed on a case-by-case basis; appropriate safety measures (such as physical distancing and PPE) would need to be taken and, where possible, SRH support sessions should occur outdoors or in well-ventilated spaces, as well as in spaces allowing privacy. In efforts to build back better and create strong resilient healthcare systems, Member States will need to balance responding directly to the COVID-19 pandemic by upholding quality and accessible healthcare services for citizens.

Recommendations

Strengthening health systems for the benefit of adolescents and young people requires a holistic approach. It is therefore important for governments and civil society to:

- **Strengthen capacity of healthcare facilities** to manage the surge in patient visits and to effectively identify, isolate, and manage people with COVID-19 infection, while supporting demand creation and health-seeking behaviours for other healthcare needs, thereby ensuring universal health coverage

  Governments should continue to invest in partnerships with the private sector to put in place infection prevention and control measures. They should ensure health workers have access to PPE, proper training and compensation for all health workers. Digital health platforms and tele-health approaches should be used to support essential health delivery.

- **Ensure equity in the provision of the COVID-19 vaccines** by providing citizens with correct information on the benefits of COVID-19 vaccines, and equal vaccine access particularly for poor and vulnerable communities
• **Ensure continuous routine essential healthcare**, including but not limited to, a vaccination campaign and maternal healthcare for pregnant women, new mothers and under 5-year-olds, as well as the continued use of youth-friendly spaces in healthcare facilities so that young people can access SRHR services

Healthcare facilities should use triage models to begin opening healthcare units for other essential healthcare services for children and young people.

Support and training—including remote training—on the provision of gender-sensitive and non-discriminatory SRH health services should be provided for healthcare workers.

• **Continue to commit to the ESA SRHR commitments**, with a renewed focus on linking schools with healthcare clinics, and engaging with community leaders for strengthening care and supports for young people to receive the urgent and necessary SRHR and MHPSS services

Where contexts allow, governments should encourage mobile health drives and telemedicine to address the SRH needs of adolescents.

• **Support efforts for CSE delivery in schools**

CSE should be resumed, with the assumption that CSE delivered virtually during school closures was likely to have been piecemeal and fragmented, and would not have reached many sub-populations, particularly housebound young people who had no internet access.

• **Invest at least 15% of public budgets in the health sector and remove financial barriers to access** to reach the 2001 AU target to build health centres for long-term health system strengthening to respond to future pandemics, improve the health sector and ensure universal health coverage for all by 2021

• **Prioritize MHPSS interventions for adolescents and young people** by promoting education, health and protection sector coordination aimed at providing specialized services by skilled and supervised personnel who know how to address the specific mental health and emotional needs of young people

MHPSS practitioners should consider using digital platforms to provide psychosocial support and for early detection and management of mental health conditions.
CHAPTER 6: Protection of Adolescents during COVID-19

Since the outbreak of the COVID-19 pandemic and the resultant implementation of lockdowns, reports of GBV and other protection concerns have increased, with the surge in cases being referred to as “the second pandemic” or the “twin/double pandemic”. This chapter provides an analysis of the protection issues young people faced during the national lockdowns. It concludes with suggested policy and programmatic responses to address the protection issues identified.

At the outset of the global wave of lockdowns in early 2020, there was considerable and understandable concern about the prospect of increased violence against women and children. Protection practitioners warned of this as the pandemic took hold, in part due to the evidence from previous epidemics and movement restrictions that resulted in an increased risk of stress and decreases in wellbeing of caregivers, heightened exposure to sexual, physical and emotional violence, and intimate partner violence among adolescents and in the household. In addition, increases in GBV during the pandemic will profoundly impact caregiver capacity in homes where abuse is taking place.91

Key findings

- Prior to COVID-19, 35% of young women globally had experienced either physical or sexual intimate partner violence.
- Emerging data shows that since the outbreak of COVID-19 there has been an overall increase in the number of women calling helplines and reporting violence.
- 52% of adult respondents, including CSO service providers, believed that despite the presence of victim-friendly or community policing units to support access to justice for women, certain aspects of GBV, including emotional violence, were trivialized.
- 79% of young respondents in Lesotho, Malawi and Zimbabwe voiced their concerns about the increased crime and gangs, particularly in informal settlement and high-density areas.
- Four out five youth respondents knew an adolescent or young person staying in an abusive household or in an abusive relationship.
- 72% of female and 61% male respondents reported that newer forms of abuse, such as cyberbullying and street calling, were on the increase.
- 81% of adult respondents and 91% young respondents stated that police instituting lockdown measures used violent force.
- The limited access to justice is perpetuating GBV, with perpetrators seeming to commit violations with impunity.
- Calls to child helplines have risen markedly during the pandemic, suggesting a rise in violence, or threat of domestic violence, against children and adolescents.

Marginalized groups need tailored support to prevent exacerbating inequalities. To address and challenge inequity and discrimination, programme design must proactively consider social contexts, socio-demographic categories, social processes and social systems.
6.1 Gender-based violence—the pre-existing pandemic

The COVID-19 pandemic has prompted an escalation in GBV, in particular violence against women and girls. It has magnified the pre-existing structural problems that perpetuate GBV, including poverty, inequality, high unemployment, harmful cultural norms and mental health issues, as well as systematic failures of the criminal justice systems to address GBV in many countries. The World Bank estimates that before COVID-19, at least 35% of young women were living with an abusive partner or had experienced either physical or sexual intimate partner violence or non-partner violence.92 These numbers are projected to increase by 15% due to the lockdown measures. UNFPA now estimates that six months of lockdowns could lead to 31 million additional cases of GBV, and another fifteen million cases for every three months the lockdown continues.93 Ten million more girls are most likely to marry before their 18th birthday,94 and boys who were already at risk of dropping out of school will be engaged in hazardous work.

The SADC Region is no exception to the high prevalence of GBV and other protection concerns. Across Southern Africa, young women and girls experienced various forms of violence before COVID-19. A review of the literature shows that reporting of physical, sexual, and emotional violence was on the increase even before the lockdown. However, reports to police, helplines and NGO protection service providers intensified and increased in frequency during the March 2020 to March 2021 period. Adolescents, women and men who suffered GBV during the COVID-19 lockdowns struggled to report abuse; organizations working to provide protection and support to young women and girls were not considered as an essential service. This curtailed movement of service providers and GBV survivors led to a dire situation where the latter were trapped in homes with abusers, isolated from social support and with nowhere to report or find solace.

The analysis shows that out of the six Member States studied, Madagascar, Namibia, Zambia and Zimbabwe did not prioritize GBV services and response as part of critical or essential services during lockdowns. In addition to intimate partner violence, most young respondents (65%) reported that child marriages in their communities had increased since lockdown, citing the reason of families “forced to” marry off their daughters to ease financial burdens (because of job losses leading to increased economic insecurity) or unplanned pregnancies (to avoid negative community perceptions).

