Sexual and Reproductive Health 2

Youth take part in a World AIDS Day event in Manzini, Eswatini, in 2012. Engaging with young people on their sexual and reproductive health rights must be a priority in all SADC countries. Photo: Thandokuhle Dlamini

KEY POINTS

- Stakeholders should align sexual and reproductive health and rights (SRHR) policy and legislative frameworks against the targets of the SADC Protocol on Gender and Development and the SADC SRHR Strategy and Scorecard 2019 to 2030.
- Menstrual health campaigns must be rolled out in tandem with strategies to provide water, sanitation and hygiene across SADC. Only 10% of Madagascar's population has access to basic sanitation and most of this is available in urban areas.
- Only two SADC countries, Seychelles and Mauritius, meet the global target of less than 70 deaths per 100 000 live births for pregnant women and girls. The maternal mortality rate is ten times more in the DRC.
- Most pregnant women and girls have access to at least one antenatal visit, fewer have four or more and very low proportions have postnatal visits. Lawmakers must prioritise access to antenatal and postnatal maternal care.
- Family planning services must be expanded to include conditions such as polycystic ovarian syndrome and fibroids, which are on the rise and affect fertility.
- Stakeholders should view SRHR services in the paradigm of universal health care (UHC) and the provision of essential health services to ensure it is integrated.
- Health system and infrastructure financing remains below the recommended Abuja Declaration goal of 15% expenditure on health. Only Eswatini and Madagascar meet this target.

Introduction

Sexual and reproductive health is not merely the absence of disease, dysfunction or infirmity, but also a state of physical, emotional, mental and social wellbeing in relation to all aspects of sexuality and reproduction. A positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall wellness. All individuals have a right to make decisions governing their bodies and to access services that support that right.[1]

The Guttmacher-Lancet's definition of sexual and reproductive health and rights (SRHR) provides a comprehensive view that "integrates the full range of peoples' needs and services including sexual well-being and personal autonomy." In 2018, the SADC Gender Protocol Alliance launched the **#VoiceandChoice** campaign, recognising the need to move beyond a gender-based violence (GBV) agenda to a holistic one that addresses citizens' wellbeing.

Achieving sexual and reproductive health relies on realising sexual and reproductive rights, which are based on the human rights of all individuals to:

- Have their bodily integrity, privacy and personal autonomy respected;
- Freely define their own sexuality, including sexual orientation and gender identity and expression;
- Decide whether and when to be sexually active;
- Choose their sexual partners;
- Have safe and pleasurable sexual experiences;
- Decide whether, when and whom to marry;
- Decide whether, when and by what means to have a child or children, and how many children to have; and
- Have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.[2]

In 2018, Gender Links launched the **#VoiceandChoice** Campaign to address citizens' overall wellbeing

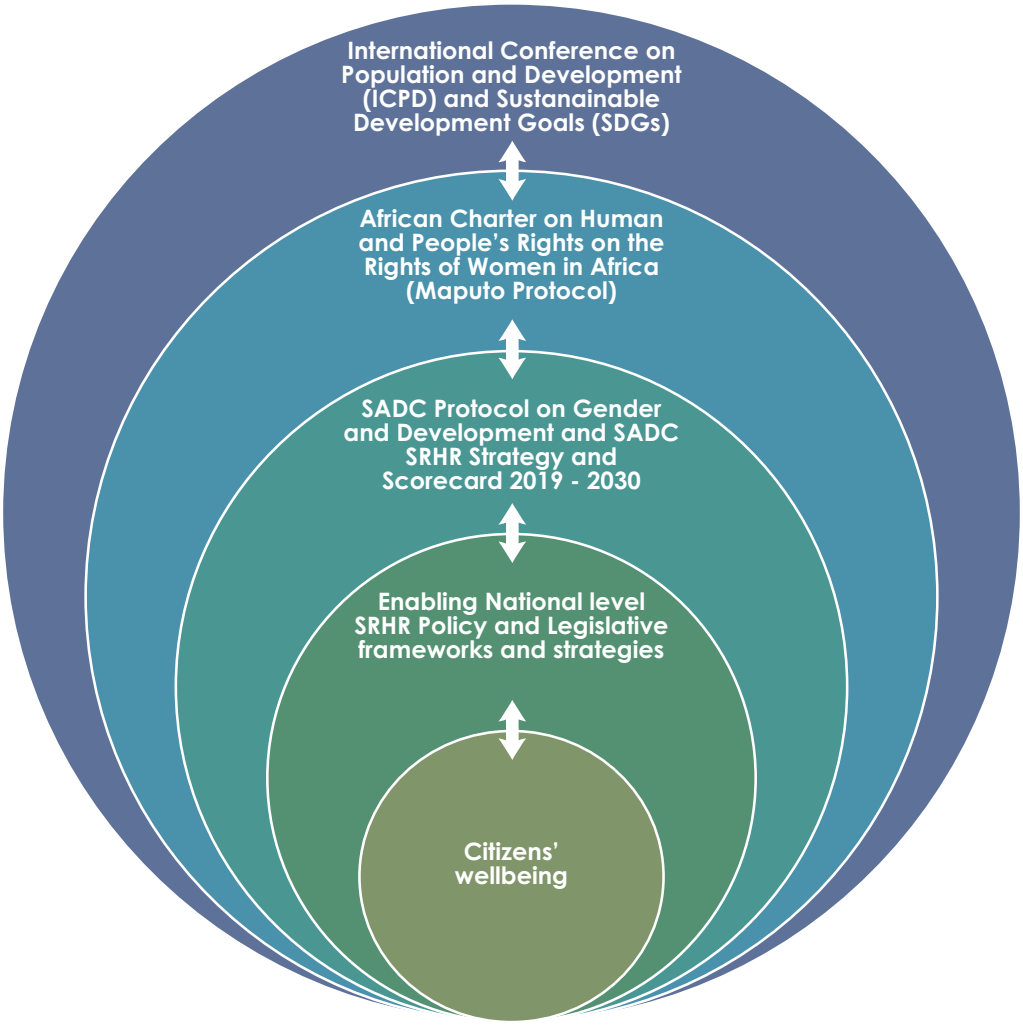
The 2019 SRHR Barometer occurs against the backdrop of three key developments. In November 2018, the Southern African Development Community (SADC) adopted the SADC SRHR Strategy and Scorecard (2019 to 2030). All SADC countries signed up to a regional roadmap to achieve key SRHR milestones. Additionally, the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) has been in place for 15 years and 2019 marks the 25th anniversary of the International Conference on Population and Development (ICPD), a 1994 meeting in Cairo where 179 governments affirmed that women's reproductive health and rights would become central to global development efforts.

The three instruments, together with the revised 2016 SADC Protocol on Gender and Development and the Sustainable Development Goals (SDGs), include SRHR targets relating to or impacting on: maternal health, menstrual health, comprehensive sexuality education, teenage pregnancies, unrestricted safe abortion, contraception and family planning, SRHR services, GBV, HIV and AIDS, sexual diversity and sex work.

1 https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary
2 IBID

The nexus of these significant events provides an important opportunity to take stock, identify gaps and plan how to address them and include new areas to improve SRHR across the region. To establish baseline indicators for SRHR in 2019, Gender Links reviewed the targets in all the instruments and identified a set of about 100 indicators to measure SRHR progress in SADC from 2019 to 2030.

Figure 2.1: Visual representation of the SRHR context



As illustrated in Figure 2.1, stakeholders must leverage the global, continental and regional instruments to create enabling environments for effective SRHR. This will foster a critical citizenry that enjoys a high level of wellness and result in more people exercising choices about their lives and bodies, articulating their needs and holding duty-bearers accountable.

The vision of the SADC SRHR Strategy is to: "Ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realise and exercise their SRH rights, as an integral component of sustainable human development in the SADC region." The first hand account from Mauritius, which has one of the best developed public health systems in SADC, shows that there is still a long way to go in providing SRH services.

Table 2.1: Sexual and reproductive health baseline indicators in 2019

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
SRHR policy and legislative framework															
Existence of SRHR policies/ guidelines[3]	No	Guide-lines	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015 -19 Policy	2011 -15 Guidelines	2008 Policy	2010 -15 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation[4]	No	No	2016 - 2020 Policy	No	2015 - 2020 Policy	2016 - 2020 Policy	2016 - 2020 Policy	No	No	No	No	2017 Policy	No	2016 - 2020 Strategy	No
Menstrual health															
Provision of free menstrual ware[5]	No	Yes	No	No	Yes	Yes	No	No	No	No	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware[6]	No	No	No	No	No	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Basic drinking water status (%)[7]	41	79	42	68	72	51	67	100	47	79	96	85	50	61	67
Access to basic sanitation (%)[8]	39	60	20	58	44	10	44	93	24	34	100	73	24	31	39
Contraception															
Contraceptive preva-lence rate amongst women aged 15-49 (%)[9]	17	60	25	66	62	47	62	67	30	60	49	57	43	55	67
Unmet need for contraception amongst women aged 15-49 (%)[10]	36	14	27	14	16	18	16	10	24	16		14	21	18	10
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[11]	62		31	49	61	74	77	49	49	71			47	47	60
Age of access to contraception[12]	15	12	18	15	No age stipulated	12	16	16	16	12	15	12	12	16	16
Maternal mortality															
Maternal mortality ratio (per 100 000)[13]	447	129	693	389	487	353	634	53	489	265	0	85	398	224	443
Antenatal care visits (at least one visit) (%)[14]	82	94	88	97	95	82	95		91	97		94	91	96	93
Antenatal care visits (at least four visits) (%)[15]	61		48	76	74	51	51		51	63		76	51	56	76
Skilled attendance at birth (per 100)[16]	50	99	80	99	78	44	90	100	54	88	99	97	64	63	78
Postnatal care coverage (%)	23		44		88	62	42			69		84	34	63	57
Neonatal mortality (per 1 000)[17]	29	25	29	17	38	18	23	8	27	18	9	11	21	22	22
Nursing and midwifery personnel per 10 000 of the population[18]	13	33	5	20	7	1	3	34	4	28	32	35	4	9	12
Universal health coverage															
Proportion of population receiving essential health services (%)[19]	36	60	40	58	45	30	44	64	42	59	68	67	39	56	55
Health budgets															
Health expenditure as proportion of GDP (%)[20]	2.9	5.5	3.9	7.7	8.1	6.0	9.8	9.8	5.1	9.1	3.9	8.1	4.1	4.5	9.4
Health expenditure as proportion of total government expenditure (%)[21]	5.4	9.1	3.7	15.25	10.1	17.8	9.8	9.8	8.3	13.8	10.0	13.3	9.5	7.1	14.5

Source: Gender Links, 2019.

