CHAPTER 6

Sexual and Reproductive Health and Rights

Articles 26

KEY POINTS

- There is renewed emphasis on Sexual and Reproductive Health and Rights, recognising that individual human rights and dignity, including the equal rights of women and girls and universal access to SRHR, are a necessary precondition for sustainable development.

Youth friendly facilities are key to SRHR. *Photo: SAFAIDS*

- The unmet need for contraception in SADC varies from a low of 4% in Mauritius (the lowest in Africa) to a high of 29% in Mozambique. An unmet need of greater than 25% is considered very high.
- Mauritius, whose Maternal Mortality ratio (MMR) was 53 per 100 000, is the only country in SADC which has already achieved the SDG target of an MMR below 70. DRC and Malawi with MMRs of 693 and 634 respectively are considered to have very high levels of maternal mortality.
- The percentage of births attended by skilled personnel varies from a low of 44.3% in Madagascar to a high of 99.9% in Botswana.
- Malawi has made significant progress in expanding access for deliveries in a health institution with an urban: rural differential of only 96:91 and differential between the highest income quintile and lowest of only 96:89.
- Births before the age of 18 range from 13% of young women who had given birth before the age of 18 in Lesotho, to 40% in Mozambique. Angola has the highest adolescent fertility rate in SADC at 191 of girls age 15 to 19 per 1000 giving birth (which is also the fourth highest rate in Africa), while Mauritius has the lowest at 31.
- Seychelles and Mauritius are far ahead of the rest of SADC in provision of water and sanitation. Ten SADC countries do not have even 50% coverage of basic services nationally and though urban coverage is much better, seven countries do not have even 50% coverage of basic sanitation in urban areas.

Mauritius, **only** **SADC** **country** **to** **achieve** MMR target BELOW 70

The **Protocol** recognises **Sexual** and Reproductive **Health** as a women's right

What the Protocol requires

As before, the Protocol calls on Member States to develop, adopt and implement legislative frameworks, policies, programmes and services to enhance gender sensitive, appropriate and affordable quality healthcare. It also calls on Member States to address the mental, sexual and reproductive health needs of women and men; and ensure the provision of hygienic and sanitary facilities and nutritional needs of all women, including women in prison.

Table 6.1: The Revised Gender Protocol

Old provisions	New provisions
State parties shall, in line with the SADC Protocol on Health and other regional and international commitments by Member states on issues relating to health, adopt and implement legislative frameworks, policies , programmes and services to enhance gender sensitive, appropriate and affordable quality health care, in particular, to: a) reduce the maternal mortality ratio by 75% by 2015, in line with Millennium Development Goal Five (MDG 5)	State parties shall, in line with the SADC Protocol on Health and other regional and international commitments by Member states on issues relating to health, adopt and implement legislative frameworks, policies , programmes and services to enhance gender sensitive, appropriate and affordable quality health care, in particular, to: a) Eliminate maternal mortality
	b) Develop and implement policies and programmes to address the mental, sexual and reproductive health needs of women and men in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action

As reflected in Table 6.1, the Post 2015 SADC Gender Protocol has been strengthened to:

- Aim for *elimination* of maternal mortality. Though this is not impossible, many countries in SADC experienced AIDS related increases in maternal mortality ratio until widespread availability of ARVs. The region is therefore beginning from a very high MMR.
- Recognise *Sexual and Reproductive Health as a right* for women, men and youth. This approach focuses on promotion of sexual wellbeing for all people, not simply enabling them to reproduce safely. While indicators are reduction in Maternal Mortality and increased access to contraception, the focus is a fulfilling sexual life for all, with the right to choose when to reproduce. This in line with the International Conference on Population and Development (ICPD) Programme of Action consensus that individual human rights and dignity, including the equal rights of women and girls and universal access to sexual and reproductive health and rights, are a necessary precondition for sustainable development. SRHR includes eliminating unsafe abortion, unwanted pregnancy, sexual violence and GBV as well as coerced sterilisation and ensuring adequate access to family planning. These rights are basic rights of all individuals and couples.