Information from some FGDs and key informant interviews suggested that certain forms of GBV that are associated with moving in public spaces (particularly sexual harassment and bullying) may have been curtailed somewhat by the stay-at-home measures. However, given the level of stigmatization of GBV, respondents may have been in denial or may have been hesitant to state openly that these instances had increased. The high levels of GBV reported across the region in the past twelve months of lockdown are at odds with the vision of Agenda 2063 of “ensuring gender equality”.

Figure 28 shows the most prevalent forms of GBV reported by young people in Lesotho, Malawi, and Zimbabwe.
Youth respondents in Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe reported intimate partner violence, rape, child marriage and cyberbullying as the most prevalent forms of GBV experienced during lockdown. In South Africa before the crisis, 88% of the reported cases of GBV were perpetrated by husbands or intimate partners. However, during the first two weeks of the lockdown, case management agencies reported a 6% spike of reported cases by both intimate partners and non-partners. In Lesotho, a third of all crimes reported since the start of COVID-19 were related to sexual violence. In Malawi, reported incidents of GBV more than doubled between January and April 2020. The young respondents (65%) female and (53%) male believed that the high prevalence of GBV in the Southern African region was due mainly to financial challenges because of limited livelihood opportunities during the lockdown. This tended to increase tensions in the family, as well as on decisions of resources and food security. Proximity to the perpetrator, lack of access to a private mobile phone and limited knowledge of hotline numbers and trust in online services, are all factors that contribute to the increase in GBV cases. Increased consumption of alcohol and other substances also contributed to the increases in GBV.

Young respondents (53%) in Lesotho, Malawi, Zambia and Zimbabwe reported that victim-friendly police units remained open; however, most police officers did not prioritize GBV and de-prioritized investigations of such cases due to restricted movement in neighbourhoods and communities. Young girls also felt that those who had been abused were unable to access SRH services, such as emergency contraception, pre-exposure prophylaxis (or PrEP) and post-exposure prophylaxis (or PEP). This limited access exacerbated health risks, such as unwanted pregnancies, childbirth complications and HIV infection. This was confirmed by the reviewed literature, showing that protection services and referral mechanisms had been disrupted. At the same time, lack of access to child protection services and information places
adolescents and young people at greater risk of experiencing and remaining trapped in exploitative situations that can have long-term physical and emotional consequences.

The closure of youth-friendly spaces or “corners” and “girls-safe spaces” meant the loss of vital social support and related networks essential for coping with violence, particularly when young people experience domestic violence from their caregivers. For contexts that have traditionally had low levels of reporting of GBV cases, the numbers have worryingly been much higher during the pandemic. Furthermore, the closure of schools has made the most widely used avenue for reporting of child abuse cases inaccessible, and it has become extremely difficult to identify learners who may be experiencing violence in the home and to seek appropriate intervention. It was unanimous in the FGDs held that the social supports provided within healthcare facilities and in schools were important for the protection of young people and for their emotional support. Although “care mothers” and community-based protection committees are bridging the gap in Malawi, for example, they have been cut off from supportive linkages with formal protection agencies.

**Box 25: Ms Abigail Solomons—Positive Vibes, Namibia**

“The issue of GBV in the region is concerning. The violence on women and girls shows us the need to address gender norms that perpetuate othering and discrimination of young people most at risk. Those experiencing or at risk of violence may have trouble accessing relevant protection services, due to social isolation measures. The diversion or withdrawal of necessary funding and resources, including those for SRH, mental health and psychosocial support can make the situation extremely dangerous for girls and women, and countries need to support GBV prevention and response.”

As case management and home visits for adolescents and women at risk of abuse were disrupted, child helplines and crisis lines stepped up efforts to provide psychosocial support, referral to legal aid services and access to needed SRHR services for sexually abused clients. Childlines in Lesotho, South Africa, Zambia and Zimbabwe reported that their emergency numbers for children had been inundated with calls from young people reporting domestic violence by caregivers, cyberbullying and sexting, and for counselling on the mental stresses brought about by the lockdown. Table 6 shows the hotlines in the review Member States providing online protection services during the COVID-19 lockdown period.

**Table 6: Child Helplines/Hotlines reporting increased GBV cases during COVID-19**

<table>
<thead>
<tr>
<th>Member State</th>
<th>Hotline</th>
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<tbody>
<tr>
<td>Lesotho</td>
<td>Lesotho Child Helpline</td>
</tr>
<tr>
<td>Malawi</td>
<td>Tithandizane Child Helpline</td>
</tr>
<tr>
<td></td>
<td>YONECO</td>
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<tr>
<td>South Africa</td>
<td>National Centre for Missing and Exploited Children</td>
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<tr>
<td></td>
<td>ChildLine</td>
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<tr>
<td></td>
<td>Broadcasting Commission of South Africa</td>
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<tr>
<td>Zambia</td>
<td>Lifeline/Childline</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>ChildLine Zimbabwe</td>
</tr>
<tr>
<td></td>
<td>National GBV Hotline</td>
</tr>
</tbody>
</table>
The devastating effects of domestic violence on young people are well documented. Adolescents who witness a caregiver being subjected to violence in the home may suffer a range of severe and lasting emotional and psychosocial effects. Young people who grow up in violent homes are more likely to be victims of child abuse and to themselves exhibit violent behaviour and other psychosocial issues. It is therefore critical that governments and CSOs prioritize violence prevention and response services for children, young people and women.

6.2 Other protection concerns during COVID-19

Adolescents and young people face various protection risks during crises and emergencies. Other protection concerns that have been reported during the lockdown period included online sexual exploitation, cyberbullying and economic exploitation including transactional sex and harmful child labour.

The study revealed that young learners studying through digital means were more likely to be at risk of cyberbullying and online sexual exploitation. One in three young male respondents stated that they knew a peer who was sexting or using mobile phones inappropriately. Many female youth respondents mentioned that comments from other users on social media platforms such as Facebook and Twitter were often offensive and disrespectful, leading them with feelings of inadequacy.

When asked whether they knew how to protect themselves when using the internet, 62% of young learners said that they were aware of strategies to keep themselves safe online, including what information they should and should not share and/or how to change whom they share content with; 33% dealt with cyberbullying by telling a caregiver or a friend, while 25% blocked the person concerned; 20% would not add anyone they did not know in the first place. Of the male respondents, 27% stated they would tell a caregiver or a trusted friend or block the bully, compared to 37% of female respondents who would do so. Yet despite knowing internet safety approaches, young learners disclosed that they did not always follow these protective steps.

**BOX 26: FEMALE LEARNER (18)—LESOTHO**

“COVID-19 has made life so hard. We go to bed hungry most days. I have to look for a job to help at home. I am not very proud of how I am getting money right now.”