First-hand account of SRHR health services in Mauritius[22]

On 28 March 2019 a private doctor diagnosed me with menorrhagia; a state of prolonged menstrual bleeding characterised by heavy blood flow and abdominal cramps. I was advised to go to Jawaharlal Nehru Public Hospital in Rose Belle for medical tests.

I had never been to a public hospital before but given the severity of the situation I followed the doctor's advice. Upon my arrival I was admitted and the necessary examinations were made and different tests done by the gynaecologist who was on call.

A series of blood samples were taken and after all those the nurse showed me to bed and I was told not to eat anything until the tests were done the following morning. Before the doctor came to see me that morning, I decided to freshen up and then went to the bathroom in the same ward. To my horror the toilet and bathroom area smelled so badly I could not stand being in that room. Instead of a hospital bathroom, which I expected to be clean, I felt like I was in pig sty. To my shock I returned to my bed with total disgust without using those facilities.

The patient next to me who had the same diagnosis ran out of sanitary towels and had to ask for one from one of the nurses, she came back in disarray with a piece of cotton wool. I went to change my sanitary pad in the toilet and to my surprise only one of the toilets was working and had a drizzle of water from the tap. There was no toilet paper and no soap; too much of a luxurious commodity I suppose.

Sheistah Bhundhoo making her voice heard.
Photo: Anushka Virahsawmy

It is totally unacceptable that in a hospital ward where approximately 25 women are admitted with gynaecological issues and heavy bleeding, there is no running water and sanitation facilities are non-existent. Bed sheets and pillow covers are only changed if they are stained and toilets and bathrooms are not cleaned as they should be. This was a perfect bacterial breeding place. There are no sanitary bins, instead a huge uncovered bin near the toilet area is filled with used sanitary pads, stained cloths and cotton wool.

This experience with the public health sector has triggered a few alarm bells. As an advocate for gender equality and SRHR, that includes menstrual health, I believe that our public system needs to be studied by our leaders. It is not people-centred and the service is deplorable. Women's sexual and reproductive health is a right and it is totally unacceptable to get such abysmal service.

Source: Sheistah Bhundhoo, Gender Links News Service, 2019

3 GL Audit of SRHR Policies and Laws in SADC, 2019
4 aho.afro.who.int/profilesinformation/index.php/
5 GL Audit of SRHR Policies and Laws in SADC, 2019
6 IBID
7 WHO/UNICEF (2017) Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline
8 IBID
9 https://www.unfpa.org/data/world-population/
10 IBID
11 https://www.unfpa.org/data/world-population/
12 GL Audit of SRHR Policies and Laws
13 Maternal and Newborn Health Coverage Database, UNICEF, 2019
14 IBID
15 IBID
16 IBID
17 https://childmortality.org/data
18 http://apps.who.int/gho/data/view.main.HWFNURv
19 http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv
20 https://databank.worldbank.org/data/source/world-development-indicators#
21 IBID
22 https://genderlinks.org.za/news/mauritius-public-hospitals-and-poor-srhr-services-for-women/

SRHR policy and legislative framework in SADC

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

Ensuring that member states align their SRHR policies and laws with global and regional commitments, as well as international human rights standards, is the first step towards addressing the legal and policy gaps that perpetuate gender inequality and impact on SRHR in the region. Many SADC countries ratify international and regional instruments, but they lag in domestication and implementation. During the next 11 years, governments must implement programmes to achieve their targets linked to each of their SRHR commitments.

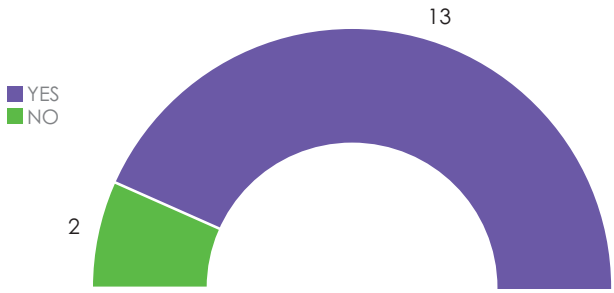
The promotion and realisation of women and girls' reproductive rights and access to SRH often entails long-term processes of legal reform, policy change and institutional transformation as well as social norm change. Transformation and reform at all these levels is necessary for women and girls to enjoy the exercise their SRHR.[23] SRHR policies and laws ensure that countries focus on SRHR issues in line with global and regional commitments aimed at fostering equitable development outcomes.

13 out of 15 SADC countries have standalone policies or guidelines on SRHR

Status of SRHR policies and laws in SADC

Figure 2.2 shows that 13 out of 15 SADC countries have standalone policies or guidelines on SRHR. Of the 13 countries, 11 have SRHR policies, while Botswana and Tanzania have SRHR guidelines. Angola and the DRC do not have standalone policies or guidelines.

Figure 2.2: Countries with standalone SRHR policies or guidelines



Source: Audit of SRHR policies and laws Gender Links, 2019.

[23] https://www.ippfar.org/sites/ippfar/files/2018-09/SOAW-Report-Chapter-7-Sexual-and-Reproductive-Health-and-Rights.pdf

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Adopted more than five years ago		
Namibia	National Policy for Reproductive Health	2001
Mauritius	National Sexual and Reproductive Health Policy	2007
Lesotho	National Reproductive Health Policy	2008
Zambia	National Reproductive Health Policy	2008
Malawi	National Reproductive Health and Rights Policy	2009
Zimbabwe	National Adolescent Sexual and Reproductive Health Strategy	2010 - 2015
Mozambique	National Sexual and Reproductive Health Policy	2011
Seychelles	Reproductive Health Policy for Seychelles	2012
Five years or fewer		
Eswatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy	2014 - 2019
Madagascar	Reproductive Health and Family Planning Law	2017
SRHR guidelines		
Botswana	Policy guidelines and service standards for sexual and reproductive health	2015
Tanzania	SRHR guidelines and National Adolescent Reproductive Health Strategy	2011 - 2015
No SRHR policy or guidelines		
DRC	Included in the Constitution	2011
Angola	Included in the Constitution	1975

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

Table 2.2 shows that eight SADC countries have SRHR policies that are more than five years old. Namibia's SRHR policy is 18 years old. These policies need urgent review and revision. South Africa, Eswatini and Madagascar have newer policies. Madagascar adopted its SRHR policy in 2017. The new Madagascar SRHR policy is a welcome development; however, it is important to note that it prohibits abortion under any circumstances.

Botswana and Tanzania need to review their guidelines and lobby for relevant longer-term SRHR policies. Angola and DRC do not have SRHR policies. These are urgent as both countries are dealing with post conflict conditions that compromise citizen's access to SRHR.

Madagascar adopted an SRHR policy in 2017, yet it still prohibits abortion

Unmet needs and growing inequality in Angola[24]

Young women take part in educational and recreational activities at a UN-supported women-friendly space in the Lóvua refugee settlement in Angola in 2018. Photo: Tiril Skarstein

In 2014, reports estimated the population of Angola to be 19.8 million, of which youth aged 10 to 24 represented 33%. The high total fertility rate of 6.4 children per woman and the low modern contraceptive prevalence rate of 12.8% (both statistics from 2010), contribute to Angola's annual population growth rate of 3.52%, one of the highest in the world.[25] Adolescent fertility is also very high at 152.1 per thousand women aged 15 to 19. This contributes to high maternal mortality and morbidity, including from obstetric fistula, stillbirths and unsafe abortions.

The main reason for Angola's high adolescent fertility rate is due to the limited availability of, and access to, youth-friendly sexual and reproductive health services and information. This also explains the high incidence of unprotected sex, estimated at 70%.

While most recognise the prevalence of adolescent sexual relationships, there remains inadequate provision of appropriate behavioural change education and youth-friendly reproductive health services and information. Instructors do not have the skills to teach sexual and reproductive health classes and no specific policies exists to integrate sexuality education in school curricula. Consequently, only 44.6% of youth have accurate knowledge about HIV and AIDS and only 14.9% know their HIV status.

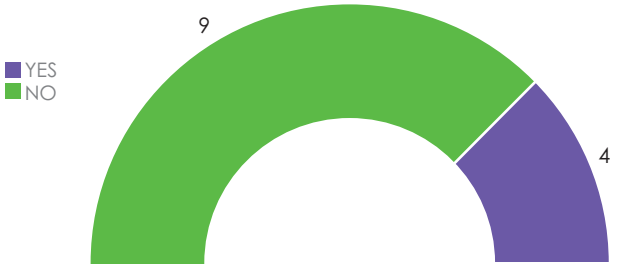
The United Nations Population Fund (UNFPA) puts maternal mortality in Angola at 450 women per 100 000 live births. This high ratio stems from a combination of the low percentage of deliveries attended by qualified health personnel nationally (49%) and in health units (42%), the low ratio of population to qualified health care providers (one doctor per 10 000 people), and the low capacity of health facilities to provide emergency obstetric care services. Leaders established the National Audit Committee for the Prevention of Maternal and Neonatal Deaths in March 2012 to implement the recommendations of the Campaign for Accelerated Reduction of Maternal Mortality in Africa. However, it is not yet functional.

Lawmakers also approved a National Policy for Gender Equality and Equity in 2013 by Presidential Decree No. 222/13. Yet gender stereotypes and GBV remain widespread and no systematic coordination mechanism exists to address these harmful attitudes and practices.

Source: Final country programme document for Angola, UNFPA, 2014

[24] https://www.unfpa.org/data/transparency-portal/unfpa-angola
[25] https://www.statista.com/statistics/264687/countries-with-the-highest-population-growth-rate/

Figure 2.3: Number of countries reviewing SRHR policies



Source: Audit of SRHR policies and laws Gender Links, 2019.

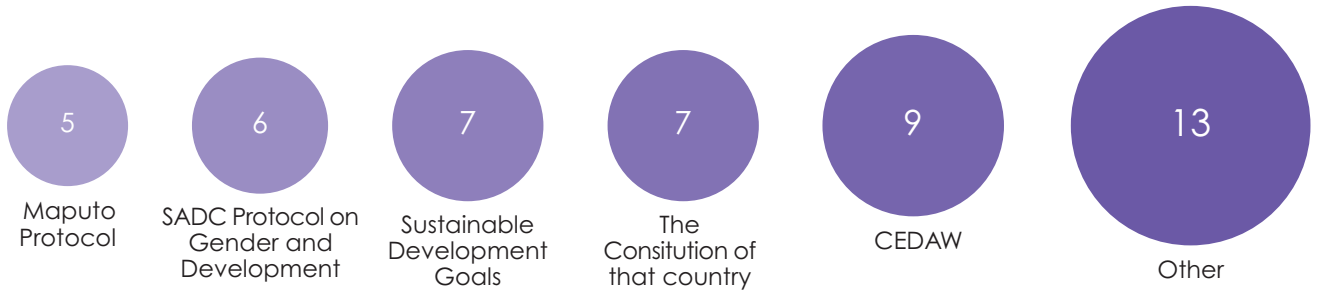
Figure 2.3 shows that, out of the 13 countries that have standalone SRHR policies or guidelines, four (Botswana, Namibia, Seychelles and South Africa) are reviewing them. South Africa is in the final stages of adopting a new SRHR policy.