Key trends

Table 6.2: Trends in Health 2009, 2015 and 2017

Parameter	Target 2030	Baseline 2009	Progress 2015	Progress 2017	Variance (Progress - target)
CONTRACEPTIVE USE AMONG SEXUALLY ACTIVE WOMEN					
Highest proportion of women	100%	Mauritius (76%)	Mauritius (76%)	Mauritius (76%)	24
Lowest proportion of women	100%	Angola (6%)	Mozambique (12%)	Mozambique (12%)	88
CURRENT MATERNAL MORTALITY RATE (MATERNAL DEATHS PER 100 000 BIRTHS)					
Highest	0	Angola (1400)	DRC (730)	DRC (693)	693
Lowest	0	Mauritius (13)	Mauritius (73)	Mauritius (53)	53
BIRTHS ATTENDED BY SKILLED PERSONNEL					
Highest	100%	Mauritius (100 %)	Mauritius (100%)	Botswana (99.9%)	0.1
Lowest	100%	Angola/Tanzania (46%)	Mozambique (19%)	Madagascar (42%)	48
% WHO SAY A WOMAN SHOULD BE ABLE TO CHOOSE TO TERMINATE A PREGNANCY IN THE FIRST THREE MONTHS OF HER PREGNANCY					
Highest	100%			Tanzania (80%)	N/A
Lowest	100%			DRC (27%)	N/A
TOTAL COVERAGE OF SANITATION					
Highest coverage	100%	Mauritius/ Seychelles (100%)	Seychelles (97%)	Seychelles (98%)	2
Lowest coverage	100%	Madagascar (14%)	Malawi (10%)	Madagascar (12%)	88
SCORES					
SGDI	100%	N/A	68%	63%	37
CSC	100%	58%	67%	65%	35

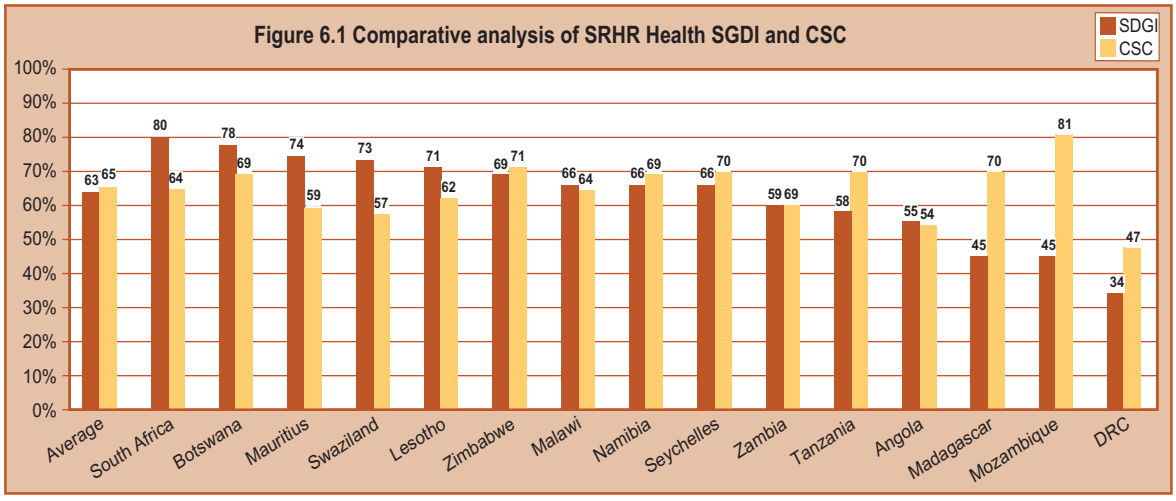
Source: Gender Links 2016.

Table 6.2 shows that:

- The highest use of contraception among sexually active women in in Mauritius (76%) and lowest in Mozambique (12%). This is the same as in 2015. Mauritius has all through the tracking period had the highest level of contraceptive usage. Mozambique has taken over from Angola as lowest, and Angola has gone up from 6% at baseline to 18% in this report.
- Mauritius also has the lowest maternal mortality rate in the region (53 per 100,000) and has consistently been in top position during the tracking period. DRC (693 per 100,000) has the highest level of maternal mortality. DRC has taken over from Angola, whose maternal mortality rate over this period has dropped from 1400 per 100,000 to 477 per 100,000.
- At close to full coverage, Botswana now has the highest level of births attended by skilled personnel while Madagascar (12%) has the lowest. Generally this has been an area of marked improvement in the SADC region.
- Attitudes towards abortion have been introduced in the tracking for the first time. The trends table shows that Tanzania (80%) had a surprisingly high proportion of women and men agreeing of strongly agreeing that "a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy". DRC (27%) had the lowest proportion of women and men agreeing with this statement.