Even though child labour was prevalent before COVID-19, the pandemic has exacerbated this reality as young people are forced to work in hazardous conditions as an economic necessity for many families’ survival, especially after lockdown job layoffs. Studies show that in sub-Saharan Africa, a one percentage point rise in poverty leads to at least a 0.7% increase in child labour. We now see that millions of children are at risk of being pushed into child labour, which could lead to the first rise in child labour after twenty years of positive progress.97

Being engaged in paid work impacts children’s ability to attend school or limits their ability to learn in the future. This study found a statistically significant association between children’s expectations about going back to school and the proportion of children reporting to be engaged in paid work. The 3% of the boys and girls who thought they would not be going back to school once COVID-19 is over reported getting paid for work they were engaged in during lockdown. Asked what forms of work young people were engaged in, youth respondents stated that boys
were engaged in fieldwork, work in mines and selling of produce, while girls were doing domestic work. During the FGD discussions, young people in Lesotho, Malawi, Zambia and Zimbabwe reported that girls in border towns were engaging in transactional sex with truck drivers to earn money.

Many young male respondents (79%) in Lesotho, Malawi and Zimbabwe were vocal on their concerns about the increased crime, particularly in informal settlements and high-density areas. They reported house robberies and theft on streets as common in their neighbourhoods; many people formerly working in the informal sector were unemployed and so needed a means of livelihood. In some mining cities in Zimbabwe, and farming areas in Malawi, learners highlighted the increase in gangsterism among young men between 16 and 35. Young men in the gangs were raping women or engaging in transactional sex with young girls. Drug and substance abuse were also on the increase, with young people taking part in drugs and substance distribution within urban areas.

Although they had no firm statistics to back them up, young people in Zimbabwe reported that in certain high-density areas such as Epworth and Mabvuku-Tafara in the capital Harare, and in border and mining towns such as Beitbridge and Gwanda, there have been reports of sexual exploitation and “sextortion” against women and girls, perpetrated by water suppliers at mobile water points in areas where there are water shortages. Youth in Malawi mentioned that in the Mangochi District there were similar reports. FGD respondents (56%) reported that police enforcing lockdown measures used unnecessary force, particularly on women and girls. This was confirmed by youth in Zimbabwe and Malawi.

Asked where they felt most safe the most, young female respondents (68%) said at home, while young male respondents felt that they derived a sense of safety with their friends and peers (72%), see Figure 29. These findings corroborate the gender-specific trends associated with lockdown. Girls are most likely to stay at home for safety and not be granted the same liberties to move as would boys; furthermore, they were also spending more time at home supporting caregivers with the household chores and sharing the care burden, hence would associate home as a safe place. However, as young males were more likely to form stronger bonds with peers and to maintain these connections during long periods of confinement, they might feel safer in the company of friends.
These results show the COVID-19 lockdowns have heightened protection concerns. The data also suggests that the protection concerns are prominent mainly because of loss of income and changes in economic conditions, increased violence and school closures.

6.3 Perpetrators acting with impunity, and access to justice

Socio-cultural and institutional practices constitute major barriers for adolescent survivors of violence to seek justice from competent authorities. These barriers came into sharper focus during COVID-19. The already weak legal protection systems and gaps in law enforcement mechanisms tend to widen during times of crisis. This was confirmed by 52% of adult respondents, including CSO service providers, who believed that despite the presence of victim-friendly units or community policing units to support access to justice for women, certain aspects of GBV, including emotional violence, were trivialized and not taken seriously by police officers. This is because of the gender and societal norms that normalize certain types of abuse.

Similar perceptions on police indifference to young women’s and girl’s reporting on GBV, which concretizes the miscarriage of justice, were shared by 46% female and 43% male youth respondents. One of the longstanding criticisms against the police and the justice system is the lack of seriousness in handling GBV cases, and this was compounded during the COVID-19 period when police de-prioritized investigations on GBV. Some young respondents in Zimbabwe reported knowing at least one person experiencing GBV; they stated that victims were often hesitant to report it to the authorities because of police attitudes in providing legal support to GBV survivors.

Over and above police indifference and patriarchal and harmful societal perceptions, the overstretched law enforcement capacities (resulting from an increase in other crimes because of COVID-19) have reduced the effectiveness of protection services, thereby contributing to a heightened sense of impunity among perpetrators and, ultimately, increasing rates of violence against women and girls.
CSO service providers (52%) highlighted that the police are under-resourced in general, and the situation has become worse for them now as they do not have PPE. The lack of transportation to enable police officers to facilitate investigations and arrest was also mentioned. There was a perception among young respondents that the police were too busy enforcing lockdown restrictions, which meant that there were few police officers to attend to critical cases such as rape and domestic violence. Trust in local police also diminished because of their unlawful use of force in enforcing lockdowns.

Generally, when a GBV complaint is filed in a Member State, the police start an investigation process and the police commanders are responsible for analysing the records and sending them to the public prosecutor. However, many factors discourage women from filing complaints, including financial dependence on the perpetrator and lack of confidence in the judiciary system. According to many of the key informants interviewed (42%), the government, NGOs and other bodies responsible for protection were preoccupied with the COVID-19 crisis, and women’s and girls’ protection were not prioritized. Furthermore, young girls raised concerns over the way police investigate cases of GBV. In Member States such as Malawi, South Africa, Zambia and Zimbabwe, policies about mandatory reporting have been inconsistently implemented, and there are cases of administrative detention of survivors of intimate partner violence. Police have been known to treat victims of domestic violence with scepticism, or they see it as a family matter that should be resolved informally, often pressing women into mediation or merely getting perpetrators to sign a pledge to not use violence again.

The considerable social and structural barriers to help-seeking before the crisis continue to be prominent or have even intensified, with women and girl survey respondents overwhelmingly pointing to social pressures—in the form of fear of the opinions of their community and the consequences—as the cause.

**Box 27: Male youth (23)—Zimbabwe**

“The police should treat women and men fairly when they come to the police station to report. Asking for evidence and whether there is a history of a relationship seems to suggest that it is ok for violence to happen in relationships. Police must be trained to treat victims with respect.”

Many courts were closed during the lockdown and access to the justice system was affected. Courts were open only for critical criminal cases, such as rape and murder. Changes in the operations of justice systems were also cited by some adult respondents (33%) as a barrier to seeking justice for GBV and other protection concerns. The average time it took during COVID-19 to get a case from the police to the court was four to six months in Zimbabwe (with a similar projected same waiting time in Malawi and Lesotho). These lengthy timelines to access justice (coupled with limited access to legal aid; challenges with travel to and from court, where physical appearance was necessary; and the delays and postponement of court cases) were cited as bringing additional stress and uncertainty for young people seeking justice for GBV cases.

While it may be difficult to reach vulnerable populations when country-level COVID-19 public health control measures are in place, CSOs and NGOs nevertheless need to actively monitor incidents of human rights violations by law enforcement and military personnel who enforce
stay-at-home orders and social distancing measures. More broadly, CSOs ought to be involved in mitigating unintended consequences of the pandemic, including GBV and discrimination.

6.4 Impact on civil society operations

The study also interviewed service providers in SRH, GBV and youth empowerment fields, as well as key informants from the Ministries of Health and Child Protection. The key informant interviews were performed to provide insight on how services have been impacted from the perspective of both frontline and managerial-level providers.

GBV service providers described an initial push to provide information to beneficiaries on COVID-19 and the measures they should take, which mainly took the form of remote awareness-raising sessions, WhatsApp and other social media group messages, and flyers. Service providers made efforts to transition service packages to internet or phone platforms. For GBV services and targeted support services for youth, this includes hotlines, awareness sessions on Zoom or other platforms, and WhatsApp and Facebook groups.

The shift to remote services has been an adjustment, yet most organizations interviewed report that their staff are adapting well, considering the limiting circumstances of working remotely. The CSOs and ministry officials reiterated that working from home is not easy as workers had to balance home and work routines, while coping with intermittent internet access. Despite the challenges, most direct service provision organizations interviewed self-rated their staff’s capacity to adapt highly, which would indicate that they perceive their organization to be rising to the challenge of helping young people under what are still very new and challenging circumstances.

Several service providers for youth and GBV acknowledged that virtual MHPSS sessions are something that they can offer, but they should not be considered a true alternative for in-person activities.

About 72% of adult respondents, including service providers, confirmed that in Malawi, Zambia and Zimbabwe protection and GBV organizations were not considered essential services, thereby limiting their support to GBV survivors. Women activists and human rights defenders in these Member States were unanimous that referral support services and access to other services had been disrupted. They pointed out that access to support services for survivors of GBV had been constrained due to restrictions on movement and reduced availability of public transport (the most common mode of transport used by survivors). With limited access to public transport, young women and girls walked longer distances to reach protective services, thereby increasing the risks of more violence. Most halfway houses or care shelters were mandated to follow social distancing protocols, limiting the numbers of young girls and women they could support at any given time. Restrictions on movement impacted the survivors’ access to shelters—an essential services permit was required to travel to the city to report cases to the police; without this permit, many victims in Lesotho, Malawi Namibia and Zimbabwe were confined to home.

The pandemic created a heavy burden on CSO staff. Although most CSOs benefitted from a reallocation of donor funding to prevent COVID-19 infection through the provision of PPE (masks, sanitisers, etc.) and emergency relief packs, staff also had to take additional safety
measures to protect themselves when supporting survivors. Mental wellbeing of staff was
affected, as in general they did not benefit from clinical supervision or MHPSS. The analysis
shows that staff experienced high levels of fatigue and vicarious trauma when dealing with
complex protection issues affecting children, adolescents and women.

Box 28: Mr Caleb Thohle—GLOHOMO, Malawi

“It has not been an easy time for NGOs workers particularly case workers. Most of the young
survivors are abused by people around them. So sometimes you carry around the burden, and still
have to support them to recover.”

6.5 The uneven impact of COVID-19
Which young people in the SADC Region are at risk of being left behind?

Pandemics such as COVID-19 expose the weaknesses in every society and widen persistent
inequalities. The COVID-19 outbreak is predicted to have significant impacts on various
groups of adolescents and young people.

SADC Member States should proactively consider social contexts, socio-demographic
categories, social processes, and systems to address and challenge inequity and
discrimination. Such inequalities threaten young people’s futures and their transition to
productive and healthy citizens. The COVID-19 pandemic is also likely to further increase
virtual communication and reduce in-person contact in the short- and possibly longer-term.
This risks leaving other specific groups of adolescents more vulnerable, for example those
who are dependent on in-person support (including those with disabilities or in need of in-
person care) and adolescents in more resource-deprived or geographically isolated
households without access to social media through internet or phone connectivity.

With regards to efforts to build back better, certain vulnerable and marginalized groups need
tailored support to prevent exacerbating pre-existing inequalities. Box 29 below indicates
specific groups that should be given particular attention in post-COVID-19 recovery plans. The
specific groups of adolescents and young people most at risk from the direct and indirect
impacts of COVID-19 shocks are those who: depend heavily on the informal economy; occupy
areas prone to shocks and diseases; have inadequate access to social services or have no
political influence; have limited capacities and opportunities to cope and adapt; have limited
or no access to technologies; live in remote or rural areas.
Recommendations

At a time when young people’s safety, protection and wellbeing is threatened by the immediate and long-term impacts of COVID-19 and efforts to contain it, never has it been more critical to prioritize and collaborate on protecting them. The protection of children from violence, abuse, exploitation and neglect requires a coordinated involvement of actors across sectors, including health, education, social welfare, justice, and law enforcement at all levels. The study shows that protection concerns are on the increase, and in efforts to build back better there is a need to accelerate efforts to guarantee adolescents and young people a protective environment so that governments and other stakeholders can prevent and mitigate the long-term impacts of violence on young people.

Member States are therefore called upon to:

- **Ensure the continuity of prevention, reporting and care services for all forms of violence**
  
  The protection system should be strengthened in the context of the COVID-19 pandemic, paying particular attention to at-risk populations, including women, children, youth and people with disabilities.

- **Integrate SRH services into the GBV response**
  
  The GBV response should be considered lifesaving and part of essential services during COVID-19.

- **Increase the provision of virtual and telephone-based hotlines providing psychosocial support to adolescent GBV survivors**
  
  Mobile applications can be used to communicate relevant messages to help girls and women report GBV and child marriage, and to identify girls and women at risk.

- **Expand services to provide secure, confidential and accessible reporting channels for all GBV and SEA (sexual and economic exploitation cases)**

- **Ensure remote psychosocial support and referrals to the police, and for the reintegration of victims**

- **Provide legal, medical, psychosocial and socioeconomic services**

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**Box 29: Critical groups of youth requiring care and support in COVID-19 recovery**

- Young people with low levels of literacy and at risk of dropping out
- Young people with limited or no access to internet and cellular services
- Young people living with disabilities
- Married girls and pregnant girls
- Young people living with HIV&AIDS
- Young people who identify as LGBTQI
- Young migrants, young people who have been internally displaced or refugees
- Young people living in low-resource settings, high-density areas, informal settlements and/or remote, rural communities (particularly adolescent girls and young women)
• Ensure capacity building of social workers in the context of the COVID-19 outbreak and for the protection of children and the most vulnerable groups, including for GBV

• Designate all GBV services (including shelters, victim-friendly units and helplines) as essential services

• Prevent perpetrators from acting with impunity and ensure young survivors can access support and justice during COVID

• Equip NGOs with relevant information management systems to ensure the service-based data they collect is of sufficient quality to support GBV trend-monitoring and inform policy and programming responses

• Promote virtual helpdesks (using phone calls, WhatsApp, SMS, etc.) as a means of reaching survivors during lockdown periods

• Develop short- and long-term strategies to mitigate the economic impact of COVID-19 on young people

Member States should provide immediate food relief, cash transfers and/or income-generating activities to decrease household financial stress and to ensure survivors are not financially dependent on their violent partners.
CHAPTER 7: Impact on Youth’s Participation in Decision-making

Young people have the right to participate in decisions affecting their lives and expect that decision-makers will listen to and consider their views. The international, regional and national normative frameworks on children and youth reinforce and build upon this right.

Young people in sub-Saharan Africa are agents of change: they are mobilizing within their communities and are keen to engage with duty bearers to address the impact of COVID-19 on their lives. This chapter reflects on the voices of youth and their recommendations to ensure that their voices are heard and their inputs are taken seriously by adults.

Key findings

- Young people have access to information about COVID-19. They are using such information to protect themselves from contracting the virus.
- While 41% of young respondents reported they were listened to during decision-making at family level, only 22% said their opinion was asked for by family members; but 65% were able to freely ask adults about issues concerning them.
- Participation at national level is markedly lower, with only 3% of young respondents mentioning that governments or local authorities engage them meaningfully in public decision-making processes.
- The surveys and FGDs showed near unanimous agreement by adult (90%) and youth respondents (95%) that young people were rarely consulted in the formulation of COVID-19 strategies and programme actions to address their education, SRHR and psychosocial needs.
- Peer-to-peer interaction is strongly related to young people’s right to access information and their freedom to associate. Two in three youth respondents reported being deprived of social interaction with their friends and peers during the COVID-19 lockdowns.
- The pandemic has created opportunities for innovative ideas and solutions to COVID-19 from young people. Using digital technology, young people are rising to the challenge.
- Young people are asking leaders to be genuine, to involve them systematically and meaningfully in national development processes.
- Governments are called upon to be accountable, and to create job opportunities and prospects for success by improving the economy. Young people want governments to provide them with opportunities to engage in political and decision-making processes.

7.1 What do young people know about COVID-19?

The COVID-19 infection rates for young people in the SADC Region remain relatively low, and their prospects for recovery were projected as high. However, young people can still contract the virus and infect older populations, which have lower recovery rates. But the general
perception is that young people cannot catch the virus and are safe from it. At the onset of the pandemic, SADC governments and CSOs prioritized mass communication and awareness-raising to demystify COVID-19 myths among populations, including adolescents and young people.

The results show that adolescents in the study have good knowledge and relatively detailed information about the virus. Adolescent boys and girls from various backgrounds generally know about its symptoms, mode of transmission and preventive measures to take against its spread. How informed they were varied, with older adolescents being more knowledgeable than younger ones, due to their greater access to information and the internet.

Older adolescents and youth (19–25) learnt about the virus from WHO’s website, Wikipedia, Google Scholar, specific pages on Facebook and their Ministries of Health’s websites. Those who were active in searching for information were regarded as key sources of knowledge by their families and peer networks, and youth respondents noted that they actively disseminated the information they obtained. Some adolescents also learnt about COVID-19 from teachers during online classes, and from peers and friends. The youth FGD findings revealed that young people rarely obtained information from their caregivers.

Figure 30: Young people’s sources of information on COVID-19 (Youth responses)

The study findings show that learners with better academic achievement at school know more about the virus, possibly because they are used to looking for new information or because they are more interested in getting it. This might also be related to the availability of information through internet access. Respondents from urban areas had access to information on COVID-19 at a faster pace than those living in rural areas. In general, adolescents with disabilities have limited access to information. The analysis also shows that young people were sharing and disseminating the information they had to their families and peers.

Almost all participants perceive the virus as a serious threat, mainly because it spreads quickly, widely and endangers general health. Most respondents (71%) thought people in their countries should take the virus seriously, because of the number of deaths that were occurring.
A few respondents (19%) believed that the virus is part of a broader political ploy, playing down its impact on young people, and subscribed to other conspiracy theories.

Although adolescents in Lesotho, Malawi, Zambia and Zimbabwe have adequate information about the virus, many are interested in knowing more about the progress of the pandemic locally and internationally, as this affects their practices, especially social distancing. They are also keen to know about the best protective methods, and in the advances in developing a vaccine or cure for the disease: their primary focus was to keep themselves, their families and peers protected. Most respondents revealed that they were checking on their peers and friends regularly, and when they had an opportunity to meet during the lockdowns, peers would encourage each other to wear masks.

**Box 30: Male youth facilitator (22)—Zambia**

“I only trust information from the WHO website, and I regularly follow the MOH [Ministry of Health] daily press release. I don’t trust other sources. I share the information I receive with parents and my peers.”

Young people play a critical role in disseminating accurate information on COVID-19, tackling myths and stigma, policing fake news, and supporting information-sharing programmes on risk reduction, national preparedness and response efforts. They can be at the forefront of finding new and innovative ways to communicate with their governments, mass media, medical services and their communities through channels such as the radio, WhatsApp, text messages and videoconferencing platforms. Through social media, they are finding ways to remotely check on, and support, others’ mental health.

The findings of the study buttress the fact that effective risk communication and community engagement strategies for young people require specific interventions and strategies relevant to their contexts that do not depend solely on the internet or cellular services or that require high levels of literacy. The objective remains to improve young people’s knowledge, attitudes, and/or behaviours—including increasing their risk perception, reinforcing positive behaviours, influencing social norms and empowering them to change and improve their wellbeing and resilience. Messages must be inclusive and transmitted through multiple media options, including radio, visual guides and community mobilization, in a diversity of languages, using accessible formats and technologies. Programmes need to reach all young people, regardless of their background and context, to ensure that they have the information, tools and support systems they need to make informed decisions that will have a direct impact on the health and safety of their communities and the progression of this pandemic.

Despite the digital divide, young people today are more connected than any previous generation. With many critical activities and institutions moving online, young people are well-positioned to respond and adapt to COVID-19. They can also be critical in bridging the digital divide by providing information and knowledge to communities that do not have access to digital technologies, and tailoring messaging and channels to reach diverse audiences and reflect multiple voices. Yet in the context of acute reliance on online technologies and remote platforms, it becomes even more critical to address the digital divide.
7.2 Youth initiatives on COVID-19

Youth CSOs are often uniquely placed to understand the specific challenges faced by their communities, as well as the existing coping mechanisms that may help their peers and communities mitigate the effects of the pandemic. The current crisis is likely to have long-term effects on the critical work that youth organizations undertake. Such organizations tend to rely on volunteer work and even before COVID-19 they faced major challenges accessing reliable, sustained and flexible funding for youth development and empowerment work. Youth leaders and organizations generally have little access to power and decision-makers. The scale and complexity of humanitarian decision-making structures, funding mechanisms, and reporting structures further marginalize and threaten the survival of youth CSOs.

Despite the operational challenges youth-led organizations face, and the multiple impacts of COVID-19 on young people’s lives, many adolescents and young people mobilized immediately to respond to the crisis. The pandemic has proved the ability of young Africans to innovate in the face of a crisis. Community-based responses are an important part of the fight against COVID-19, and this is where many young people have emerged as leaders and frontline responders. Amid shortages of PPE, young health professionals and learners are risking their lives on the frontlines of the pandemic. Youth are mobilizing communities to protect themselves and supporting governments and health workers together. For example, in Zimbabwe, the Rare Diseases & Disabilities Africa Foundation (RADDA), a youth-led disability organization, is collaborating with the local government to distribute masks and hand sanitisers to young people with disabilities who do not have access to them.

Young women and men researchers and specialists are also helping to combat this disease by contributing to the development of life-saving measures, supporting medical interventions that can be implemented and replicated quickly (such as low-cost, low-tech ventilators), contributing to knowledge generation and promoting the diffusion of scientific and fact-based information online. In Malawi, for example, a 23-year-old technology specialist designed an offline mobile learning app called INSPIRE to make e-learning work in a country with low digital literacy, poor infrastructure and widespread poverty. “The idea is to reimagine education in Malawi and offer equal opportunities for continued learning to a boy or girl in a remote village and a privileged urban child with high-end devices.” Grassroots organizations are at the forefront of risk communication initiatives and countering disinformation, misinformation and stigma in their communities. For example, Generation Alive in Zambia runs an advocacy and handwashing campaign; the Hub in Lesotho runs a “skills & soup” project offering bi-weekly care and support groups for learners to receive a nutritious meal and participate in a range of activities and educational programming (including HIV&AIDS and life skills-support, dance, taekwondo, Maths and Science lessons and COVID-19-awareness sessions). Many young people are volunteering to support the elderly and other vulnerable populations and contributing as scientists, social entrepreneurs and innovators.

Many youth-led organizations leveraged online communication platforms and social media to educate and share information on COVID-19 and to influence advocacy on the specific needs of adolescents and young people. Young people have participated in several online conferences and webinars that have been organized “for” and with” young people on the role and impact of COVID-19 broadly on society, and more specifically in their lives.
7.3 Barriers to youth participation during COVID-19

The benefits of child and youth participation are well documented. Available literature and advocacy efforts on children’s civil and political rights and agency in all settings confirm that there is added value in meaningfully engaging children and young people in decision-making processes affecting them. It increases their autonomy as human beings with rights and contributes to their development and protection. Yet, young people face challenges to participating in political processes, institutions and policymaking at the best of times, owing to factors such as their presumed lack of experience by adults, limited opportunities and legal barriers (such as the minimum age of running for office being higher than the age of voting). Based on the survey and interviews, the challenges faced by youth and youth-focused organizations can be categorized into three factors: the absence of or inadequate institutional and social support to adolescents and young people; inadequate resources to execute their actions; and the absence of guidance and collaboration to execute their priorities or initiatives.

The research found that in most SADC Member States the participation of young people in the COVID-19 response was limited or even almost non-existent. Yet decades of youth programming and promotion of rights has shown the added value of having young people at the centre of any development or humanitarian agenda. The present health crisis puts youth at risk of being further relegated to the background, with no voice and no means to influence policies and decisions. As it is, there is a huge deficit of young peoples' leadership in COVID-19 responses. National mechanisms such as COVID-19 task forces and committees rarely included young people’s voices. Interviews with CSOs also indicated that the voices of young people were left out of the decision-making processes in COVID-19 response and mitigation processes. Without taking the voices of young people into account, there is a higher probability that decisions that are taken would not address the differential challenges that young people —especially girls, those with disabilities and those living in disadvantaged and marginalized communities—face.

The surveys and FGDs showed near unanimous agreement by both adult respondents (90%) and young people (97%) that that young people were rarely consulted in the formulation of national COVID-19 strategies and programme actions to address their education, SRHR and psychosocial needs. More specifically, young people mentioned that they were involved in some home decision-making processes during COVID-19, and some participated in school through bodies such as youth groups and school clubs. Young people who shared their experiences said they believe their participation has resulted in stronger family dynamics. They said their families listened to them better, offered more support for their ideas and activities, and were more receptive to having a dialogue to reach an agreement. But female
respondents mentioned that even in the home there were certain decisions that young people simply could not participate in.

While there has been clear progress and evidence of the personal and community-level benefits of young people’s participation, myriad barriers prevent the full realization of young people’s right to be heard at national level and in political processes. The research results confirmed the need to uphold young people’s civil and political rights, even during crises such as the current COVID-19 pandemic. It is precisely in these settings that investing in and tapping into the power of young people become critical by acknowledging their role as rights-holders, which can make a difference to improving the quality and impact of humanitarian responses.

**Box 32: SUMMARY OF COMMON RESPONSES OF LEARNERS AND OTHER YOUNG PEOPLE**

“Adults don’t listen to us. They do not ask us what we feel is best for us. They think they know what is best for us, and sometimes when they ask us what they need, they never act on our recommendations.”

“We want to be part of the change in our countries. Please give us an opportunity to contribute to laws and policies.”

“There is no future for us. Governments need to create more job and business opportunities for our parents and for us. COVID-19 has shown us that our economies need to do better to provide better education, health and safety for its citizens.”

“The police and law enforcement officials should protect the most vulnerable.”

“We need to support each other as youth to make better decisions about our health, sexuality. We say No to Drug Abuse and urge other learners to finish their education so they can be successful adults.”

Even when adolescents and young people can contribute to decision-making processes in matters concerning them, adults do not always take their views and opinions into consideration. This was confirmed by 62% of the adult respondents. Besides, most of the youth-focused and youth-led organizations faced financial challenges in implementing their COVID-19 initiatives. They did not have adequate funds to procure hygiene and other protective apparel for communities and volunteers. To reach the “unreached” population in small towns and villages who did not have access to information from modern mainstream communication media (radio, TV and internet), young people had to travel long distances to these remote and marginalized communities. Those organizations that leveraged ICT to do their online advocacy or to share information on social media, organize or take part in webinars sometimes did not have enough funds to buy internet time. Besides, even when they had the funds, the connection might be unstable.

While digital technologies (such as large-scale surveys and online platforms for mobilizing and sharing information) offer new opportunities for young people’s participation, the digital divide between adolescents and young people who have access to ICT and electricity, and those who do not, can result in an uneven realization of young people’s right to be heard. In the context of the COVID-19 pandemic, digital exclusion has grave repercussions in all SADC Member States for children’s access to civic participation, as well as the fulfilment of other
fundamental rights. This divide can mean the difference between children having or not having access to spaces from which they can share their messages and have their voices heard.

In the context of the COVID-19 global pandemic, digital exclusion has massive repercussions in all countries for children’s access to civic participation, as well as access to healthcare, education and other essential services.

7.4 COVID-19 through the eyes of young people
Fears, hopes and dreams: a vision for the future

Although the adolescents and young people surveyed or interviewed came from a wide range of backgrounds, contexts, and countries, their experiences and actions in the face of COVID-19 reflected common themes. Participants openly discussed the sudden and vast changes they were experiencing in their lives; they described the ongoing coping mechanisms they are using, their self-direct activism to spread knowledge in new ways while staying safe, and the overwhelming need many of them felt to do more to respond to the crisis by being engaged meaningfully.

The young participants in both the FGDs and survey were asked to share their views on how the COVID-19 pandemic affected their lives, personally and in their respective countries. Across all six Member States, the interviewees pointed out various common concerns that can be grouped under the following four critical themes that directly changed children and young people’s lives on a massive scale:

- School disruptions and increasing school dropouts due to child marriage and early pregnancy
- Emotional distress due to social distancing
- Loss of quality education and access to SRHR information and services
- Increased protection risks and lack of youth participation

In every country, the youth respondents highlighted the need to focus on the most vulnerable populations particularly, knowing well that they are more at risk of being left behind and/or that they face further discrimination. They said that governments, CSOs and NGOs need to consider their voices in their responses to this crisis.

Reflecting on their fears during COVID-19, female (89%) and male (82%) respondents were worried about the high rates of unemployment. Most respondents (79% female and 68% male) feared not completing their education, thereby jeopardizing their future. Another common concern was the issue of bad governance and corruption, as well as increased inequalities. Young people expressed feeling “forgotten” by governments and are concerned that the lockdown measures in place do not account for differences in life experiences.
In considering a post-pandemic future, young people expressed a vision for a more equal, caring, and understanding world, with greater accountability of governments and improved internet connectivity. They want government to strengthen economies so that when pandemics such as COVID-19 happen, their communities are not put in a state of shock due to poor service delivery. Young people also desire a secure future, where employment opportunities are available for all after school: “everyone should be allowed to be successful”.

They also expressed concern for other groups, such as the elderly and key workers, and saw it as a key role for governments to provide more support for vulnerable and marginalized communities both during and after lockdown.

Young people hope decision-makers would do more to understand both the existent complexity of their lives and how lockdown has added to this. Most of the interviewed young people (69%) were of the view that their government lacked understanding of the reality of young people’s lives during the lockdown and overlooked policy responses to address their needs.

Young people want things to return to “normal” after the pandemic, which includes living in a world without the danger of COVID-19, being able to go back outside, seeing friends again and feeling connected to other people. Overwhelmingly, they expressed the desire to live in a world that feels safe and under control. However, simply returning to normal is not viewed as good enough. The COVID-19 pandemic has made young people feel more appreciative of what they have, the time they spend with their family and the freedoms they enjoy. Young people hope that more of them will feel the same post pandemic.
Box 33: Youth Facilitator (21)—Lesotho

“I would like the government to put money back into the services that actually save people’s lives. I would like the health and wellbeing of us young people to be a main focus for the government after the pandemic, for the poverty stricken to not be abandoned and the people in those situations to be helped and not made to feel like scum for having government aid which is barely enough to keep them going.”

Figure 32: Young People’s Hopes and Dreams (Youth Responses)

Box 34: Female Learner (16)—Madagascar

“We ask for governments to spend more money to make sure that our peers living in rural areas and those with disabilities learning while at home by providing radios, TVs and internet learning. They must make sure that children in rural areas and from poor families also get to learn. We want to see mobile libraries passing in our communities delivering books for us to learn.”

7.5 Building back better with young people at the centre: “the final asks”

As SADC governments work towards recovering from the impact of COVID-19, young people are calling for their participation in decision-making processes. Adolescents and young people called on duty bearers to respect, value, and listen to their voices. Other messages from children for their government leaders included requesting measures to ensure child safety;
sharing information on COVID-19 and increasing efforts and coordination to fight it; ending corruption in government; and talking to, listening to and involving children in decision-making.

To respond to these recommendations, governments need to create and strengthen existing infrastructure to enable children to communicate with each other and advocate on issues that matter to them—recognizing these as critical mechanisms to enable children to navigate the present crisis and its consequences. Children’s meaningful participation in decision-making processes needs to be systematized in local, national and global public decision-making processes. Following international and regional standards, every decision-maker impacting a child’s life must be held accountable.

Recommendations

All Member States must:

- **Fully recognize and support young people as rights holders**
- **Strengthen systems at all levels** (particularly at home, school and community levels) to allow for children’s safe and meaningful participation in matters affecting their lives
  This includes civic discourse and the development and review of services, policies, budgets and other frameworks.
- **Develop, adopt and implement laws and policies that require wide consultation with young people**
- **Ensure young people have direct access to appropriate decision-makers**
- **Create spaces and platforms, particularly digital platforms with multilingual capabilities,** which enable young people to interact with decision-makers and peers to influence decisions in a safe, accessible and age-appropriate way
- **Provide free access to the internet and necessary technology** that enables young people to participate in digital platforms and other online opportunities
- **Build the capacity of young people to gain the requisite skills, knowledge, leadership capabilities and confidence to share their views**
- **Facilitate adolescents’ and young people’s access to the necessary, age-appropriate information to support their participation**
CHAPTER 8: Conclusion and Recommendations

The COVID-19 pandemic is disrupting every aspect of young people’s lives. While young people are not significantly infected by COVID-19, they are disproportionately affected by the socioeconomic impact of the pandemic. The report shows that despite a progressive legal and policy landscape across the region, previous years of underinvestment in health and education sectors will likely reverse the many progressive gains made by SADC Member States in education, health (including SRHR), and protection outcomes.

The study indicates that in a situation where millions of families live under extreme poverty and where adequate social protection and community safety nets are nearly non-existent, young girls, youth with disabilities, those living with HIV&AIDS, LGBTQI persons, and those in rural and remote areas suffer the greatest from ill health and the lack of access to education, healthcare and nutrition.

The report has also shown that education centres, including schools, are safe havens for support and services for adolescents and young people. Not only are classrooms places for teaching and learning, but they also provide the necessary nutrition, psychosocial support and linkages to critical health services to keep young people healthy and safe. Schools serve as the first port of call for reporting protection issues, and a safe setting for accessing SRH services. The widespread school closures during the pandemic have meant that many young people are losing out on education without the necessary ICT tools and caregiver and teacher support to help them thrive. With crippling healthcare systems pre-occupied with saving lives during this pandemic, young people are failing to access SRHR support and other essential healthcare services.

It is equally concerning that the stay-home and lockdown measures have brought young people and women in close and routine proximity with potential perpetrators of sexual abuse. As mentioned by the government duty bearers, homes are not always safe places for young people. There are far too many reports of GBV in homes across SADC, and we ought to question the harmful societal gender norms and practices that perpetuate GBV in the region.

The research findings show that adolescents and young people are active, competent social actors who can make decisions and influence their environments. It was clear from the participants’ ongoing COVID-19 response actions that they play a pivotal role in decision-making processes. They want accountable governments that make the necessary investments for their countries’ economic and political stability.

As unprecedented as the crisis is, it has also shown the resilience of SADC Member States and their potential to tap into their youthful populations. The capacity of various actors to adapt home-grown resourcefulness presents unique opportunities for creating a better future for Africa. Many African governments have taken quick and decisive leadership in managing the COVID-19 pandemic, with the international aid community playing a supportive role. This could set the pace in the future for greater government ownership and assertion of control of emergencies and humanitarian crises within their borders.

The analysis in this report is forward-looking and takes into account the multiplicity of actors—ranging from the SADC Secretariat, Member States, UN agencies, development partners, CSOs, and above all ordinary citizens involved in the fight against COVID-19 in the region. It
acknowledges MIET AFRICA's limitations in addressing the challenges by itself, but provides strategic recommendations designed to contribute to a collective regional effort to address the impact of the COVID-19 pandemic on adolescents and young people in the SADC Region.

Call to action

COVID-19 has multi-dimensional impacts on youth, who comprise the majority of the population in the Southern African region. Youth are most likely to be disproportionately affected by the impact of this pandemic; ignoring their concerns and needs in the COVID-19 responses could threaten the gains made in the advancement of SRH, education, gender and youth's rights on the continent. It is therefore critical that responses towards the prevention, containment, management and eradication of COVID-19 consider the needs of young people, especially adolescents and those with disabilities. Providing high-quality services to all adolescents in an inclusive way requires taking urgent action to protect their learning, health and wellbeing.

In light of this, we recommend that SADC, Member States and other stakeholders take the following and other related measures to protect the rights of young people from the pandemic and its effects.

SADC Secretariat

- Coordinate regional efforts to intensify COVID-19 response and recovery plans, and set policy guidance and standards on the necessary economic, trade, and corporation processes needed to support Member States
- Support a coordinated regional response on containing the spread of the virus, strengthening health systems and developing mitigation measures to reduce the economic impact of the pandemic and cushion those vulnerable
- Provide technical support to Member States as they implement AU and UN COVID-19 response guidance on various themes, including on education, health and fiscal investment in social sectors
- Conduct a trend analysis on the impact of crises such as COVID-19, and utilize mega-trends to establish regional early warning systems
- Provide strategic leadership for the implementation of the SADC SRHR Strategy and the continued commitment by Member States to the ESA SRHR commitments.

SADC Member States

- Revise laws and policies that perpetuate GBV, such as the minimum age of marriage and for sexual consent
- Prioritize the digitalization of economies and improve internet infrastructure and penetration rates for benefit of their citizens
- Address gender-related barriers to education, including laws, policies, and harmful social norms that prevent girls from continuing their education if they are pregnant, married or child mothers
• Provide re-entry support to pregnant girls and young mothers to return to school
• Develop and implement fully-funded, national COVID-19 education response and recovery plans, with targeted actions to ensure that girls and the most marginalized children can keep learning through distance learning initiatives and return to school when safe to do so
• Ensure that COVID-19 response plans are sensitive to adolescent and youth-specific healthcare needs, including SRH and MHPSS
• Commit to the ESA SRHR strategy as part of efforts to accelerate youth-friendly SRHR services and continued provision of CSE
• Ensure national response plans include provision of medical, menstrual health management, and WASH supplies (this includes water, sanitation, and handwashing facilities with soap) and services to all adolescents and youth, including migrants, refugees and displaced persons, at home, informal/camp settings, schools, health facilities, community centres and workplaces, where they are still open
• Protect health, education and social protection financing by strengthening domestic revenue mobilization, increasing the share of expenditure for key wellbeing sectors, and ensuring efficiency in the use of public resources
• Create platforms for safe, respectful engagement with youth organizations and young people in public decision processes, and ensure that the views of adolescents are considered
• Strengthen social protection systems to build resilience of the most deprived learners and young people
• Consult young people and include them in government decision-making mechanisms for COVID-19 response
  
  If “sitting at the table” is not a realistic option, find creative ways of conveying the voice of young people to decision makers, through recorded video messages, for example.

UN Agencies, NGOs and CSOs

• Support the urgent but safe opening of schools by equipping them with the necessary WASH services
• Provide professional development and support for teachers so that they can adapt to new circumstances in schools as part of the frontline response and recovery, and to adapt to supporting distance learning when some schools remain closed or have to close again
• Advocate for continued investments in health, education and protection policies and programmes aimed at longer-term gender transformation and socioeconomic wellbeing for young people
• Monitor government efforts to implement international, regional and national laws for adolescents and young people, and support programmes to bridge implementation gaps
• Defend the share of the budget spent on education, or advocate for governments to maintain or increase the share of domestic budgets allocated to public education

• Ensure that response plans for COVID-19 are informed by a comprehensive analysis of the short and long-term consequences of the pandemic, based on age, gender and diversity, including collecting data disaggregated for age, sex and disability

These considerations should be central to national responses, which must involve collaborating with civil society, including girls and young women themselves.

• Train government, civil society, youth networks, and community partners in the prevention of and response to GBV, and how they can support and increase information-sharing on referrals, linking communities with facilities and other support services for adolescents

• Build the capacity of teachers, caregivers and young people to provide and protect a safe online learning experience and to stay safe online in general

• Provide women and girls with dignity packs or menstrual health management kits and coordinate their distribution with WASH, adolescent-SHR and humanitarian organizations

Distribution points can be entry points for providing services to women and girls, for instance.

Youth and youth networks

• Advocate for adolescents and youth to be treated as partners in all phases of the COVID-19 response

They should be systematically included through consultations and knowledge-sharing, involved in decision-making at all levels, including budget allocations, and engaged in the implementation of response measures.

• Prioritize innovation efforts to devise solutions to address the impact of COVID-19 on societies in the SADC Region

Private sector and academia

• Document learning about what works in different settings in terms of mitigation strategies during the various phases of the pandemic

• Work with governments to reduce the costs of essential WASH supplies or provide them for free so that they are accessible to and affordable for all adolescents and youth

• Involve youth in rapid data collection and analysis on the pandemic’s impact on their peers, families and caregivers, as well as on the success of the response

• Implement inclusive digital and non-digital solutions to distance learning

• Consider the digital divide, especially among girls in rural areas

This includes putting in place measures to ease internet access and to facilitate learning through non-digital tools.
• Support ongoing youth-led research on the intersectoral impacts of COVID-19 programmes
• Support government efforts to set up early warning systems and disaster risk plans
• Link youth leaders and youth-led organizations to the media to amplify their voices and better address fake news and stigma
  They should be on how to give good interviews and improve their public-speaking skills. Robust safeguarding, support, and protection measures will need to be in place.
• Collaborate with artists, social media influencers, or other figures popular among young people to spread reliable information in creative and youth-friendly ways
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