Moving forward, all SADC countries should align their SRHR policies with the provisions of the SADC Protocol on Gender and Development and the SADC SRHR Strategy and Scorecard 2019-2030.

Linking SRHR policies with regional and global instruments

Several global and regional instruments address reproductive health, GBV, HIV and AIDS, and women's rights. SADC member state SRHR policies should refer to, and align with, the targets of these existing instruments for easier coordination.

Figure 2.4: Global and regional instruments referenced in SRHR policies



Source: Audit of SRHR policies and laws, Gender Links, 2019.

Figure 2.4 shows that SADC countries reference several global and regional instruments as overarching frameworks in their SRHR policies and guidelines. Five include the Maputo Protocol; six countries reference the SADC Protocol on Gender and Development; and seven refer to the SDGs and national constitutions. Thirteen countries cite other sources. These include the Millennium Development Goals (MDGs); the 1994 International Conference on Population and Development (ICPD); the SADC minimum pack-age for SRHR services; the global Family Planning 2020 framework; and the Beijing Platform for Action.

Support group members take part in a GBV campaign event at Matukeng Clinic in Lesotho in April 2019.
Photo: Kelello Rakolobe

SADC countries reference global and regional instruments as overarching frameworks in their SRHR policies and guidelines

The challenge for all SADC member states is how countries domesticate and harmonise these regional and global instruments with national laws and policies. This is the process of creating common standards across the region for adolescent sexual and reproductive health rights. Leaders base harmonisation on international and regional conventions and commitments that they have already ratified or signed linked to adolescent SRHR.[26]

Many countries struggle with both implementation and overcoming contradictions between regional and global commitments and national laws and policies. Despite these challenges, harmonisation and domestication remain urgent priorities in the region.

Adolescent SRHR

Children and youth younger than 24 constitute a majority of the population living in most countries in the region, except for Mauritius and Seychelles. If the region is to reap the benefits of this demographic dividend and advance social and economic development, lawmakers must prioritise investments in SRHR, particularly for adolescents and young people.[27] It is imperative that countries in SADC develop focused adolescent SRHR strategies and policies.

Table 2.3: Overview of adolescent and youth SRHR policy frameworks across SADC[28]

Country	Standalone policy or strategy
Angola	No
Botswana	No
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020
Eswatini	No
Lesotho	Yes, National Health Strategy for Adolescents and Young People 2015-2020
Madagascar	Yes, Adolescent and Youth Health Strategy (2016-2020)
Malawi	Yes, National Youth Friendly Health Services Strategy 2015-2020
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
South Africa	Yes, Adolescents and Youth Health Policy 2017
Tanzania	No
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)
Zimbabwe	No

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

Table 2.3 shows that only six SADC countries have standalone SRHR policies or strategies: DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia. They include adolescent SRHR in these national SRHR policies, strategies or guidelines. Going forward, it will remain important for stakeholders to analyse if these strategies have improved SRHR for young people in those countries.

[26] https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
[27] Strategy for Sexual and Reproductive Health and Rights in the SADC region, 2019-2030
[28] aho.afro.who.int/profiles_information/index.php/

Table 2.4: Countries with laws and policies requiring parental consent for adolescents to access SRH services in SADC[29]

Country	Consent not required	Yes, if younger than 14	Yes, if younger than 16	Yes, if younger than 18
Angola				✗
Botswana			✗	
DRC[30]				✗
Eswatini				✗
Lesotho		✗		
Madagascar	✗			
Malawi		✗		
Mauritius		✗		
Mozambique	✗			
Namibia	✗			
Seychelles				✗
South Africa	✗			
Tanzania	✗			
Zambia			✗	
Zimbabwe			✗	

Source: UNAIDS data, 2018.

As illustrated in table 2.4 only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) do not require parental consent for adolescents to access SRH services. Youth must get parental consent for these services in Lesotho, Malawi and Mauritius if they are younger than 14; this applies to Botswana, Zambia and Zimbabwe if youth are younger than 16. Meanwhile, in Angola, DRC, Eswatini and Seychelles youth younger than 18 cannot access SRHR services without parental consent. Adolescents and young people face many barriers in accessing SRH services, including health centre staff with disapproving attitudes towards sexually active unmarried youth, inconvenient opening times and locations for clinics, lack of privacy, fear of lack of confidentiality and high cost.[31] Lobbying for unrestricted access to SRHR services on the part of adolescents is an important strategy to address key regional issues such as increasing HIV infections amongst young people, early pregnancies and marriages, menstrual health and unsafe abortions.

A body mapping exercise for adolescents at a workshop on SRHR in Botswana in December 2018. Access to SRHR information helps reduce HIV infections and early pregnancies.. Photo: Keletso Metsing

Menstrual health

Research shows that 800 million women and girls menstruate every day, but menstruation remains shrouded in silence and taboos.[32] A key step towards demystifying menstruation is providing free menstrual products. This will enable girls to go to school and engage in everyday activities without restriction.

[29] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
[30] https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html
[31] https://esaro.unfpa.org/sites/default/files/pub-pdf/SYP%20Annual%20Report%202017%20V2.pdf
[32] https://iwhc.org/2018/07/integrating-menstrual-hygiene-management-achieve-sdgs/

Table 2.5: Status of menstrual products in SADC

Country	NO VAT on sanitary ware	Provides free sanitary ware in schools
Angola	No	No
Botswana	No	Yes
DRC	No	No
Eswatini	No	No
Lesotho	No	Yes
Madagascar	No	Yes
Malawi	No	No
Mauritius	Yes	No
Mozambique	No	No
Namibia	No	No
Seychelles	No	Yes
South Africa	Yes	No
Tanzania	Yes	No
Zambia	Yes	Yes
Zimbabwe	Yes	No

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2019.

As illustrated by figure 2.5, five SADC countries (Lesotho, Mauritius, South Africa, Tanzania, Zambia and Zimbabwe), have removed VAT on menstrual products. The removal of VAT on menstrual products, while welcome, should be seen as a first step: burgeoning costs due to economic recession means that the base cost of menstrual products continues to rise.

Only five SADC countries, Botswana, Lesotho, Madagascar, Seychelles, and Zambia, provide free menstrual products in schools. A lack of safe products puts young girls at risk of using unhygienic methods such as rags or newspapers.[33] This is a health hazard and often leads to poor school performance. The provision of free menstrual products must be accelerated in all SADC countries as an integral part of adolescent SRH services. Only Zambia provides free sanitary ware in schools and has removed VAT on sanitary ware elsewhere.

Only five SADC countries provide free menstrual products in schools

eZulwini Municipality Mayor's walk 2018. Photo: Gender Links

[33] https://genderjustice.org.za/article/high-cost-sanitary-pads-puts-south-african-girls-education-risk/

Lesotho provides free sanitary ware in schools[34]

Thabo Morena distributes sanitary pads at Mamantso Council in Mafeteng, Lesotho, in 2019. Photo: Ntolo Lekau

Reports indicate that some girls in Lesotho use old clothes, socks and sheep skin during menstruation instead of safe sanitary products (World Vision, 2018). So the government's decision to provide free sanitary ware in schools on 12 March 2019 came as a relief to many girls and women. Menstrual health talk in public remains largely taboo in Lesotho. However, Lesotho National Assembly member Kose Makoa challenged this barrier when he moved the motion on sanitary towels and provide them for free to all girls.

'Makhotso Akhosi, a nurse from Lesotho Defence Force Clinic, believes that this move will reduce many illnesses caused by unhygienic material used during menstruation, allowing her clinic to use the money typically spent on this for other things. However, the next step is to remove VAT on sanitary ware as a step towards improving adolescent health. Many girls and women still cannot afford sanitary towels.

The government and civil society need to come up with strategies to ensure that disadvantaged women have access to free sanitary towels provided in convenient places. Menstrual health is a vital component of SRHR and it is the role of the Ministry of Health and other relevant stakeholders to create a healthy country by ensuring a healthy populace.

Source: Gender Links News Service, 2019

Water and sanitation

Article 26 (c) SADC Gender Protocol: Ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.
SDG 6.2: By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.
Article (15a) Maputo Protocol: Provide women with access to clean drinking water, sources of domestic fuel, land, and the means of producing nutritious food.

[34] https://genderlinks.org.za/casestudies/lesotho-government-scraps-tax-from-sanitary-wear/

A young girl in Sharpeville, South Africa, accesses water outside her home in 2007. Safe water provision has improved in the region over the past decade, but many still do not have access to clean drinking water. Photo: Colleen Lowe Morna

Women continue to bear the primary responsibilities linked to water, sanitation and hygiene (WASH). Yet communities often leave women out of decision-making on water provision. Similarly, the sphere of administration - local government - that controls the provision of water and sanitation seldom engage in strategic national-level discussions on WASH.

The lack of WASH compromises health and safety and affects all aspects of daily life, including school attendance. Safe water and sanitation facilities at home and at school are particularly important for girls who are menstruating.

While discussions about provision and cost of menstrual products is important and receiving substantial attention currently, there is also an urgent need to focus on WASH as a critical SRHR concern. It is important to include local government in national, regional and global strategies to ensure that all communities have access to good quality WASH.

Table 2.6: Access to basic drinking water in SADC

Country	National basic drinking water status (%)	Urban basic drinking water status (%)	Rural basic drinking water status (%)
Angola	100	100	100
Botswana	96	-	-
DRC	85	97	63
Eswatini	79	95	58
Lesotho	79	97	63
Madagascar	72	87	66
Malawi	68	95	60
Mauritius	67	87	63
Mozambique	67	94	54
Namibia	61	86	44
Seychelles	51	82	34
South Africa	50	79	37
Tanzania	47	79	32
Zambia	42	70	21
Zimbabwe	41	63	23

Source: Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline, WHO/UNICEF, 2017.