Scores - SGDI and CSC

The SADC Gender and Development Index (SGDI) is a composite empirical measure of progress. In the case of SRHR, this is based on the indicators captured in the trends table. The new indicator introduced relates to attitudes on abortion. Since the introduction of the SGDI in 2011, the overall average score increased from 62% to 68% but has dropped to 63%, in part due to the new "choice" indicator that has been introduced in line with the Post 2015 agenda. The Citizen Score Card (CSC) is a measure of how citizens (women and men) rate their governments' efforts to provide accessible and quality services. This score has also been expanded to take account of the new additions in the Post 2015 era. Not surprisingly, the overall score dropped from 67% to 65% with these tougher tests in place.



Source: Gender Links, 2017.

Figure 6.1 compares the SGDI and CSC scores for 2017. It shows that overall at 63% for the SGDI and 65% for the CSC, these scores (based on empirical data and perceptions respectively) are quite close. Variance is calculated as the difference between the SGDI and CSC. South Africa, Swaziland and Mauritius had the highest positive variances (ie people who are more sceptical than what the numbers tell us). Mozambique and Madagascar had the highest negative variances, ie where citizens are more optimistic than what the facts on the ground tell us.

Health provisions in the region are gradually improving.
Photo: Gender Links

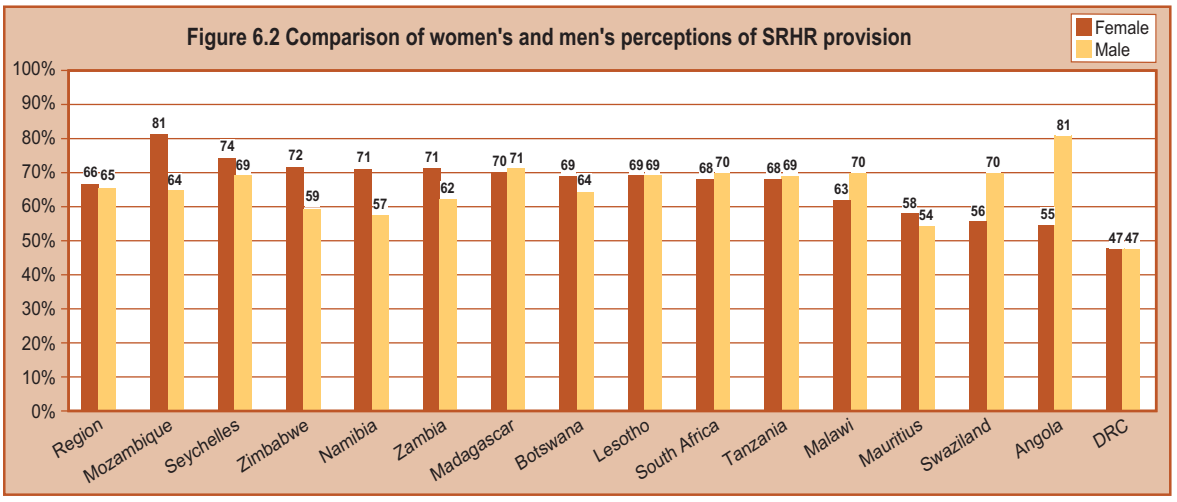
SGDI has gone **down** to **63%** in **2017** from **68%** in **2015**

CSC has **dropped** from **67%** in **2015** to **65%** in **2017**

66%

scored higher than

63%



Source: Gender Links, 2017.

Figure 6.2 provides sex disaggregated data on the CSC for the sector for 2017. On average (66%) women had slightly higher scores than men (63%). As this sector largely concerns women's health, it is a positive sign that women are overall even more optimistic than men about the progress achieved. This is especially so in Lesotho, which has the highest variance between women and men. In Tanzania, Malawi, Mauritius, and Swaziland, women are slightly less optimistic than men.

Women are slightly more optimistic about the changes than men. *Photo: Gender Links*