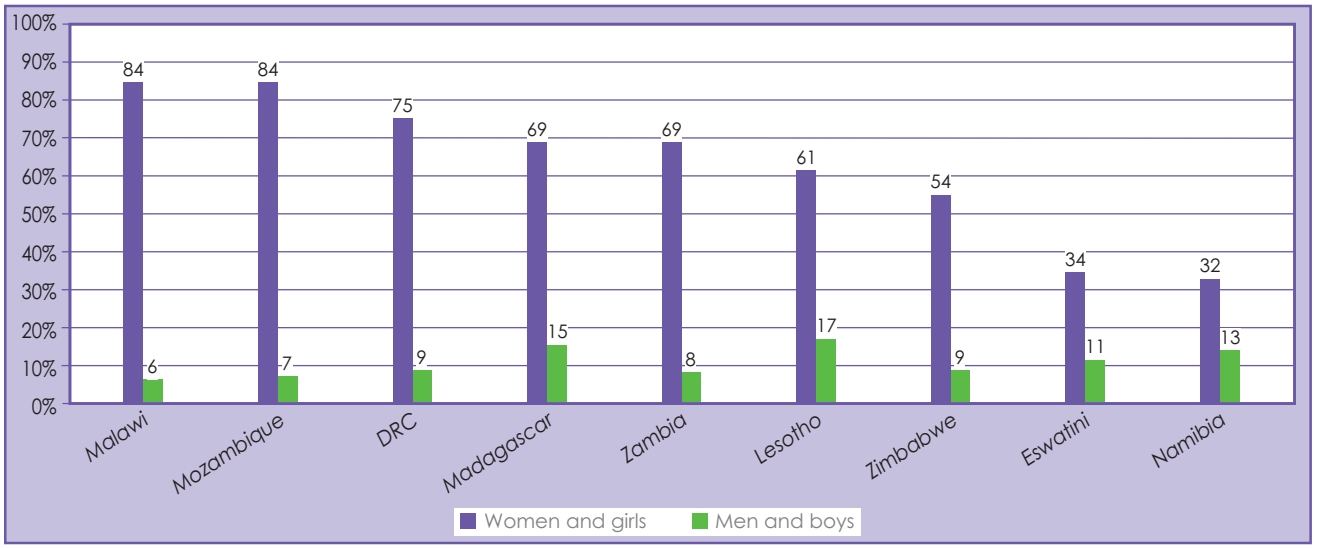
As shown in Table 2.6, four SADC countries - Angola, DRC, Mozambique and Tanzania - have less than 50% coverage for basic drinking water. Meanwhile, Eswatini, Madagascar, Malawi, Zambia and Zimbabwe have between 50-68% coverage, with only Mauritius, Seychelles and South Africa enjoying more than 80% coverage.

While this scenario points to serious concerns about access to water, the picture in rural areas is most alarming. Water provision and access in urban areas is between 63% and 100%, but in stark contrast it sits as low as 21% in rural areas in the DRC followed by 23% in Angola. Mozambique, Madagascar, Tanzania and Zambia have between 32% and 44% access to basic drinking water in rural areas.

South Africa is a relatively well-resourced country, but it has not met the basic needs of its citizens in terms of water supply, particularly in rural areas: 97% of communities have access to water in urban areas as opposed to 63% in rural areas.

There is a need for amplified lobbying and advocacy to push for increased water provision. It is important to continue to monitor how governments meet their promises on this front.

Figure 2.5: Gender division of labour for water collection in nine SADC countries



Source: Safely managed drinking water, UNICEF, 2017.

Figure 2.5 illustrates data from a 2017 report by UNICEF on safely managed drinking water. The report assesses access to water in countries where at least one in ten households have water off premises. In Mozambique and Malawi, it found that 84% of women and girls collect water for the household as opposed to 6% and 7% percent men and boys, respectively.

In the nine countries studied, more women and girls collect water than men and boys without exception. This has an impact on women and girls' time, safety, health and general wellbeing. These findings provide urgent impetus for accelerated safe water provision.

The link between water, sanitation and gender equality is clear. Limited access to water compromises the provision of sanitation. The lack of sanitation in communities and particularly schools impacts the quality of education, girls' attendance and access to education facilities.

In nine SADC countries studied, substantially more women and girls collect water than men and boys without exception

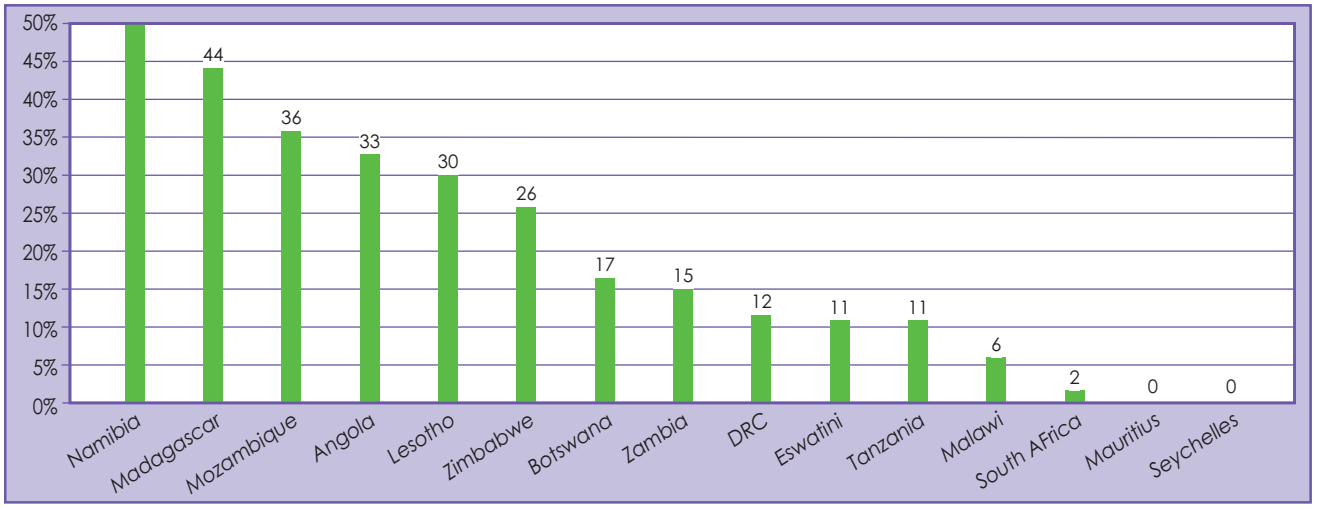
Table 2.7: Status of access to basic sanitation in SADC

Country	National access to basic sanitation (%)	Urban access to basic sanitation (%)	Rural access to basic sanitation (%)
Seychelles	100	-	-
Mauritius	93	94	93
South Africa	73	76	69
Botswana	60	75	39
Eswatini	58	58	58
Lesotho	44	46	43
Malawi	44	49	43
Angola	39	62	21
Zimbabwe	39	54	31
Namibia	34	55	15
Zambia	31	49	19
Mozambique	24	47	12
Tanzania	24	37	17
DRC	20	23	18
Madagascar	10	16	6

Source: Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline, WHO/UNICEF, 2017.

Table 2.7 shows that ten SADC countries provide basic sanitation for less than half of their citizens. Madagascar, with 10% coverage, sits at the bottom in the region, while Seychelles, with 100%, sets a gold standard. Governments clearly prioritise sanitation services in urban areas. Four countries (DRC, Madagascar, Mozambique and Tanzania) provide basic sanitation to less than 25% of the population.

Figure 2.6: Percentage population practicing open defecation



Source: https://data.worldbank.org/indicator/SH.STA.ODFC.ZS. Accessed 23 May 2019.

The lack of proper sanitation services and, significantly, open defecation present serious health challenges in the region. Figure 2.6 shows that, at 50%, Namibia has the highest proportion of people practicing open defecation, followed by Madagascar at 44%. Many people also still practice open defecation in Angola, Lesotho, Mozambique and Zimbabwe. While the levels drop in other countries, the practice of open defecation remains a concern in the absence of proper sanitation.

Tanzania: Sanitation is a right, not a "nice to have"[35]

"Sometimes having your period is a challenge. It stops girls from going to school."

Rebeca, who was 17 when she spoke to Human Rights Watch in 2016, should know. She and other schoolgirls in Tanzania told the international advocacy group that they lacked menstrual supplies, toilets with privacy, and information needed to handle menstruation. They described taunts and humiliation when they leaked blood, missing school as a result.

Girls around the world face the same challenge - often with the same, dispiriting result.

The right to sanitation entitles everyone to sanitation services - including the management of menstruation - that provide privacy, ensure dignity, and are safe and hygienic. Human Rights Watch research from 2005 to 2017 documented obstacles people encounter when trying to perform the simple acts of relieving themselves or managing menstruation safely and with dignity.

In almost every setting researchers examined, including schools, prisons and jails, and refugee camps, they found that discrimination based on caste, gender, disability, age, or other status makes it even harder for some people to access adequate sanitation services than others. They found women and girls often lack safe and private sanitation facilities and materials to manage their menstruation. This can undermine their health, education, work, and gender equality.

Female and male latrines at a secondary school in Mwanza, north eastern Tanzania, in 2016. Many students told Human Rights Watch that they had to use dirty and congested pit latrines. Photo: Elin Martínez, Human Rights Watch

A lack of access to safe and accessible sanitation facilities can also impact the rights of people with disabilities, older adults, and transgender and gender non-conforming individuals. To ensure adequate sanitation for all people, governments need to do more than simply commit new funding and resources. They also need to address discrimination and distinctive challenges for certain populations that prevent some people from accessing sanitation.

Sanitation is a human right for all people. Governments need to be treating it that way.

Source: Annerieka Daniel, Human rights Watch, 2017

[35] https://www.hrw.org/news/2017/04/19/sanitation-right-not-nice-have

Access to contraception

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

Contraception changes lives. When contraception increases, states can have higher levels of economic growth, become less dependent on foreign aid, see more girls continue their education, and see more stability and security - and less gender inequality.[36] The ability to control when, where, how many and under what conditions to have children are key indicators of women's agency and decision-making power. This impacts on every aspect of a woman's life.

In Southern Africa, women's ability to control their fertility is compromised by high levels of sexual violence, customary laws and lack of access to contraception. Early pregnancies severely impact young women and their futures. SADC states should have separate strategies on the provision of contraception and family planning. The first addresses the need for all women across all ages to access contraception. The second helps women who want to have children to plan in a way that does not negatively affect their wellbeing from a health, social or economic perspective. This is a key policy imperative.

Stories like the alleged suicide in 2018 of Blessing Mangena, a Zimbabwean female university student, over an unplanned pregnancy, provide stark reminders of how major gaps in the provision of reproductive health services impact women's lives. The National University of Science and Technology (NUST) learner chose a painful way to die, being crushed by a train, instead of carrying the "shame" of an unwanted child. The death robbed her family, community and the nation of a future statistician who could have contributed to building the country.

At a global level, the DRC, Lesotho, Mozambique, Tanzania, Zambia and Zimbabwe have committed to the Family Panning 2020 (FP2020) initiative. FP2020 works with governments, civil society, multilateral organisations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

Achieving the FP2020 goal is a critical milestone to ensuring universal access to sexual and reproductive health services and rights by 2030, as laid out in SDGs 3 and 5. FP2020 supports the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health.[37]

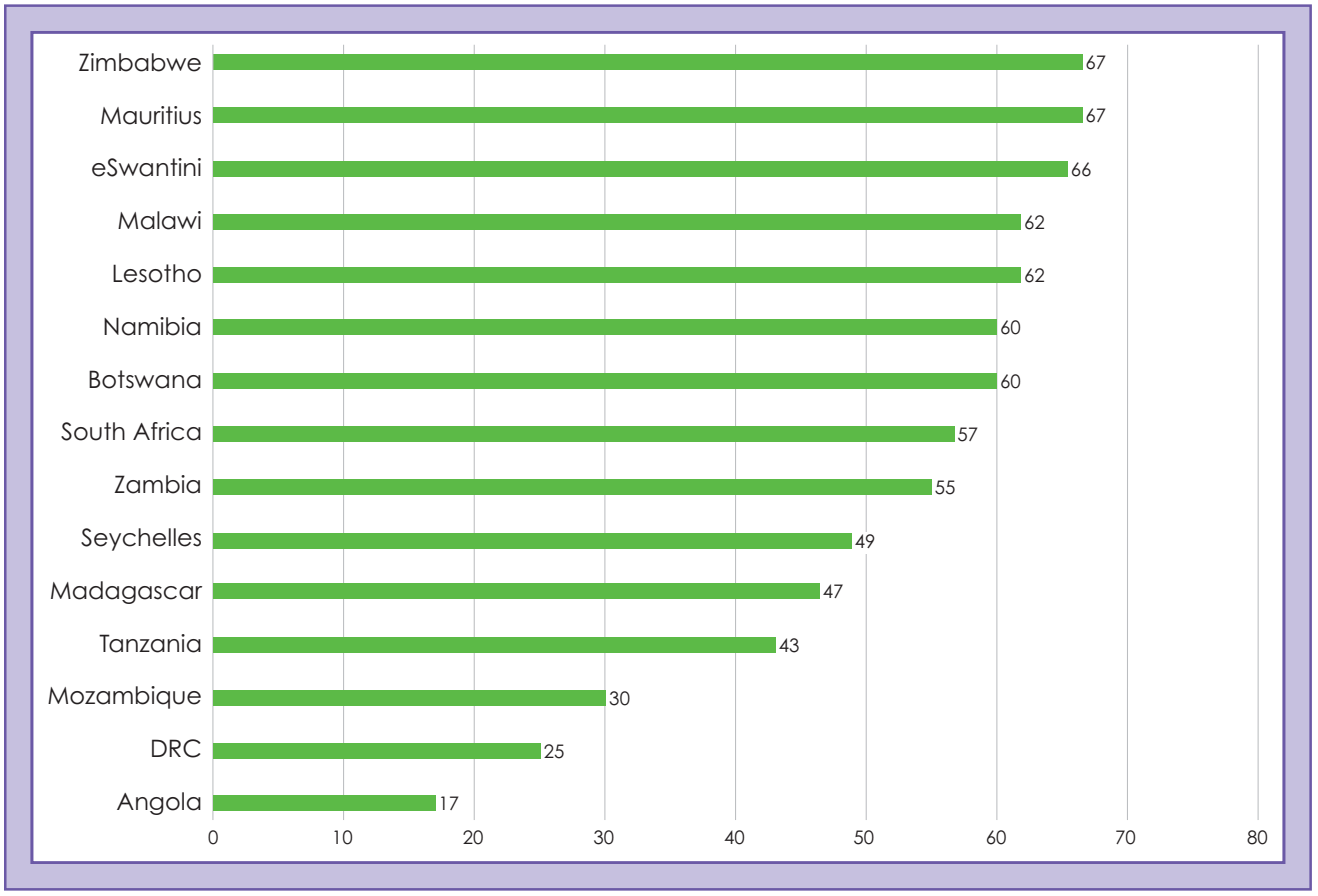
The contraceptive prevalence rate (CPR) is an important indicator of health, population and women's empowerment

[36] https://mariestopes.org/media/2146/time-to-invest.pdf
[37] https://www.familyplanning2020.org/about-us

Contraceptive prevalence rates

The contraceptive prevalence rate (CPR) shows the percentage of women between ages 15 and 49 in marital or consensual unions who use, or whose sexual partner uses, a traditional or modern method of contraception. The CPR is an important indicator of health, population and women's empowerment.[38]

Figure 2.7: Contraceptive prevalence in SADC



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

Figure 2.7 shows wide disparities in contraceptive prevalence rates across SADC countries. The CPR is highest in Zimbabwe and Mauritius (67%) and lowest in Angola (17%). It is critical for governments to identify the groups of women not accessing contraception in order to target local and regional lobbying and campaign efforts. Failure to provide contraceptive care has huge implications for unintended pregnancies, unplanned births, abortions, and miscarriages, increasing levels of maternal mortality in countries.

[38] https://www.africanhealthstats.org/cms/?pagename=indicator&indicator=RMNCH3

Malawi: Spike in unwanted pregnancies following contractive shortages[39]

Thirty-year-old Doris Chikwina from Chigwaja village in Blantyre is furious. She has just discovered that she is pregnant again. "I am fuming yet I am supposed to be happy with this bundle of joy news. But I am not," she says. "I did not expect this pregnancy. I am already nursing a year and half old baby, and I have four other children. I was supposed to be on injectable (Depo-IM), but last time I went to my health centre I came back emptyhanded as I was told that the clinic had run out of this family planning method."

Chikwina said she was receiving an injectable contraceptive at Chigwaja clinic, but she has been off them since the shortage. "I visited three clinics including one at Chilomoni. They were all out of stock and the staff were not sure when the situation would return to normal."

Elsewhere in Chikwawa, two teenage girls say they are one month pregnant because their clinic is also out of contraceptives. They say they had been taking contraceptive pills until last month. The girls, who did not want to be named, said they are sad because they will now not be able to write exams because they are pregnant.

The story is the same for Chilomoni-based Chikondi Phiri, a sand collector who is also pregnant following her inability to access an emergency contraceptive pill. The clinic had run out. "We were told that we had to buy on our own, but I did not have money. I already have nine kids and it is not easy to feed them all in this economy."

Many Malawi clinics have run out of contraceptives like injectable Depo-IM.
Photo: Mayo Foundation

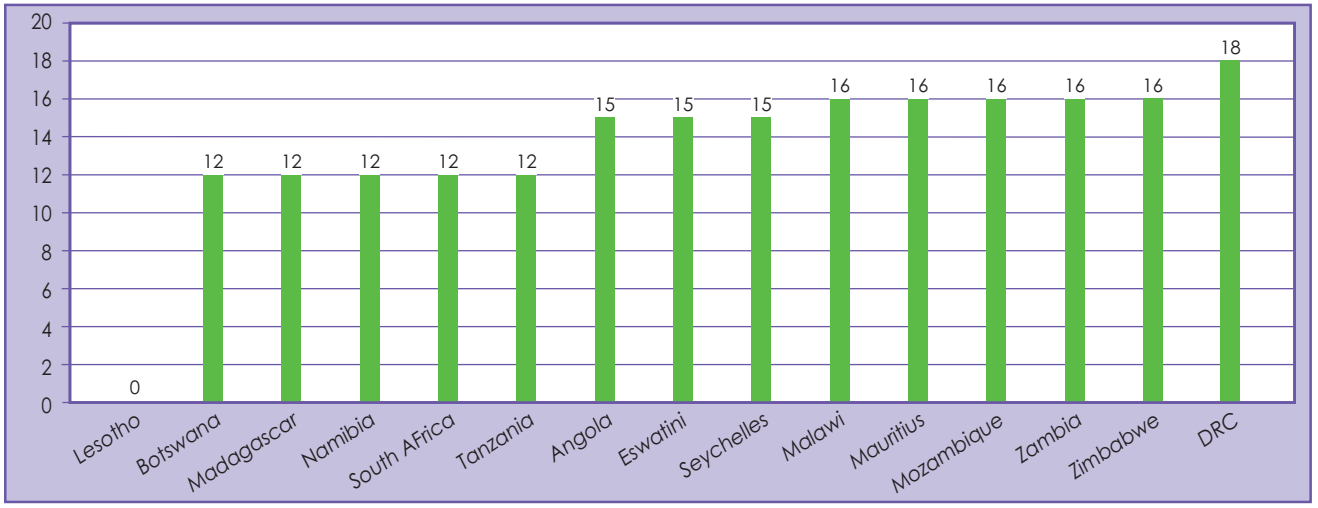
In recent years, lawmakers have attempted to address Malawi's high birth rate by providing better access to contraceptives like those used by Chikwina and Phiri. These recent shortages pose a threat to any gains they've made in reducing the soaring birth rate.

Health rights activist Mary Mbonela said in an interview that worries of the brief shortage of all contraceptives, coupled with the absence of access to abortion services in many parts of the country, had put women at increased risk of unwanted pregnancy and undermined their reproductive and contraceptive health rights.

Source: Penelope Kamanga-Paliani, Gender Links News Service

[39] https://genderlinks.org.za/news/malawi-shortage-of-contracptives-hits-women-hard/

Figure 2.8: Age of access to contraceptives



Source: Audit of SRHR laws and policies in SADC, Gender Links, 2019.

As is evident in figure 2.8, five SADC countries (Botswana, Madagascar, Namibia, South Africa and Tanzania) provide contraceptives to young people from the age of 12. Angola, Seychelles and Eswatini start at age 15, while all other countries allow for contraception from age 16 and up. The SADC SRHR Strategy provides for contraception from age 10. Given the high level of early pregnancies in the region, the age of consent for contraception should be lowered in those countries where it is higher than 12 years.

Lesotho does not stipulate any age for access to contraception because the country recognises access to contraception as a right and it must be available to anyone at any age.

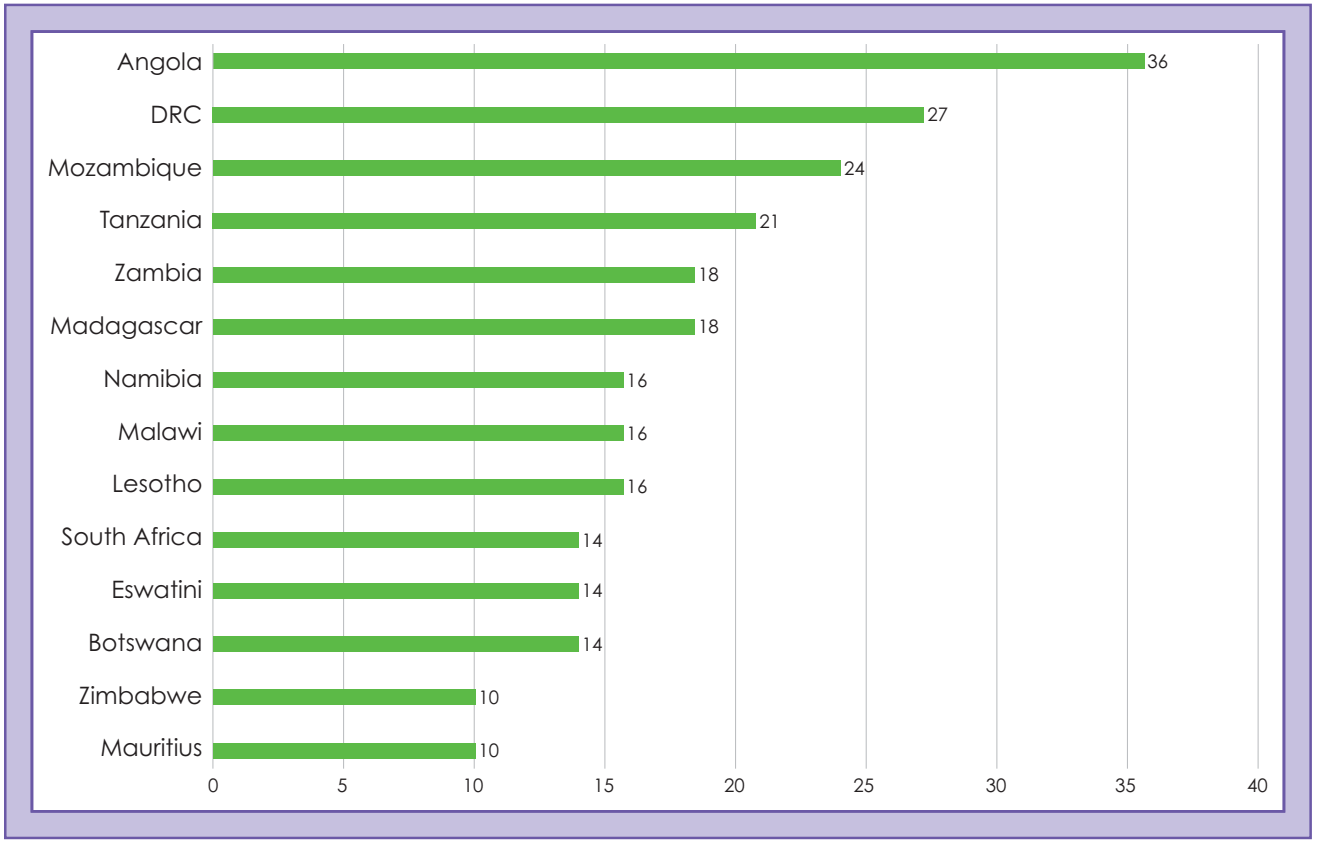
While the approach provides much needed open access, it is concerning because it can be open to interpretation by health care providers and facilities.

There is a need to interrogate the cultural practices and social norms that hinder youth access to contraceptives and integrate them into strategic SRHR planning. Experts define the unmet need for family planning as the percentage of women of reproductive age, either married or in a union, who have an unmet need for contraception. Women with unmet need are those who want to stop or delay childbearing but are not using any method of contraception.[40]

She Decides launch August 2018. Photo: Colleen Lowe Morna

[40] https://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2014/Metadata/WCU2014_UNMET_NEED_metadata.pdf

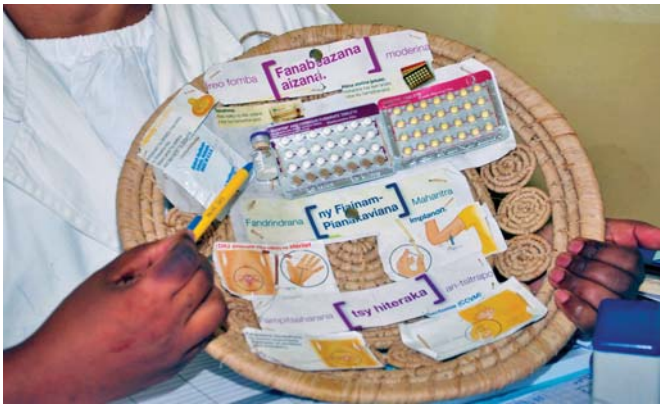
Figure 2.9: Unmet need for contraceptive use amongst women aged 15 to 49



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

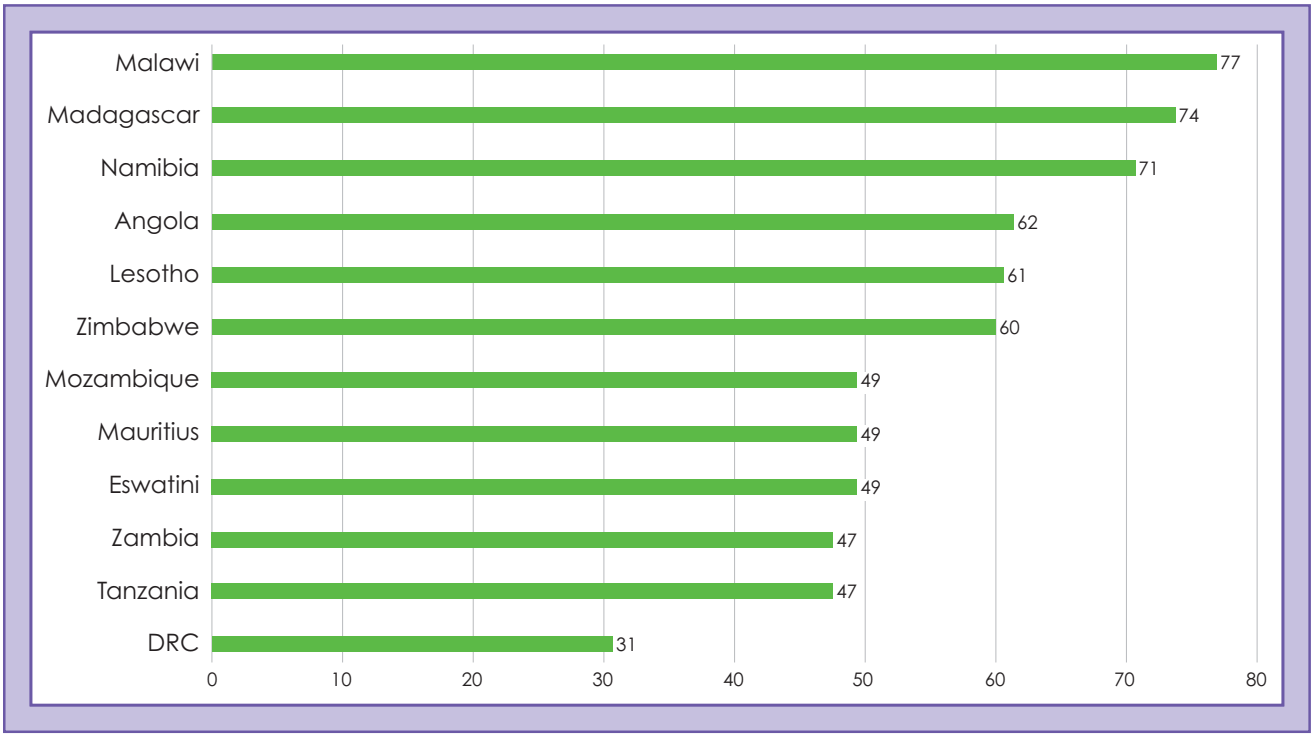
Figure 2.9 shows that Angola, at 36%, has the highest unmet need for contraceptive use. The DRC, Mozambique and Tanzania rank between 21% and 27% in terms of unmet needs. The unmet need for contraceptive use amongst women coupled with the criminalisation of abortion in 13 SADC countries results in elevated levels of unwanted pregnancies and compromises women's ability to have control over their bodies.

Angola has the highest unmet need for contraceptive use



Explaining contraception at the Basic Health center in Tsaralalana, Madagascar.
Photo: Gender Links

Figure 2.10: Females involved in decision-making for contraceptive use amongst women aged 15 to 49



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 25 May 2019.

Malawi has a high proportion of women involved in decision-making about contraceptive use at 77%, followed by Madagascar and Namibia with 74% and 71% respectively. In DRC, Eswatini, Mauritius, Mozambique, Tanzania and Zambia less than 50% women between 15 to 49 using contraceptive are involved in decision-making. The DRC, at 31%, ranks as the lowest in the region. No data exists for Botswana, Seychelles and South Africa.

Maternal health

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

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

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

a) The right to control their fertility;

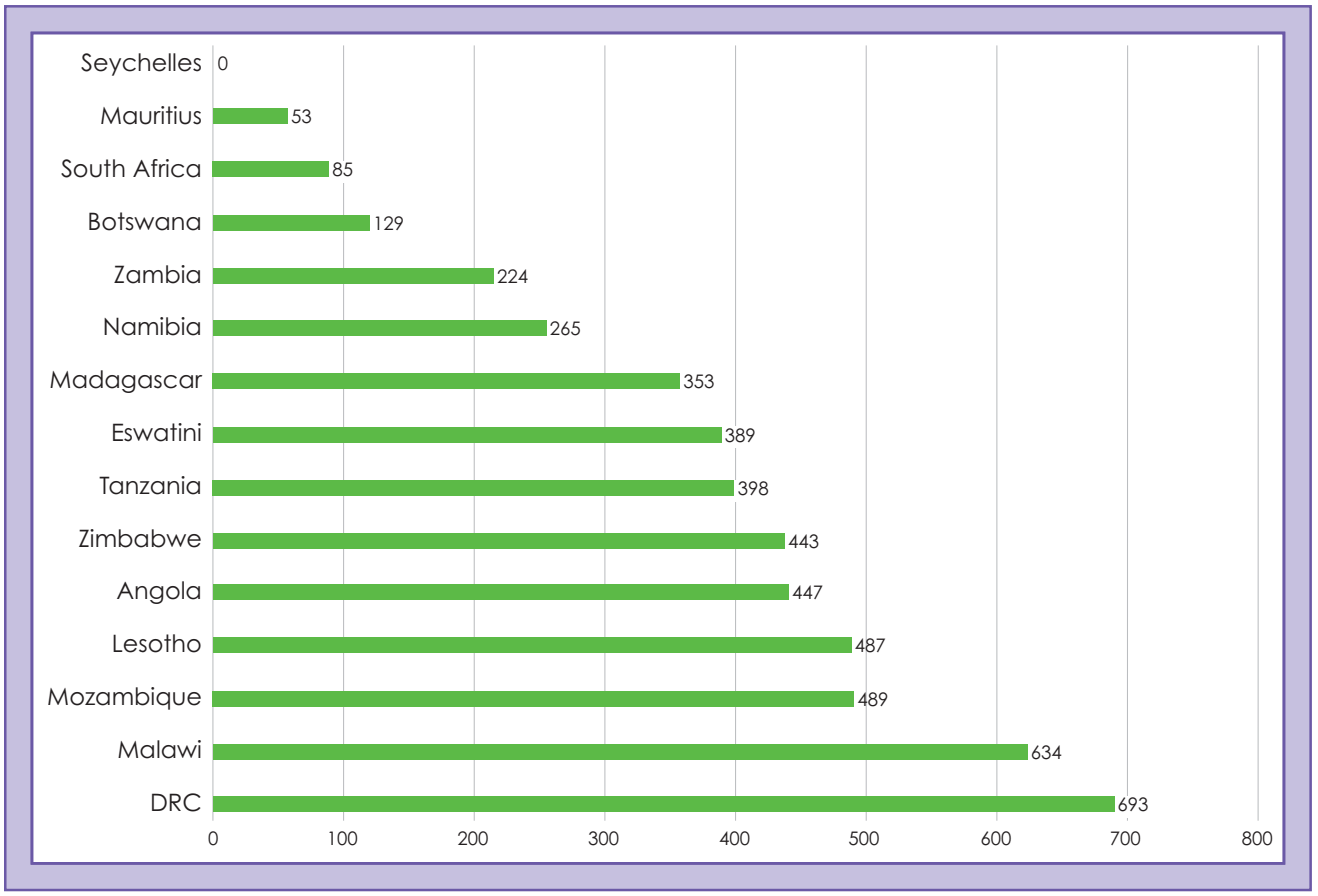
b) The right to decide whether to have children, the number of children and the spacing of children; and

c) The right to choose any method of contraception.

Maternal Mortality Ratio

The WHO defines maternal health as the health of women during pregnancy, childbirth and the postpartum period.[41] The Maternal Mortality Ratio (MMR) represents the number of women of childbearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy; from any cause related to or aggravated by the pregnancy or its management (but not from accidental or incidental causes) per 100 000 live births.[42] More often, women die because of lack of access to proper reproductive health care.

Figure 2.11: MMR per 100 000 in SADC



Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019.

Figure 2.11 shows that MMR varies considerably by country: it is lowest in Seychelles and highest in the DRC. The MMR for the Seychelles has substantially reduced over the last ten years to a figure that cannot be computed out a 100 000 because it is so low. Mauritius is also below the target of 70 per 100 000 live births.

Thirteen countries in SADC remain above the target, with the DRC being almost ten times higher than the required target. Improvements in SRHR are critical in reducing maternal mortality, as well as ensuring social and economic development for women. There is a need for the SADC region to improve health outcomes for women by providing access to comprehensive maternal health care, contraception, family planning, HIV and AIDS services and unrestricted abortion.

[41] https://www.who.int/maternal-health/en/
[42] UNICEF MMR definition

Mozambique is one of the most dangerous places in the world to have a child[43]

"Who wants to give birth here?" asked the midwife, as she threw open the door of the maternity ward: a mud-and-straw hut, baking hot under the merciless sun in Ngapa village, Mueda district, in northern Mozambique.

Four beds, two mattresses, a torn, ramshackle gynaecological bed, a rusty stand holding a plastic pail, and little more. The midwife had no aspirator, no electricity and no running water.

A young woman sits in the Chiquque hospital in Mozambique's Inhambane province after suffering a severe hemorrhage following a miscarriage.

Photo: Mercedes Sayagues

And she was tired. Diabetic, a few months away from retirement, worn by a hard life, bitter because she had been promised a brick house with running water but was living in a *pau-a-pique* (mud) hut, not much different from the maternity ward. She had not bothered to register any of the births or deaths in the last three months.

In remote rural clinics in the remote Mueda plateau, along the border with Tanzania this is what I saw:

- In Imbuo village, the clinic is freshly painted red and white, but a woman in labour must bring her own water, food, sheets and a paraffin lantern. To request an ambulance from the district capital 50 kms away, a relative must ride a bike for 15 minutes to find cell phone reception.
- In Mpeme, instruments cannot be sterilised properly between patients for lack of gas canisters.
- In Namatil, the nurse can diagnose HIV but the nearest centre for antiretrovirals is US$5 and two hours on a bad road away. Most rural people survive on one dollar a day.

Until when will rural Mozambican women have to live as if biology and geography determine their destiny? As if their destiny is to risk their lives with every birth, to give birth more than is healthy (on average, more than six births per woman, while fertility rates are climbing, an anomaly in Africa), and to have the babies in a place, whether a home or a rural clinic, that makes it unsafe to bring life into this world?

Source: Mercedes Sayagues, Daily Maverick, 2014

[43] https://www.dailymaverick.co.za/article/2014-06-19-maternal-mortality-in-mozambique-who-wants-to-give-birth-here/

Access to health services

Table 2.8: Provisions for antenatal and postnatal care

Country	At least one ANC (%)	At least four visits (%)	Postnatal care (%)
Angola	82	61	23
Botswana	94	73	
DRC	88	48	44
Eswatini	99	76	-
Lesotho	95	74	88
Madagascar	82	51	62
Malawi	95	51	42
Mauritius	-	-	-
Mozambique	91	51	-
Namibia	97	63	69
Seychelles	-	-	-
South Africa	94	76	84
Tanzania	91	51	34
Zambia	96	56	63
Zimbabwe	93	76	57

Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019.

Table 2.8 shows that between 82% and 99% of pregnant women and girls across all SADC countries have at least one antenatal visit. A much lower proportion of women have at least four antenatal visits. The figures in Botswana, Eswatini, Lesotho, South Africa and Zimbabwe are encouraging, with more than 70% of pregnant women and girls having at least four antenatal visits. But an area of serious concern is postnatal care. Only Lesotho and South Africa provide postnatal care to more than 80% of women. The MMR will only decrease if women receive high quality and more frequent antenatal and postnatal care.

Many women in SADC do not receive postnatal care, which is a serious concern

Table 2.9: Availability of skilled health personnel

Country	Skilled birth attendants (%)	Nursing and midwifery personnel per 10 000 of the population
Angola	50	13
Botswana	99	33
DRC	80	5
Eswatini	99	20
Lesotho	78	7
Madagascar	44	1
Malawi	90	3
Mauritius	100	34
Mozambique	54	4
Namibia	88	28
Seychelles	99	32
South Africa	97	35
Tanzania	64	4
Zambia	63	9
Zimbabwe	78	12

Source: Maternal and Newborn Health Coverage Database, UNICEF, 2019; https://www.who.int/gho/health_workforce/nursing_midwifery_density/en/. Accessed 25 May 2019.

Exceptionally low proportions (between 44% and 54%) of women and girls have skilled birth attendants during delivery in Angola, Madagascar and Mozambique. Six SADC countries (Botswana, Eswatini, Malawi, Mauritius, Seychelles and South Africa) provide skilled birth

attendants to more than 90% of pregnant women and girls.

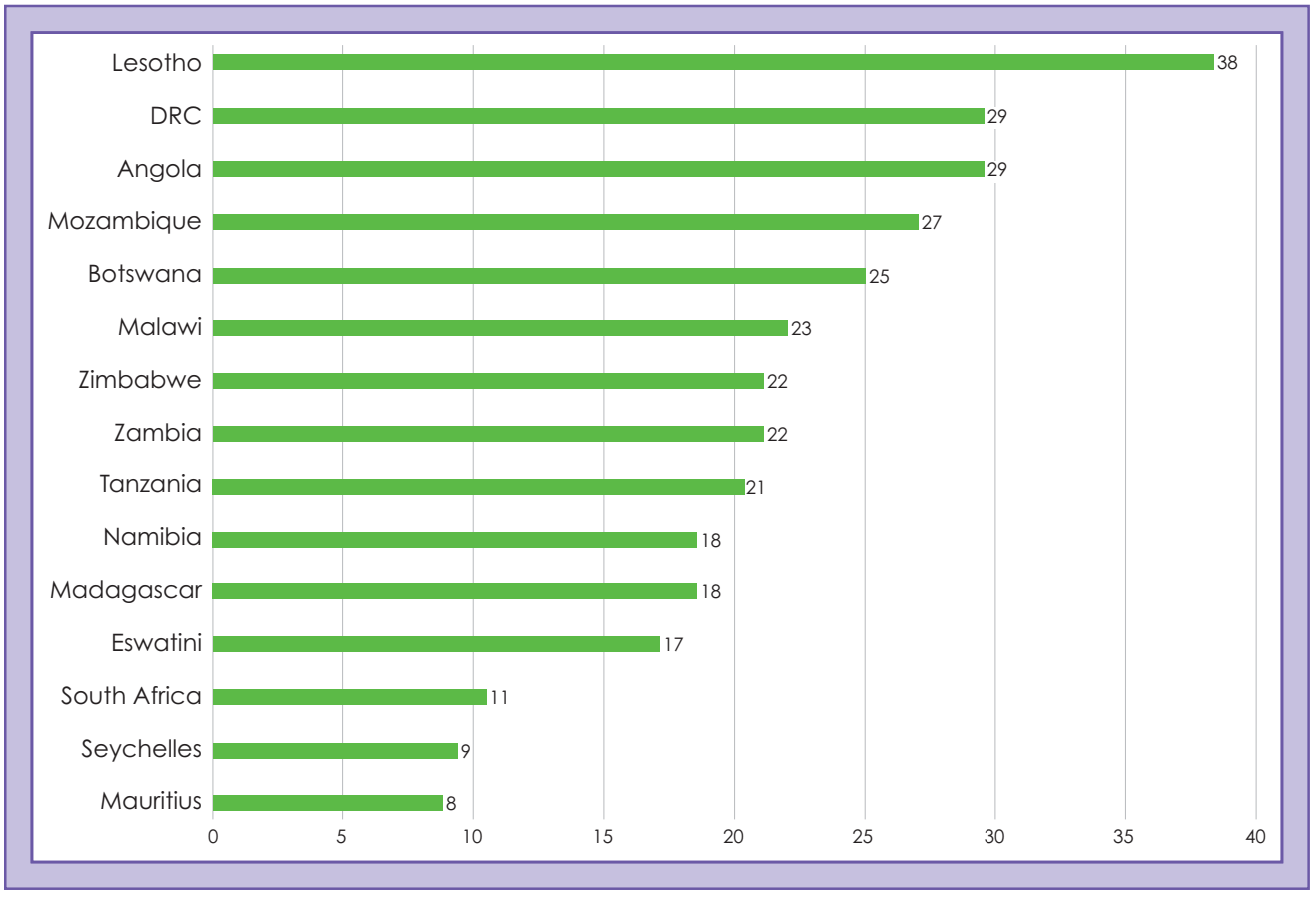
The bigger concern across the region is the lack of nursing and midwifery personnel. The World Health Organisation (WHO) recommends at least 5.9 skilled health professionals (midwives, nurses and physicians) per 1000 population as the workforce requirement as part of the Ending Preventable Maternal Deaths initiative, which entails reducing global maternal deaths to 50 per 100 000 live births by 2035.[44]

Based on current data, none of the countries in SADC reach that goal. South Africa comes closest with 3.5 nurses and midwives per 1000. DRC, Madagascar, Malawi, Mozambique and Tanzania have five or fewer nurses or midwives per 10 000 people. Madagascar is facing a health personnel crisis with only one nurse or midwife per 10 000 people.

Neonatal mortality

Neonatal mortality refers to the number of deaths during the first 28 completed days of life per 1 000 live births in a given year or period. Neonatal deaths subdivide into early neonatal deaths, occurring during the first seven days of life, and late neonatal deaths, occurring after the seventh day but before 28 completed days of life.[45]

Figure 2.12: Neonatal mortality per 1000 live births



Source: http://apps.who.int/gho/data/view.main.HWFNURv. Accessed 25 May 2019.

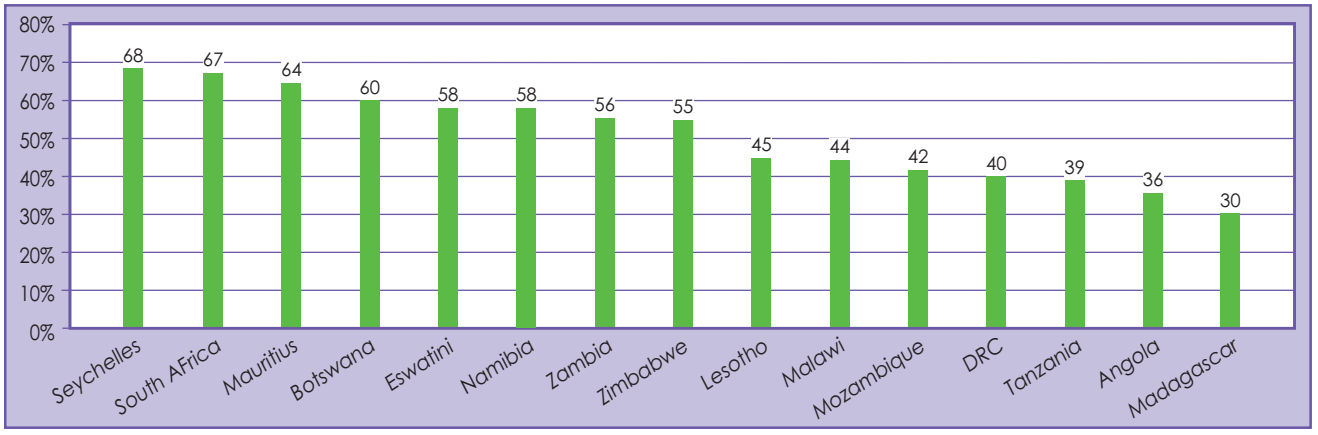
[44] https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-?sequence=1
[45] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf

Figure 2.12 shows that Lesotho has the highest rate of neonatal deaths, 38 out 1000 live births. Angola, Botswana, DRC, Malawi, Mozambique, Zambia, Zimbabwe and Tanzania follow, with between 21 and 29 neonatal deaths per 1000. Neonatal mortality in SADC is attributable to low levels of antenatal and postnatal care for pregnant women and newborns.

Universal health care

Universal Health Coverage (UHC) ensures that all people and communities, without leaving anyone behind, receive the quality services they need, and are protected from health threats without suffering financial hardship.[46] To achieve UHC, governments need to create health provision policies, develop strategies and plans and allocate realistic budgets. The process requires the collective conceptual capacity, skills and will of government, civil society organisations, citizens, business and other stakeholders.

Figure 2.13: Percentage of the population receiving essential health services



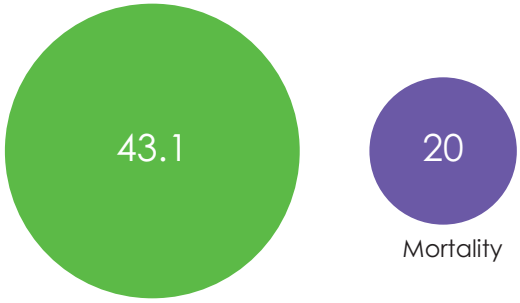
Source: http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv. Accessed 26 May 2019.

Figure 2.13 shows that SADC countries provide essential health services to less than 70% of their citizens. Angola, Madagascar and Tanzania provide essential health services to between 30% and 39% of their populations. These statistics send important warning signals about the extent of essential health services available to people living in SADC. The associated impact will be that SRHR services will be available to low proportions of the SADC population.

When defining an essential package of health services, it is critical to include key SRHR services. Stakeholders must expand these essential SRHR services to include cervical and uterine cancer as well as Polycystic Ovarian Syndrome (PCOS) and fibroids. The human papillomavirus or HPV is the most common sexually transmitted infection. HPV is usually harmless and goes away by itself, but some types can lead to cancer or genital warts. Provision of the HPV vaccine prevents cervical or uterine cancer.

[46] https://uhcpartnership.net/about/

Figure 2.14: Cervical and uterine cancer prevalence and mortality rates per 100 000 in SADC



Source: http://gco.iarc.fr/today/data/factsheets/cancers/23-Cervix-uteri-fact-sheet.pdf. Accessed 26 May 2019.

Figure 2.14 shows the current incidence rates of cervical and uterine cancer at 43.1 per 100 000 women of all ages. While this figure is not at crisis, these cancers have emerged as a leading cause of death amongst women. The mortality rate in SADC is 20%.

These cancers are preventable with the HPV vaccine. SADC countries must start rolling out the HPV vaccine as a routine part of the inoculation regime. There is an opportunity to stop cervical and uterine cancer before they reach crisis levels.

Issues such as fibroids and PCOS are becoming more commonplace and many women do not yet have the resources or knowledge to make informed decisions. The public health system must include treatments for these conditions in the SRHR package of services in essential health services.

Seychelles: Reproductive health complications[47]

Significant numbers of women and adolescent girls live with either cysts or fibroids in Seychelles. These two health conditions attack ovaries and challenge women's ability to have children. At the moment, the Ministry of Health does not have any statistics on the number of cases reported at the hospital and district clinics. Educators also do not discuss these issues in schools.

Young girls need information and knowledge to make informed choices about their bodies. Photo: Gender Links

Jasmine Talma is a 25-year-old living with polycystic ovarian syndrome without really knowing anything about the condition. "At the age of 14, I got my period, but it was irregular, sometimes I did not get my periods for six months. At the age of 16, I began to worry and went to see a gynaecologist to see what was going on" she says.

Talma affirmed that aside from the internal change, her physical appearance also changed: she gained weight without any explanation and her face became covered with pimples. "When I visited the doctor, I was told that I have a cyst on my ovaries and got contraceptive pills to regulate my period. I went back to the doctor at the age of 23 in January last year (2018), and only then did the doctor explain what was really going on with my body and told me what polycystic ovarian syndrome (PCOS) was exactly.

"I suspected that something was wrong with my reproductive health, it only confirmed my suspicion, it made me feel sad but at the same time relieved because I finally I got a name for my condition, and became more aware of what I should do. I feel ready to have a child and I keep trying but I do not get pregnant. It has been one and a half year since I have been trying to have a child. We did reproductive health in science class at school but did not address the topic of causes of infertility."

Source: Juliette Dine, Gender Links News Service, 2019

[47] https://genderlinks.org.za/news/seychelles-i-suspected-something-was-wrong-with-my-reproductive-health/

Health expenditure analysis

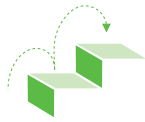
Experts use two measures to assess health financing: the level of health spending as a proportion of the total government spending and health spending as a proportion of the country's Gross Domestic Product (GDP). The GDP is the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within the country's boundaries, their production is included in GDP.[48]

Table 2.10: Health financing analysis

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Madagascar	17.8	6
Eswatini	15.3	7.7
Zimbabwe	14.5	9.4
Namibia	13.8	9.1
South Africa	13.3	8.1
Lesotho	10.1	8.1
Seychelles	10	3.9
Malawi	9.8	9.8
Mauritius	9.8	9.8
Tanzania	9.5	4.1
Botswana	9.1	5.5
Mozambique	8.3	5.1
Zambia	7.1	4.5
Angola	5.4	2.9
DRC	3.7	3.9

Source: https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 26 May 2019.

Table 2.10 shows that only Eswatini and Madagascar meet the recommended Abuja Declaration goal of 15% expenditure on health.[49] Zimbabwe is close at 14.5%. Angola and DRC allocate the lowest budgets to health at 5.4% and 3.7% respectively. All SADC countries allocate less than 10% of their GDP to health. Angola, DRC, Seychelles, Tanzania and Zambia allocate less than 5% of their GDP to health expenditures. This has a negative impact on women's health and the push to achieve SDG 3 globally, not to mention the attainment of the targets in the SADC SRHR Strategy 2019 to 2030. There is a need to advocate for increased spending on health across SADC.



Next steps

Key recommendations and next steps to ensure governments continue to improve the health of their populations include:

- Update policy and legislative frameworks to align with the provisions of the SADC SRHR Strategy and Scorecard 2019-2030 and SRHR provisions in the SADC Protocol on Gender and Development.
- Develop national menstrual health policies and strategies that cover the provision of menstrual products and changing attitudes on menstruation.
- Develop plans to accelerate the rollout of water and sanitation to all communities, particularly in rural areas.
- Ensure that contraception is available to women and girls on demand in all health centres.
- Identify communities where women who need contraceptives do not have access to them and develop access and provision strategies.
- Provide family planning services to women who would like to have children.
- Review and identify the package of essential health services, including SRHR services, that stakeholders need to roll out to achieve universal health coverage (UHC).
- Develop partnerships that will facilitate the roll out of UHC, including SRHR services.
- Expand the scope of traditional SRHR services to include, amongst others, the provision of the HPV vaccine and treatment of polycystic ovarian syndrome (PCOS) and fibroids.
- Increase the scope and quality of services available to pregnant women and girls and newborns.
- Lobby politicians in SADC to invest in health systems and infrastructure.
- Conduct regular monitoring and evaluation of SRHR services and strategies to ensure that the quality and scope of services meet the needs of the those who use them.

[48] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038
[49] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf