Sexual and Reproductive Health 2

Thabo Morena distributing sanitary pads after a council meeting in Mamantso, Lesotho, in November 2019. Photo: Ntolo Lekau

KEY POINTS

- Maternal mortality remains high across the region, despite political commitment to reduce it. Fourteen countries in SADC remain below the target of 70 deaths per 100 000 women.
- Of the 16 SADC countries, 14 now have stand-alone policies or guidelines on Sexual and Reproductive Health and Rights (SRHR). Only two (Angola and DRC) do not.
- However, many countries failed to mainstream SRHR into their COVID-19 responses, leaving women and girls without vital services and support throughout the region during the pandemic.
- Six SADC countries (Lesotho, Mauritius, Seychelles, South Africa, Zambia, and Zimbabwe) have removed VAT from menstrual hygiene products and five (Botswana, Lesotho, Madagascar, Seychelles, and Zambia) now provide free sanitary pads in schools.
- The COVID-19 pandemic has increased the need for clean water and sanitary facilities for menstrual hygiene and highlighted the lack of clean water in many SADC communities.
- More women than men collect water in nine of 16 SADC countries studied. In Mozambique and Malawi, a recent study found that 84% of women and girls collect water for the household, as opposed to just 6% and 7% men and boys, respectively.
- In eight SADC countries (Comoros, DRC, Eswatini, Malawi Mauritius, Mozambique, Tanzania, and Zambia) more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use.
- The COVID-19 pandemic highlighted many gaps in health systems in the region, underscoring the need for countries to adhere to their Universal Health Coverage commitments, with SRHR mainstreamed throughout.

Introduction

Sexual and Reproductive Health (SRH) represents both a human right and a significant aspect of public health that requires constant attention. Globally, more than 350,000 women still die annually while pregnant or within 42 days of giving birth - "maternal deaths." Almost all (99%) of these occur in the developing world, with 87% of maternal deaths in Sub-Saharan Africa and South Asia.[1]

SRH becomes especially important in emergencies like the COVID-19 pandemic, given that women make up 70% of the global health workforce, representing a majority of frontline health workers, nurses, midwives, and community health workers.[2]

In 2019, global leaders gathered in New York during the annual United Nations (UN) General Assembly for a summit focused on universal health coverage. They agreed to a political declaration, adopted in October 2019. This committed to: universal access to SRH care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes. Countries had already committed to universal access to SRHR in the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action.[3]

According to the United Nations Population Fund (UNFPA), good SRH comprises complete physical, mental, and social wellbeing in all matters relating to the reproductive system. It implies that people can have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.[4] The COVID-19 pandemic poses challenges in achieving SRH. Lockdown regulations and the increased burden of COVID-19 patients at health institutions resulted in limited access to SRH for women and girls. Despite governments' commitment to universal access to SRH at the 2019 UN General Assembly, COVID-19 exposed a lack of political will in many Southern African governments to mainstream SRH.

A woman nurses her one-year-old child in Sinazongwe, Zambia, in 2020.
Photo: Albert Ngosa

Key elements of realising SRH include:[5]

- Access to accurate information and the safe, effective, affordable, and acceptable contraception method of choice;
- Information availability that empowers people to protect themselves from sexually transmitted infections (STIs);
- When women decide to have children, they must have access to services that can help them have a healthy pregnancy, safe delivery, and strong baby; and
- The right to make one's own choices about SRH.

[1] World Health Organisation, Fact Sheet on Sexual and Reproductive Health accessed 30 June from https://www.who.int/hac/events/drm_fact_sheet_sexual_and_reproductive_health.pdf?ua=1
[2] WHO (2019). Gender equity in the health workforce: Analysis of 104 Countries: https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?ua=1
[3] United Nations Resolution 74/2 Political declaration of the high-level meeting on universal health coverage, October 2019
[4] United Nations Population Fund, sexual reproductive health overview, accessed from https://www.unfpa.org/sexual-reproductive-health on 30 July 2020
[5] UNFPA, News on Sexual Reproductive Health, accessed on 27 June 2020 from https://www.unfpa.org/sexual-reproductive-health

Table 2.1: SRH indicators in 2020

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
SRHR policy and legislative framework																
Existence of SRHR policies/ guidelines[6]	No	Guide-lines	2018 Stand-alone SRHR policy	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015-2019 Policy	2011-2015 Guide-lines	2008 Policy	2010-2015 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation[7]	No	No	No	2016-2020 Policy	No	2015-2020 Policy	2016-2020 Policy	2016-2020 Policy	No	No	No	No	2017 Policy	No	2016-2020 Stra-tegy	No
Menstrual health																
Provision of free menstrual ware in schools[8]	No	Yes	No	No	No	Yes	Yes	No	No	No	No	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware[9]	No	No	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes
Basic drinking water status (%)[10]	41	79	84	42	68	72	51	67	100	47	79	96	85	50	61	67
Access to basic sanitation (%)[11]	39	60	34	20	58	44	10	44	93	24	34	100	73	24	31	39
Contraception																
Contraceptive preva-lence rate amongst women aged 15-49 (%)[12]	17	60	27	25	66	62	47	62	67	30	60	49	57	43	50	67
Unmet need for contraception amongst women aged 15-49 (%)[13]	36	14	30	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 (%)[14]	62		21	31	49	61	74	47	49	49	71			47	47	60
Age of access to contraception[15]	16	12		18	15		12	16	16	16	12	15	12	12	16	16
Maternal mortality																
Maternal mortality ratio (per 100 000)[16]	241	144	273	473	437	544	335	349	61	289	195	53	119	524	213	458
Antenatal care visits (at least one visit) (%)[17]	82	94	49	88	99	95	82	98		87	97		94	98	97	93
Antenatal care visits (at least four visits) (%)[18]	61	73	11	48	76	74	51	51		52	63		76	62	64	76
Skilled attendance at birth (per 100)[19]	50	99	82	80	99	78	44	90	100	54	88	99	97	64	80	78
Postnatal care coverage (%)	23		14	44	88	62		42			69		84	34	54	57
Neonatal mortality (per 1 000)[20]	29	25	32	29	17	35	21	22	9	28	16	9	11	21	23	21
Nursing and midwifery personnel per 10 000 of the population[21]	4	54	6	11	41	33	2	4	35	7	20	80	13	6	13	19

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Universal health coverage																
Proportion of population receiving essential health services (%)[22]	40	61	52	41	63	48	28	46	63	46	62	71	69	43	53	54
Health budgets																
Health expenditure as proportion of GDP (%)[23]	2.9	5.5	7.6	3.9	7.7	8.1	6	9.8	5.7	5.1	9.1	3.9	8.1	4.1	4.5	9.4
Health expenditure as proportion of total government expenditure (%)[24]	5.4	9.1	3.6	3.7	15.25	10.1	17.8	9.8	10	8.3	13.8	10	13.3	9.5	7.1	14.5

Table 2.1 shows that:

- Except for Angola and DRC all countries now SRHR policies and/or guidelines. However, only six (DRC, Lesotho, Madagascar, Malawi, South Africa, and Zambia) allow adolescents to access SRH services without third party authorisation.
- Maternal mortality rates improved from 2019 to 2020 in Angola, DRC, Lesotho, Madagascar, Mozambique, and Namibia. However, they worsened in Eswatini, South Africa, and Tanzania, while remaining comparable to previous years in all other countries.
- Despite some improvement in maternal mortality rates, more than 250 women (of every 100 000) still die during pregnancy, childbirth, or in the first 42 days after childbirth in nine of 16 SADC countries.
- Five countries now provide free menstrual ware in schools (up from four in 2019) and six countries have removed taxes on menstrual products.

Justice Pour Elles members take part in a "silent march" against delays to justice and poor SRHR in the Democratic Republic of the Congo (DRC) in February 2020.
Photo courtesy of UCOFEM

- Access to basic drinking water and sanitation remains inconsistent across the region, with a majority of people in Angola, DRC, and Mozambique still going without both, while almost all citizens in Mauritius and Seychelles have access.

6 Gender Links Audit of SRHR Policies and Laws, June 2020
7 aho.afro.who.int/profilesinformation/index.php/
8 GL Audit of SRHR Policies and Laws in SADC, 2019
9 IBID
10 WHO/UNICEF (2017) Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG baseline
11 IBID
12 https://www.unfpa.org/data/world-population/
13 IBID
14 https://www.unfpa.org/data/world-population/
15 GL Audit of SRHR Policies and Laws
16 Maternal and Newborn Health Coverage Database, UNICEF, 2019
17 IBID
18 IBID
19 IBID
20 https://childmortality.org/data
21 http://apps.who.int/gho/data/view.main.HWFNURv
22 http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv
23 https://databank.worldbank.org/data/source/world-development-indicators#
24 IBID

- Access to contraception is still poor across the region, with a high of only 67% in Zimbabwe and a dismal low of 17% in Angola.
- Most countries spend between 4-8% of their GDP on health care, with some outliers, including Malawi at the high end (9.8%) and Angola at the low end (2.9%).
- Most women in the region now have between one and four antenatal care visits but postnatal care remains patchy, with a high of 88% in Eswatini and a low of 14% in Comoros.

COVID-19 highlighted roadblocks to some of these goals, including limited access to antenatal facilities, limited access to SRHR services, disruption to provision of contraception methods, and lack of emergency contraception, among others. While most Southern African Development Community (SADC) member states declared a state of national disaster during the pandemic, many lacked critical and robust strategies to mainstream SRH into COVID-19 responses.

Civil society organisations have actively led SRH campaigns that integrate COVID-19 responses. The Southern Africa Gender Protocol Alliance (the Alliance) championed SRHR campaigns through online platforms and community radio under the banner #VoiceandChoice throughout the pandemic.[25] Other campaign hashtags of note during this period included #SheDecides, #Femalelivesmatter, #MyBodyMyChoice, #GenerationEquality, and the #TotalShutDown campaign in South Africa.

Gender activists release this 2020 SADC #VoiceandChoice Barometer against the backdrop of key political events linked to SRH. These include the declaration by all SADC countries that the COVID-19 pandemic represents a regional disaster; South Africa's chairing of the African Union; the tenth anniversary of UN Women; the UN General Assembly High Level meeting on Universal Health Coverage; the establishment of Generation Equality Action Coalitions by UN Women; and the Beijing Declaration and Platform for Action 25th anniversary. All these political milestones affected global and regional SRH in 2019 and 2020.

This chapter focuses on SRHR policies and frameworks - the 2016 SADC Protocol on Gender and Development, the Sustainable Development Goals (SDGs), and the SADC SRHR strategy - as well as three key areas of SRH: menstrual health; family planning and maternal health. These are analysed against the backdrop of the COVID-19 pandemic and its profound effects on the sector.

SRH and the COVID-19 pandemic

The novel coronavirus (SARS-CoV-2) that causes COVID-19 spread rapidly after emerging in late 2019, leading the World Health Organisation (WHO) to declare the disease a global pandemic on 11 March 2020.[26] The pandemic has massively strained SADC's already under-resourced health institutions (only two countries - Eswatini and Madagascar - meet the target of 15% minimum for health expenditure). Regional responses to the pandemic also affected SRH, in particular lockdown measures that classified some health services as non-essential.[27]

The COVID-19 pandemic presents both opportunities and challenges to SRH. While the pandemic affects all people, it has highlighted glaring gendered dimensions around SRH for women and girls. Women seek medical help more often because of their reproductive role in society. Prenatal visits expose pregnant women to an elevated risk of contracting the virus as expectant mothers frequently seek medical help in crowded health facilities. The Guttmacher Institute estimated that a 10% reduction in the proportion of women receiving SRH services

[25] Gender Links, SADC Gender Protocol Alliance SRHR and COVID-19 consultations guide, May 2020
[26] Guttmacher Institute, April 2020, Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries.
[27] World Health Organization, COVID-19: operational guidance for maintaining essential health services during an outbreak, 2020, https://www.who.int/publications-detail/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak.

Parishioners wash their hands as a preventive measure against the spread of COVID-19 in Lilongwe, Malawi, in April 2020. Photo courtesy of BBC

would have major impact on unintended pregnancy and maternal and newborn mortality over a 12-month period. The institute further states that, during the COVID-19 pandemic, a modest decline of 10% in coverage of pregnancy-related and newborn healthcare will have disastrous implications for the lives of women and their newborns.[28] Other ways the pandemic has adversely affected SRHR include:

- Affected the supply chain of contraceptive products, resulting in reduced availability.
- Diverted equipment and staff dedicated to SRHR to fulfil COVID-19 care needs.
- Stigmatisation of the pandemic has made people reluctant to visit hospitals. For example, in South Africa 11 000 people living with HIV and AIDS did not collect their monthly medication in health facilities in May.[29]
- Classification of some lifesaving SRH services as non-essential, such as abortion care.[30]
- Worsened levels of gender-based violence (GBV).[31]
- Limited access to skilled care for childbirth, including care for obstetric and neonatal complications.[32]
- Increased maternal and neonatal mortality, largely due to poor access to skilled healthcare workers for childbirth and the difficulties faced in referring for obstetric and neonatal complications.
- Increased the risk of morbidity and mortality for women and their newborns due to loss of support and reduction of access to health facilities. Trauma, malnutrition, disease, and exposure to violence compound this.
- Closure of some family planning services, thereby increasing the risk of unwanted pregnancies.
- Increases in sexual violence and domestic abuse.

In any emergency, including COVID-19, one in five women of childbearing age is likely to be pregnant

In June, WHO technical experts arrived in **Comoros** to assist with the country's COVID-19 response. The expert team of epidemiologists, laboratory experts, pulmonologists, and others will support Comorian technicians in their efforts to fight the virus. At the time of writing, the island had 311 confirmed cases, seven deaths, and 266 recoveries.[33] Practitioners in the country's struggling and under-resourced health system welcomed

[28] Guttmacher Institute, Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low- and Middle-Income Countries, accessed on 5 July 2020 from https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health#fn1
[29] TimesLive, Almost 11,000 HIV-positive patients in Gauteng have skipped ARV collection during lockdown, 19 May 2020
[30] UNFPA, "Women are the Fabric: Reproductive Health for Com-munities in Crisis". UNFPA, http://www.unfpa.org/public/publications/pid/1348
[31] Wenham C et al., COVID-19: the gendered impacts of the outbreak, Lancet, 2020, 395(10227):846-848, http://dx.doi.org/10.1016/S0140-6736(20)30526-2.
[32] World Health Organisation (2020); Packages of interventions for family planning, safe abortion care, maternal, newborn and child health
[33] Government of Comoros, accessed from on 2 July 2020 https://stopcoronavirus.km/

the additional support. Women struggled to access pre- and postnatal care in Comoros even before the advent of COVID-19.

In the **DRC**, UN Women worked with local organisations to distribute COVID-19 resilience kits to women. Each kit contains ten kilos of food and essential hygiene products, such as sanitary pads, water purification tablets, and bleach. Kits also include soap, alcohol-based sanitary gel, and tissues, which enable women to protect themselves when caring for sick family members. Lessons from the Ebola outbreak point to the harmful impacts during a health epidemic in the absence of focused responses from governments to protect SRHR gains (such as contraceptive use and availability). Union Congolaise des Femmes de Médias (UCOFEM), an Alliance partner in DRC, has been collaborating with community radio stations and women's rights organisations to integrate SRHR into their COVID-19 response since the DRC declared the virus a pandemic on 10 March 2020.[34]

Women distribute COVID-19 resilience kits in Kinshasa in April 2020.
Photo courtesy of UN Women

In **Madagascar**, huge gaps exist in delivery of, and access to, water and sanitation in both rural and urban councils. Water shortages have a massive impact on menstrual health in the country. COVID-19 has increased household need for water. One pack of ten sanitary pads costs almost a dollar, which is the equivalent of one day's pay in rural areas. Therefore, women cannot prioritise menstruation hygiene during the pandemic over other daily necessities like food.[35]

SRHR policy and legislative framework

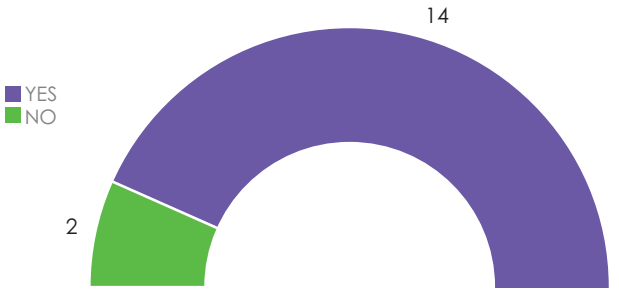
Article 6.1 (a) of the SADC SRHR Strategy obliges member states to establish a multisectoral coordinating entity that includes civil society, networks of youth, adolescents and key populations, and development partners, to domesticate, implement, monitor and evaluate their national SRHR strategies.

Stand-alone policies on SRHR underscore political commitment to realise the rights of women and girls as well as to domesticate regional, continental, and global SRHR instruments. However, the COVID-19 pandemic presented a new challenge in the region: how to integrate SRHR into state of emergency responses. SADC countries that have made strides in SRHR will find it easier to do this as part of their COVID-19 response. Strong SRHR policies and guidelines with disaster response will be a necessity as the SADC region continues to adapt to the pandemic.

[34] Anna Mayimona Ngemba, June 2020, Report on the impact of COVID-19 on SRHR
[35] Via Yolande, June 2020, Madagascar report on the impact of COVID on menstrual health.

Status of SRHR policies and laws in SADC

Figure 2.1: Countries with standalone SRHR policies or guidelines



Source: Audit of SRHR policies and laws Gender Links, 2020.

Figure 2.1 shows that 14 out of 16 SADC countries have stand-alone policies or guidelines on SRHR. Of these, 11 have SRHR policies while Botswana, Comoros, and Tanzania have SRHR guidelines. Angola and the DRC do not have stand-alone policies or guidelines.

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Older than five years		
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
Adopted in the past five years		
Eswatini	National Policy on Sexual and Reproductive Health	2013
South Africa	Sexual and Reproductive Health and Rights: Fulfilling our Commitments and "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
Comoros	Adolescent and Youth Health Strategy	2018
No SRHR policy or guidelines		
Angola	Included in the Constitution	1975
DRC	Included in the Constitution	2011

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2020.

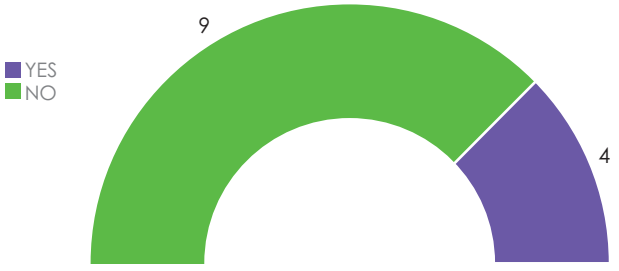
Table 2.2 shows that eight SADC countries have SRHR policies that go back five years or more. Namibia's SRHR policy is 18 years old. These policies need urgent review and revision. Eswatini, Madagascar, and South Africa have newer policies. The new Madagascar SRHR Policy, adopted in 2017, represents a welcome deve-

Comoros finalised an adolescent and youth health strategy in 2018

lopment, 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. The UNFPA notes that Comoros finalised an adolescent and youth health strategy in 2018.[36] Angola and DRC do not have SRHR policies and both countries urgently need them given their unique post-conflict SRHR challenges.

Figure 2.2: Number of countries reviewing SRHR policies



Source: Audit of SRHR policies and laws Gender Links, 2020.

Figure 2.2 shows that, out of the 13 countries that have stand-alone SRHR policies or guidelines (excluding Comoros), five (South Africa, Botswana, Namibia, Zambia and Seychelles) have these under review. Tanzania has the newest policy: the Adolescent and Health Development Strategy 2018-2022.

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 2019-2030. SRHR policies should also consider issues of access under restricted movement orders, such as those implemented during the COVID-19 pandemic.

"In many countries, there's already stigma associated with sexual and reproductive health services," says Abebe Shibru, country director for Marie Stopes International in Zimbabwe. "For this reason, women often seek out these services in secret. Lockdowns have made it harder for women in Zimbabwe to discreetly access sexual and reproductive care... because now family members may want to know where they're going. Women may also face harassment from police officers enforcing stay-at-home orders."[37]

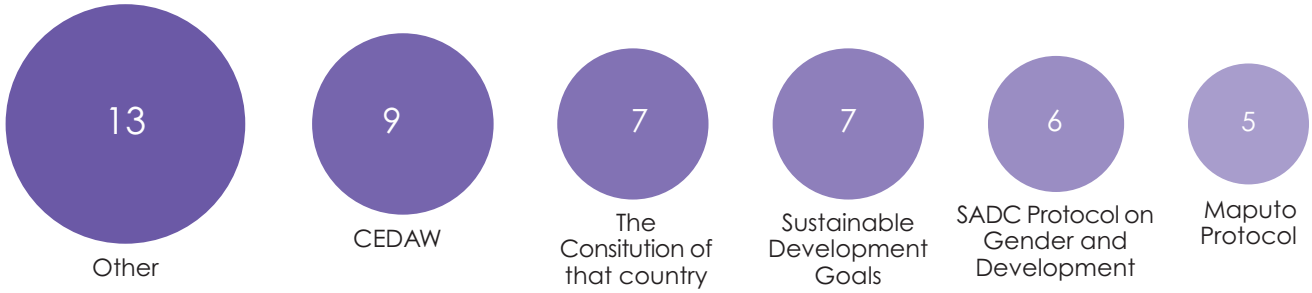
Abebe Shibru, country director for Marie Stopes International in Zimbabwe, says lockdowns made it harder to access SRHR services.
Photo courtesy of Marie Stopes International

Linking SRHR policies with regional and global instruments

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

[36] https://www.unfpa.org/data/transparency-portal/unfpa-comoros
[37] Accessed from https://www.npr.org/sections/goatsandsoda/2020/06/08/864970278/lockdown-limits-access-to-legal-abortion-in-colombia-telemedicine-is-now-an-option 25 May 2020

Figure 2.3: Global and regional instruments referenced in SRHR policies



Source: Audit of SRHR policies and laws, Gender Links, 2020.

Figure 2.3 shows that 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 countries refer to the SDGs and national constitutions. Thirteen countries cite other sources. These include the Millennium Development Goals (MDGs); Cairo 1994 ICPD; the SADC minimum package for SRHR services; the global Family Planning 2020 framework; and the Beijing Platform for Action.

Menstrual health

Menstruating women face exclusion from public and family life for a combination of reasons. These include lack of access to affordable sanitary products and sanitation facilities, cultural and religious myths and misinformation around menstruation, and absence of menstrual hygiene education that would support safer practices and reduce stigma. One in ten girls in Africa miss school for up to four days during their period, according to the United Nations Children's Fund (UNICEF) and the WHO. This affects performance in school and many girls drop out of school due to lack of sanitary pads. Although girls and women sometimes find resourceful ways to improvise sanitary pads, some of the materials they use offer limited absorbency, making it challenging to participate in school activities. Menstrual health relates to human dignity and it is a fundamental right for every girl and woman to live a healthy life during menstruation. Southern Africa's economic and patriarchal structures sometimes exclude or shame women because of menstruation. UNICEF has predicted that 1.8 billion girls, women, and gender non-binary persons menstruate, yet millions of them across the world cannot manage their monthly cycle in a dignified, healthy way.[38] COVID-19 posed many challenges for menstruating women and girls, highlighting the urgent need for safe bathing facilities and safe and effective means of managing menstruation.[39] The poorest countries and those most vulnerable to economic and social shocks have also been the most affected by the pandemic.[40]

Provision of free sanitary pads to all rural schoolgirls would demonstrate that governments understand the necessity for sanitary wear as a right for all women and girls. Improving access to sanitary wear for rural schoolgirls ensures that they will not miss lessons and sporting activities during menstruation. Long-term, it will improve educational performance. Schoolgirls will also stop using leaves, cloth, and other unsafe methods of menstruation management, which will advance their overall health.

[38] UNICEF, May 2020, Country Data on Menstrual Hygiene
[39] UNICEF Brief April 2020, Mitigating the impacts of COVID-19 and menstrual health and hygiene
[40] Ibid

Zimbabwe: Advocacy pays off for menstrual health

Girls from Hwange receive sanitary pads in February 2020.
Photo: Tapiwa Zvaraya

In a major political shift celebrated by gender activists in the country, Zimbabwe parliamentarians dedicated US$12.5 million in the country's 2020 budget to provide free sanitary pads for rural schoolgirls.

The commitment comes after persistent lobbying by opposition politicians, civil society, the media, and religious organisations to amplify the voices of women and girls on the issue.

Research in Zimbabwe shows that menstrual health issues remain deeply embedded in a culture of silence that includes lack of men's involvement; limited availability of information, and inadequate access to menstrual hygiene products.[41]

For two decades, the country has imported most sanitary ware from neighbouring countries as local production stopped during the economic collapse in the 2000s. Women in rural communities bore the brunt of the country's challenges related to this issue.

Perennial droughts in agriculturally dependent rural communities meant families often had to choose food above other necessities. The prohibitive cost of sanitary wear and the dearth of it in rural areas also exacerbated the problem, forcing many rural schoolgirls to miss school during menstruation and use cow dung, clothes, and other unhealthy items as a substitute for pads and tampons.

Since 2014, when opposition Movement for Democratic Change (MDC) MP Priscilla Misihairabwi-Mushonga moved a motion to remove import duties on sanitary wear, civil society organisations, media, and religious organisations have joined the chorus to lobby the government. To date, lack of political will represented the biggest stumbling block to change. Four years after the initial call, the government responded by removing duty on sanitary wear, but the move did not change the plight of many women and girls, especially those in rural areas.

Non-governmental organisations reacted by distributing free sanitary pads in rural areas and introducing projects to produce reusable sanitary pads in rural schools. Over the years, Misihairabwi-Mushonga consistently raised the issue in Parliament up until the recent announcement of dedicated funds.

Citizens and local governments can take some credit for the decision thanks to their advocacy, including 13 local authorities that developed SRH plans and six local authorities (Chinhoyi Municipality; Epworth Local Board; Rusape Town Council; Guruve Rural District Council; Murewa Rural District Council, and Umguza Rural District Council) that conducted SRH campaigns on menstrual health and child marriage, led by junior councils.

Councils like Masvingo City Council and Mvurwi Town have also offered SRHR services during the COVID-19 pandemic, and Zibagwe Rural District Council's junior council raised funds to buy sanitary pads for underprivileged

[41] Menstrual hygiene - A salient hazard in rural schools: A case of Masvingo district of Zimbabwe

In October 2019, the NGO Katswe Sistahood initiated the Happy Flow campaign in Harare. Photo courtesy of Katswe Sistahood

adolescent girls in their community during the lockdown.

Gender activists continue to call on the government to reduce the cost of sanitary pads, including by submitting what they dubbed a "Heavy Flow" petition, signed by more than two million Zimbabweans, to the health and child welfare minister.

Source: Thabani Mpofu, Media Lecturer at National University of Science and Technology - submitted to Gender Links as part of the Political Discourse Analysis

Table 2.3: Menstrual products in SADC

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

Source: Audit of SRHR Laws and Policies in SADC, Gender Links, 2020.

Table 2.3 shows that six SADC countries have now removed VAT on menstrual products. Tanzania had removed VAT on menstrual products in its 2018/19 budget but reversed this decision in the 2019/20 fiscal year. Removal of VAT is an important first step towards providing affordable menstrual products.

In 2017, **Botswana** became the first SADC country to provide free sanitary products to all schoolgirls after its parliament adopted a motion in a move that deputy basic education minister, Moisiraela Goya, said would give "dignity to the girl child."[42] The new law attempts to address the problem of access and information for young girls in remote schools, as well as prevent them from dropping out of school. Ashley Moyo, the gender focal point for Tsabong Sub District Council, presented on the issue at the SADC Protocol Summit in June 2019, noting that her council worked with the Tsabong Primary Health Hospital to advocate on the issue and provide pads to schools in her district.

An advert for a menstrual care bank distributed by Shamwari Yemwanasikana, an SRH agency in Zimbabwe. Photo courtesy of Women's Coalition of Zimbabwe

[42] https://www.africanews.com/2017/08/02/botswana-to-offer-free-sanitary-pads-to-girls-as-part-of-school-supplies//

Covid-19 and menstrual hygiene management

The coronavirus pandemic has reduced supplies of sanitary products in many countries, worsening an access issue that activists bemoaned long before the first case of COVID-19 hit the region. Globally, about 500 million girls did not have access to what they need to manage their menstruation before this crisis.[43] Emerging evidence suggests that the pandemic, which has increased unemploy-ment and poverty, will also exacerbate challenges linked to menstrual health. The 2020 theme for Menstrual Hygiene Day, "Periods in Pandemic," recognised this impact and encouraged women and men around the world to rally around this cause. The campaign noted that the pandemic led to suspension of many subsidised supply schemes, for example free distribution of menstrual products in schools. The economic impact of COVID-19 will also force many women and girls to prioritise other basic needs over safe menstrual products. Disrupted supply chains drive prices up, making menstrual products even more unaffordable than before.[44]

Malawi: Schoolgirls demand free pads

Schoolgirls in Malawi have a message for their leaders: periods do not stop for pandemics.

Joana Banda (a pseudonym) who attends a secondary school in Blantyre, Malawi's commercial capital, joined other students to call on leaders to provide free sanitary products in schools as the country marked Menstrual Hygiene Day during the COVID-19 pandemic on 28 May 2020.

"I know a number of girls in my school who cannot afford sanitary pads because they are expensive," said Banda, noting that the pandemic made the situation worse. "They use pieces of cloth as a substitute to sanitary pads. I suggest that schools should start distributing sanitary pads free of charge. It is possible."

Banda said monthly periods lead to anxiety for the girls in her school: "When you do not have sanitary pads you end up absenting yourself from classes. It is common for girls not to attend classes during monthly periods."

Gender activists hope that sharing stories like Banda's will push leaders to prioritise menstrual hygiene management in national and local policies. Authorities must also help to address taboos surrounding menstruation and raise awareness about the importance of good menstrual hygiene management in schools, hospitals, and elsewhere.

The indifference of authorities to this issue stands in sharp contrast to their commitments under the SDGs to ensure good health and wellbeing for all.

Source: Gender Links News Services accessed from https://genderlinks.org.za/news/periods-do-not-stop-for-pandemics-mhd2020/ on 10 June 2020

[43] https://menstrualhygieneday.org/
[44] https://menstrualhygieneday.org/wp-content/uploads/2020/05/mhday2020-covid19-and-periods-logo.pdf

During the early days of the COVID-19 pandemic, media reports regularly noted the lack of personal protective equipment (PPE) for health workers, which increased risks in their work during COVID-19. However, female health workers and patients also lacked menstrual products during this time. Lack of access to water, health, and sanitation (WASH) services at healthcare facilities prevents women from managing basic hygiene while at work. Some SADC countries still have hospitals with no running water, especially those in rural areas. Girls and women hospitalised or in quarantine centres for COVID-19 went without WASH services and menstrual health supplies in many cases.

Women in the DRC participate in a UCOFEM campaign for SRHR in Kinshasa during the 16 Days of Activism campaign in 2019.
Photo: Anna Mayimona Ngemba

Quarantine facilities must provide these to give dignity to their female patients. There is a need to train quarantine centre workers to assist girls and women with personal hygiene if needed. Governments must also consider creating separate WASH facilities in hospitals for girls and women with COVID-19, and for those without.

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.

Access to WASH services represents a crucial aspect of achieving SRHR. Reliable WASH facilities in both private and public areas help save lives, especially during a pandemic, natural disaster, or drought. Before the pandemic hit, many SADC countries faced drought in 2019/20, resulting in huge water shortages for both rural and urban areas. Some cities resorted to water rationing measures to conserve scant water resources. However, these measures affect women and girls' SRHR as they rely on water for menstrual health, maternal hygiene, and other SRHR needs.

Table 2.4: Access to basic drinking water in SADC

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

Source: Progress on Drinking Water, Sanitation and Hygiene: 2019 Update and SDG baseline, WHO/UNICEF, 2019.

As shown in Table 2.4, four SADC countries - Angola, DRC, Mozambique, and Tanzania - have 50% coverage or less for basic drinking water. Meanwhile, Eswatini, Madagascar, Malawi, Zambia, and Zimbabwe have between 50-68% coverage across urban and rural. Only Mauritius, Seychelles and South Africa provide basic drinking water coverage to more than 80% of citizens.

Citizens in rural areas remain at a disadvantage in most countries, with access to water provision as low as 21% in rural areas in the DRC, followed by 23% in Angola. Madagascar, Mozambique, Tanzania, and Zambia have between 32% and 44% coverage for basic drinking water in rural areas. South Africa, a well-resourced country, has failed to deliver the basic need for clean water to many of its citizens in rural areas, even as it does so for the vast majority of urban dwellers.

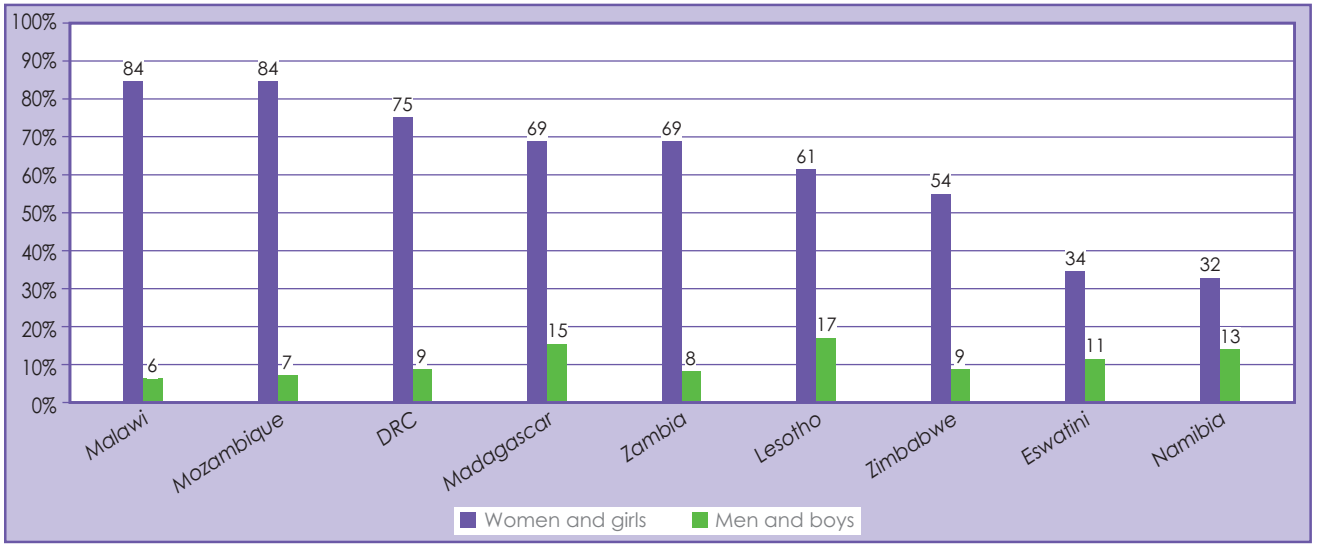
Students use a new tippy tap wash station to prevent the spread of COVID-19 in Botswana in May 2020. Photo courtesy of JG Afrika

Leaders across SADC prioritised water provision as part of their COVID-19 response, with many scrambling to send water tankers to drought-stricken areas, as well as build new boreholes and repair existing infrastructure. When the pandemic hit, several parts of the region had not yet recovered from droughts that had left many without access to water. Lack of proper water infrastructure has long been a challenge in most SADC countries, even in good times. A May 2020 report by the Partnership for Evidence-based Response to COVID-19 (PERC), a consortium of global public health organisations, found that almost 70% of Africans would struggle to access food and water if governments enforced lockdowns for two weeks.[45]

As governments advised citizens to wash their hands frequently to prevent the spread of COVID-19, many took to social media to remind their leaders that they had no water with which to do so. "We're calling for the government to do more because at the moment there are few boreholes," Khulekani Ncube, head of Gongu village in Zimbabwe, told the Thomson Reuters Foundation.[46]

[45] https://reliefweb.int/updates?advanced-search=%28S50291%29
[46] https://www.reuters.com/article/us-health-coronavirus-safrica-water-feat/in-parched-southern-africa-coronavirus-spurs-action-on-water-supply-idUSKBN22I0DY

Figure 2.4: Gender division of labour for water collection in nine SADC countries



Source: Safely managed drinking water, UNICEF, 2017.

Figure 2.4 shows 2017 data from a report by UNICEF on safely managed drinking water, disaggregated by sex. It measured access to water in countries in which at least one in ten households access water off premises. In Mozambique and Malawi, it found that 84% of women and girls collect water for the household as opposed to 6% of men and boys in Malawi and 7% in Mozambique. The numbers do not improve much for women and girls in all the other countries, with men in Lesotho collecting more water than their male SADC counterparts at 17%.

This situation affects women and girls' time, safety, health, and general wellbeing, and these findings provide yet another urgent impetus for accelerated safe water provision across the region. A clear link exists between water, sanitation, and gender equality. Limited access to water compromises the provision of sanitation. The lack of sanitation in communities, and particularly schools, impacts quality of education, girls' attendance, hygiene, and health.

Table 2.5: Status of access to basic sanitation in SADC

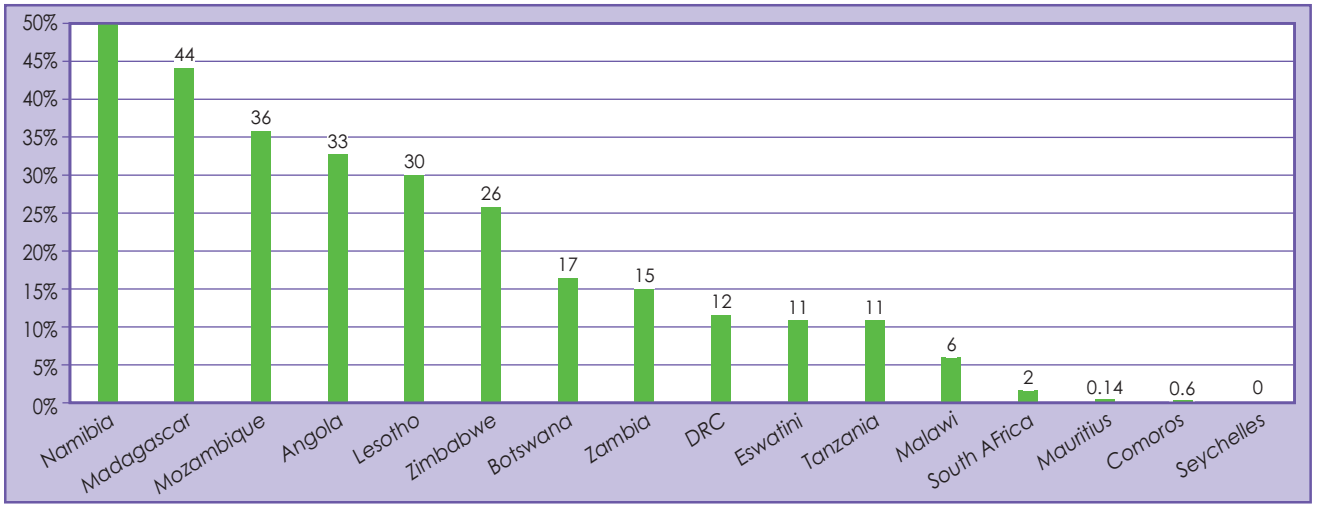
Country	National access to basic sanitation (%)	Urban access to basic sanitation (%)	Rural access to basic sanitation (%)
Seychelles	100	-	-
Mauritius	93	94	93
South Africa	73	76	69
Botswana	60	75	39
Eswatini	58	58	58
Lesotho	44	46	43
Malawi	44	49	43
Angola	39	62	21
Zimbabwe	39	54	31
Namibia	34	55	15
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 2.5 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.

Governments may balk at the cost of sanitation provision but a crisis such as the COVID-19 pandemic provides a good reminder of why sanitation is so important. Poor hygiene and lack of sanitation facilities both contributed to the rapid spread of the virus in the region.

Figure 2.5: Percentage population practicing open defecation



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

Figure 2.5 shows that, at 50%, Namibia has the highest proportion of people practicing open defecation in the region, followed by Madagascar at 44%. Open defecation increases the risk of communicable diseases such as cholera and typhoid. 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 facilities. COVID-19 worsened the situation, as lockdown measures forced many SADC citizens to defecate outdoors.

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.

Ensuring access for all people to their preferred contraceptive methods advances several human rights, including the right to life and liberty, freedom of opinion and expression, and the right to work and education, as well as bringing significant health and other benefits.

A health provider trains women on maternal health at a workshop in Eswatini in November 2019. Photo: Thandokuhle Dlamini

Use of contraception prevents pregnancy-related health risks for women, especially for adolescent girls. When women separate births by fewer than two years, the infant mortality rate is 45% higher than when they separate births by two to three years, and 60% higher than births four or more years apart.[47]

The WHO estimates that, among the 1.9 billion women of reproductive age (15-49 years) world-wide in 2019, 1.1 billion need family planning. Of these, 842 million use contraceptive methods, while 270 million have an unmet need for contraception.[48]

The COVID-19 pandemic disrupted provision of basic contraceptive methods and reduced the availability of emergency contraception. Activists worried that this would lead to increased risk of unplanned pregnancy and increased unsafe abortions. Lockdown measures during COVID-19 also reduced access to contraception for women who rely on public transportation to fetch their monthly allocations.

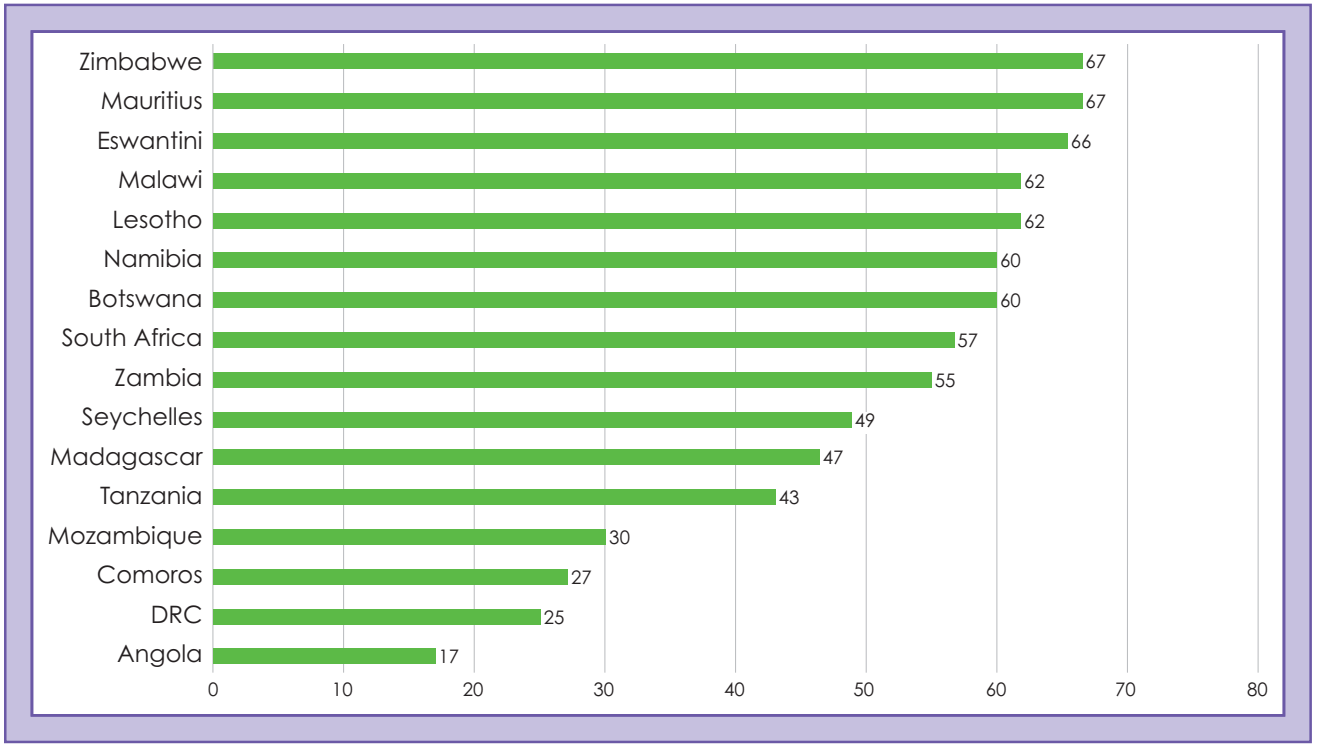
The WHO estimates that, among the 1.9 billion women of reproductive age (15-49 years) world-wide in 2019, 1.1 billion need family planning

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.[49]

[47] WHO, June 2020, Family Planning and Contraception Facts.
[48] World Health Organisation, June 2020, Key Facts - Family Planning and Contraception Methods
[49] https://www.africanhealthstats.org/cms/?pagename=indicator&indicator=RMNCH3

Figure 2.6: Contraceptive prevalence in SADC



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

Figure 2.6 shows wide disparities in contraceptive prevalence rates across the SADC region. The CPR is highest in Zimbabwe and Mauritius (67%) and lowest in Angola (17%).

Zambia: Exceeding family planning targets

Despite a challenging year marred by droughts, flooding, food insecurity, and COVID-19, Zambians have at least one reason to celebrate.

The country plans to increase access to modern contraceptives by another 17% in 2020, providing them to 82 000 more citizens than in 2019 and ensuring it meets a family planning target its leaders set eight years ago.

The country's Family Planning Scale-Up Plan 2013-2020, launched in 2012, ends later this year. It aimed to increase the contraceptive prevalence rate (among married women) for modern methods from 33% to 58% by 2020 in line with the government's regional and international commitments.

One in every two Zambian women aged 15 to 49 currently use a modern contraceptive, which demonstrates the impact of deliberate government intervention. In 2017 alone, this enabled the country to prevent an estimated 600 maternal deaths; 10 000 unintended pregnancies and 6000 unsafe abortions.

Members of Zambia's Alliance SRHR cluster discuss SRHR campaigns in May 2020 in Lusaka. Photo: Bessa Mwale

The move to continue investing in contraception access represents just the latest positive step the Zambian government has taken to improve family planning services over the past decade.

These include the introduction of innovations and capacity development for healthcare providers and encouraging family planning among poor and marginalised groups in the country.

The 2018 Zambia Demographic Health Survey also found that most women now give birth in a health facility (84%), although rural women still report issues accessing health care. The most common challenge involves long distances between facilities, which may also contribute to the country's high maternal mortality rate (213 per 100 000 live births).

Zambian lawmakers recently created several policies, guidelines, and laws to guide SRH with an aim to continue to increase access to contraceptives and family planning. These include Adopting Contraception in Zambia: the 2013-20 plan; Zambia Family Planning Guidelines and Protocols; and Zambia Family Planning Services Health Policy Project.

Research suggests that a choice among several contraceptive methods, rather than between two methods, is more likely to result in the use of contraception.

Source: Gender Links Political Discourse Analysis, June 2020, Zambia set to increase access to contraceptive and family planning Services.

Lockdown measures during COVID-19 have activists worried about an increase in pregnancies, highlighting the critical need for easier access to contraceptives. Limited transportation facilities and services in health institutions could also worsen the unmet demand for contraception. Some countries have initiated mobile facilities for the distribution of contraceptives while others have explored the use of other technologies for ordering and distribution. The economic challenges posed by the pandemic will also reduce access, as many people will struggle to pay for contraceptives.

There is a need to prioritise contraception access as an essential service during the COVID-19 pandemic. Governments should invest in innovation and technology that allows provision of contraception while limiting exposure to the virus.

Some countries have initiated mobile facilities for the distribution of contraceptives

DRC and Malawi: Family planning doorstep dialogue

Local organisations in the DRC and Malawi have been piloting new ways to reach people through family planning that goes back to the basics and door-to-door.

Both countries have family planning challenges, with high birth rates, conservative attitudes towards contraception, and poverty rates that keep women close to home with no time to access most family planning outreach.

Through its work in the Nsona Kulu district of Mbanza Ngungu in the DRC, Action for Integral Health of Women and Girls (ASIFF) decided to meet women where they live and work. In the process, they have changed the lives of at least 12 families, helping keep mothers healthier because they now wait longer between pregnancies.

Many women in the area struggle with birth spacing, which affects their health, the health of their families, and their development.

ASIFF found that ignorance of contraceptive methods and poverty are at the root of the issue, so they began travelling door-to-door as part of their work to raise awareness about the importance of birth spacing, good nutrition, sexual health, and hygiene.

Their strategy has paid dividends, allowing relationships to develop between families and health workers over several years. Local community radio stations also help get the message out to families in the region, buttressing the important family planning messages delivered in person.

In Malawi, the team at Art and Global Health Centre Africa (ArtGlo) also uses community dialogues to improve family planning for girls at Ntiya Village in Zomba.

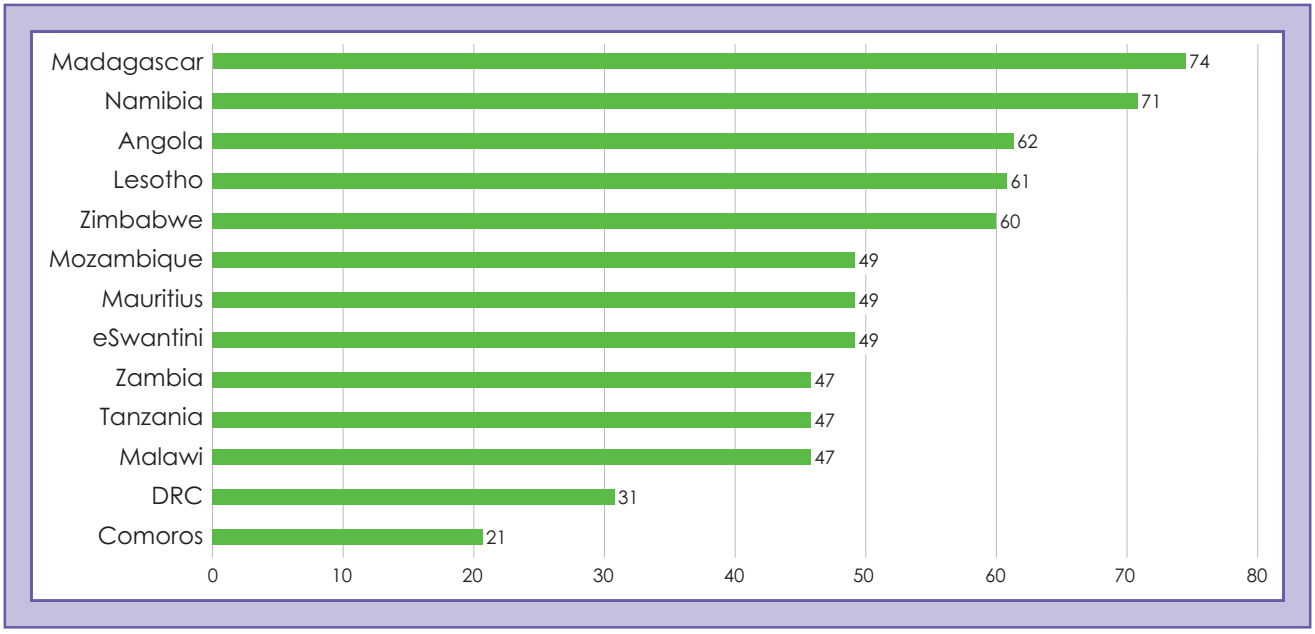
Betty Nzayambela, DRC coordinator at Action for Integral Health of Women and Girls, on a monitoring visit in the Nsana Kulu district in January 2019.
Photo courtesy of UCOFEM

Through its community-based programme, girls express their views and thoughts about family planning in front of their chiefs and religious leaders, including some who limit their access to sex education. This unique strategy breaks down barriers and allows community leaders, especially religious leaders, to remain involved in family planning instead of excluding them, which could result in girls' continued lack of access to family planning.

So far, both projects have seen some successes, opening dialogue, sharing important health knowledge in traditional ways, and helping cultural and religious leaders realise their vital role in normalising family planning.

By Betty Nzayambela, DRC Coordinator at Action for Integral Health of Women and Girls, ASIFF, and Sylverster Chiweza, intern with the Girl Rising IN Potential (GRIP) Malawi as part of the SADC Protocol Gender Links Summit June 2019 for SADC Protocol@Work

Figure 2.7: Women in contraceptive decision-making (15-49)



Source: https://www.unfpa.org/data/world-population-dashboard. Accessed 15 May 2020.

Figure 2.7 shows that Madagascar has a high proportion of women involved in decision-making about contraceptive use at 74%, even though the country also has a high unmet need for contraception and low rates of contraception use (47%). In eight SADC countries (Comoros, DRC, Eswatini, Malawi Mauritius, Mozambique, Tanzania, and Zambia) more than half of women between ages 15 and 49 do not have a say in decision-making about contraceptive use. Comoros, at 21%, 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

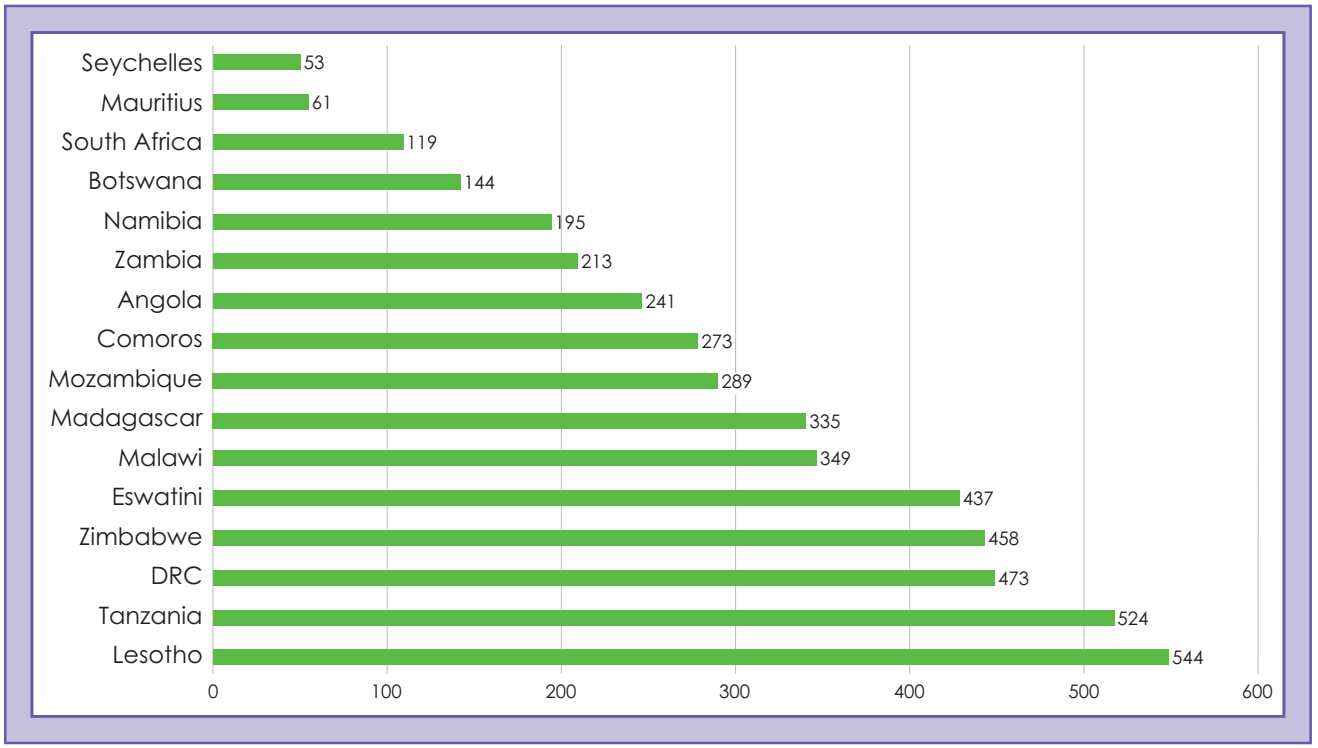
The WHO defines maternal health as the health of women during pregnancy, childbirth, and the postpartum period.[50] The Maternal Mortality Ratio (MMR) represents the number of women of childbearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy and 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.[51] Most often, women die because of lack of access to proper reproductive health care.

COVID-19 poses challenges to maternal and child health. Poor access to skilled care for childbirth, including care for obstetric and neonatal complications, sits high on the list of SRH health risks during the pandemic. Indeed, such skilled care remains hard to find across much of the region in normal times.

Most maternal and neonatal deaths occur around the time of labour, childbirth, and in the immediate postnatal period.[52] Maternal and neonatal mortality is higher in developing countries than in developed countries, largely due to poor access to skilled health care workers for childbirth and the difficulties faced in referring for obstetric and neonatal complications. COVID-19 exacerbates these conditions, as countries have shifted most skilled healthcare workers to responding to the pandemic.

The pandemic may also create a loss of support and reduction of access, compounded in many cases by trauma, malnutrition, disease, and exposure to violence. All pregnant women, including those with suspected or confirmed COVID-19, should continue to attend antenatal care visits and deliver with a skilled health provider to ensure healthy outcomes for both themselves and their newborns.

Figure 2.8: Maternal Mortality Ratio per 100 000 in SADC



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

[50] https://www.who.int/maternal-health/en/
[51] UNICEF MMR definition
[52] WHO (2019). Packages of interventions for family planning, safe abortion care, maternal, newborn and child health www.who.int/making_pregnancy_safer/documents/fch_10_06/en/index.htm

Figure 2.8 shows that MMR varies considerably by country: from a low in Seychelles at 53 and highest in Lesotho at 544 per 100 000 live births. Poor investment in health facilities, especially in rural areas, keeps MMR high in other countries, which has also given rise to expensive private maternal health care. Fourteen countries in SADC remain below the MMR target of 70, with five countries (DRC, Eswatini, Lesotho, Tanzania, and Zimbabwe) much higher. Achieving universal health coverage includes reducing maternal mortality in each country. Political commitment remains critical to ensure thriving maternal health care systems in the region.

South Africa continues to work on its National Health Insurance (NHI), a health financing system designed to pool funds to provide access to quality affordable personal health services for South Africans based on their health needs, irrespective of their socio-economic status.[53] The NHI, which South Africa has been phasing in since 2012, seeks to realise universal health coverage for all citizens. It means every South African will have a right to access free comprehensive healthcare services at the point of use at accredited health facilities such as clinics, hospitals, and private health practitioners. It represents a big change in the country, which currently has an over-burdened health system and poor infrastructure that is known for its overworked health workers. The current system benefits those with private medical aid, but most others can hardly afford to buy medication or seek SRHR in health facilities.

MMRs in **Tanzania** have remained stubbornly high over the last decade, at around 400-500 per 100 000 live births.[54] Previous research indicates large variations across regions in the country. The health system currently fails to meet the needs of women in the country, which a doctor at the government regional hospital of Temeke municipality confirmed in a recent interview. The most recent Tanzania Demographic Health Survey (TDHS) 2015/16 and National Census 2012 provide an overview of MMRs at a regional level, highlighting the high rates across the country. Politicians regularly comment on the situation, noting they encourage maternal health campaigns with "multi-stakeholder approaches."

In **Zimbabwe**'s National Strategy document for 2016-2020, the Ministry of Health and Child Care acknowledged a decline in MMR from 960 to 614 out of 100 000 live births from 2011 to 2015. It also found child mortality to be at 29 per 1000 for neonatal mortality and 75 out of 1000 live births for under-fives. The WHO, on the other hand, put Zimbabwe's MMR at 443 in 2015. All 92 local authorities offer maternal health services. These include antenatal and postnatal care, family planning, and contraception services. All 92 local authorities have also developed gender action plans, which include actions on reducing maternal morbidity. Thirteen local authorities have developed specific maternal health campaigns to raise awareness on maternal health, with messages like "Early booking for safe delivery," "Zvarira kuchipatara," and "Book early, save lives." Activists continues to advocate for a review of the Termination of Pregnancy Act, as well as the enactment of several laws to improve maternal health, including the National Maternal and Neonatal Roadmap.

Council clinics in Zimbabwe all provide maternal health services. These include access to contraception and provision of shelters for pregnant girls and mothers. Local authorities like Kadoma City Council also provide comprehensive sex education to adolescents, while Chegutu Municipality provides antenatal and postnatal care to increase community involvement in maternal health care. In rural areas, where most pregnant women must walk long distances to clinics, several local authorities have shelters for expectant mothers so pregnant women can have a place to stay prior to, and after, giving birth.

The COVID-19 lockdowns, with their stringent measures and accompanying statutory instruments aimed at stemming the spread of the

[53] Government of South Africa, Department of Health accessed on 1 July 2020 from https://www.gov.za/about-government/government-programmes/national-health-insurance-0
[54] Gender Links Political Discourse Analysis, June 2020, Maternal Health Services and Information still a major Problem to the Society

virus, has affected the right to movement and the right to health. Reports from the first week of the lockdowns noted that many clinics stopped antenatal and postnatal services and turned pregnant and new mothers away. Others discharged women too early following delivery, well before the recommended three days. Health experts worry this could lead to missed post-delivery complications and other health challenges.

Access to health services

Table 2.6: Provisions for antenatal and postnatal care, and skilled birth attendants

Country	Antenatal care (%)		Post-natal care (%)	Skilled birth attendants (%)
	At least one visit	At least four visits		
	2010 - 2015			
Angola	82	61	23	50
Botswana	94	73		99
Comoros	49	11	14	82
DRC	88	48	44	80
Eswatini	99	76	88	88
Lesotho	95	74	62	78
Madagascar	82	51		44
Malawi	98	51	42	90
Mauritius	-	-		100
Mozambique	87	52		54
Namibia	97	63	69	88
Seychelles	-	-		99
South Africa	94	76	84	97
Tanzania	98	62	34	64
Zambia	97	64	54	80
Zimbabwe	93	76	57	78

Source: Gender Links.

Table 2.6 shows that most pregnant women and girls (between 82% and 99%) in SADC now have at least one antenatal visit. However, a much lower proportion of women have at least four antenatal visits. Encouraging figures in Botswana, Eswatini, Lesotho, South Africa, and Zimbabwe show that three quarters of pregnant women and girls have at least four antenatal visits in these countries.

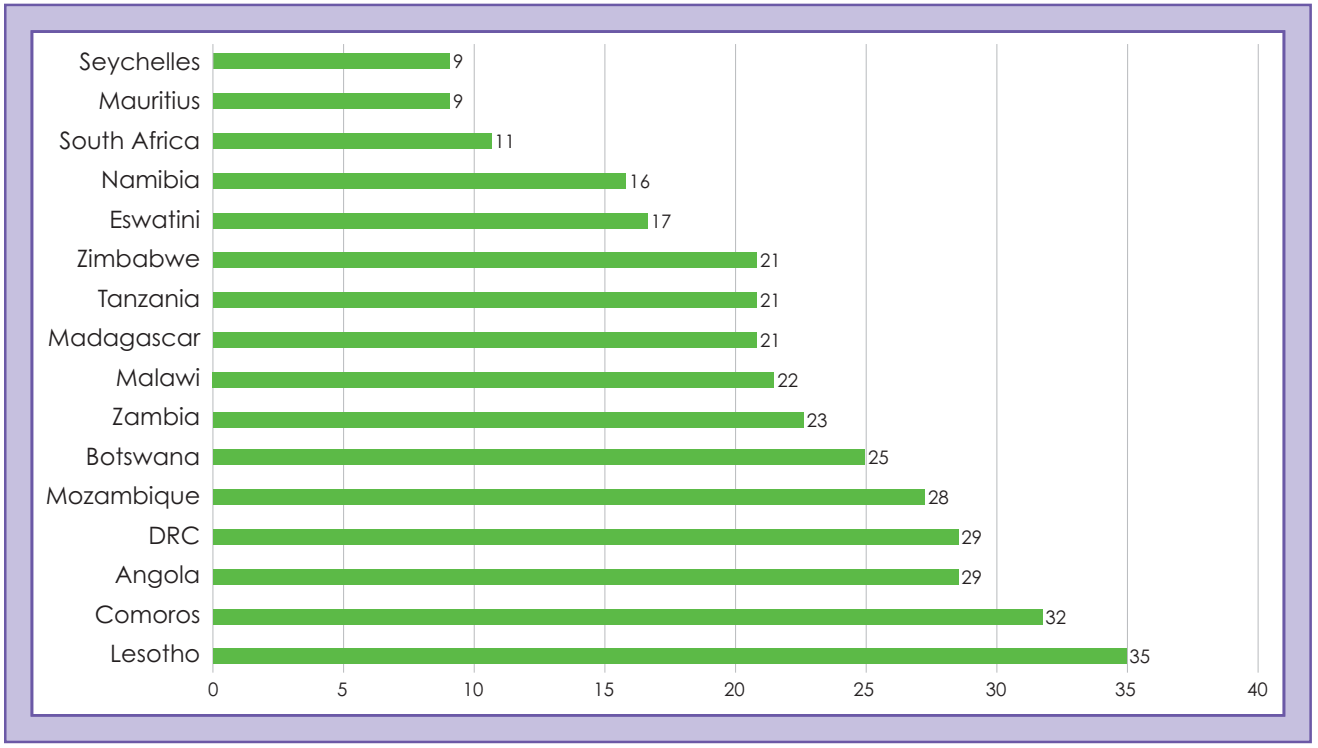
Exceptionally low proportions (between 44% and 54%) of women and girls receive care from skilled birth attendants during delivery in Angola, Madagascar, and Mozambique. Five SADC countries (Botswana, Malawi, Mauritius, Seychelles, and South Africa) now provide skilled birth attendants to more than 90% of pregnant women and girls.

Neonatal mortality

Neonatal mortality refers to the number of deaths during the first 28 days of life per 1000 live births in a given year or period. 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.[55]

[55] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf

Figure 2.9: Neonatal mortality per 1000 live births



Source: http://apps.who.int/gho/data/view.main.HWFNURv. Accessed 15 May 2020.

Figure 2.9 shows that Lesotho has the highest rate of neonatal deaths in the region at 35 out of 1000 live births. Many other countries fall between 21 and 32 neonatal deaths per 1000. Health experts attribute high neonatal mortality in SADC to low levels of antenatal and postnatal care for pregnant women and newborns.

A health worker inspects a storage facility for neonatal vaccines in Andoharanomaitso, Madagascar, in May 2020.
Photo: Zotonantenaina Razanadratefa

With health facilities overburdened during the COVID-19 pandemic, many clinics sent mothers home with babies earlier than usual to free up capacity for COVID-19 patients. Others neglected to provide vaccination and medical care for newborns, which should remain essential, even during a pandemic. It is always critical to keep dedicated facilities available to support neo- and postnatal care.

Universal health care

Universal health coverage (UHC) ensures that all people have access to effective and needed health services (including prevention, promotion, treatment, rehabilitation, and palliation), while also ensuring that the use of these services does not expose the user to financial hardship.[56] UHC includes the realisation of SRHR.

[56] World Health Organisation, accessed on 5 July 2020 from https://www.who.int/healthsystems/universal_health_coverage/en/

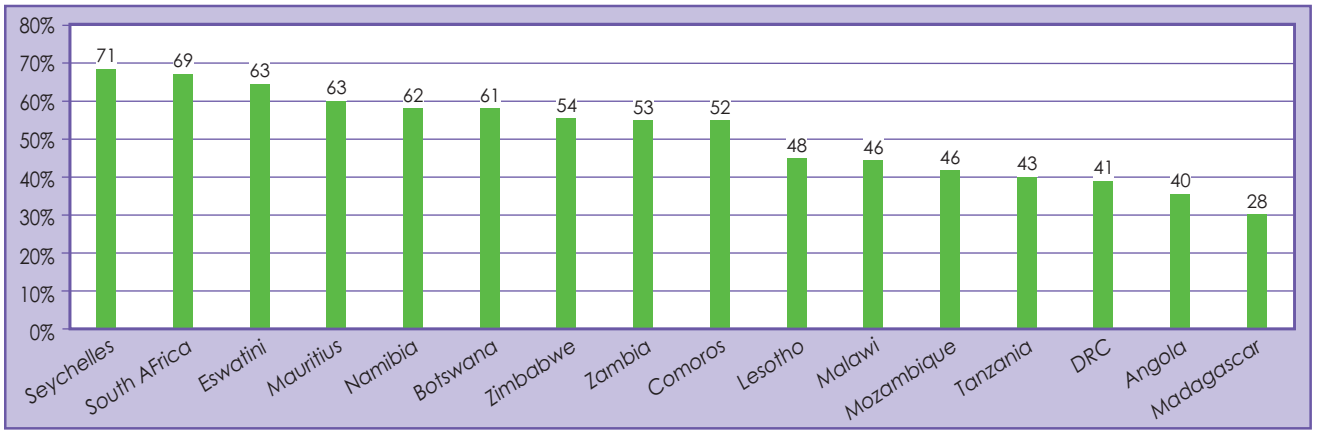
In September 2019, global leaders held a high-level meeting on UHC during the UN General Assembly. Section five of the political declaration from the meeting recognises that UHC is fundamental for achieving the SDGs, including those related to health and wellbeing, eradicating poverty in all its forms and dimensions, ensuring quality education, and achieving gender equality and women's empowerment.[57]

The UN Political declaration on UHC commits to ensuring, by 2030, universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health in national strategies and programmes. The declaration ensures universal access to SRHR as agreed in the Programme of Action of the ICPD and the Beijing Platform for Action.[58]

UHC also improves countries' ability to deliver effective and comprehensive responses to health events like COVID-19. Achieving SRHR and other health goals during a pandemic will require health systems to have the ability to ensure high rates of recovery to the virus, infrastructure for quarantine and treatment, and highly capable health workers.

Civil society should remain vigilant as watchdogs to remind SADC governments of commitments made on UHC. At times of crisis, governments often neglect the needs and rights of women and girls. So far, this pandemic suggests more COVID-19 deaths among men. Countries should report sex-disaggregated data on testing, confirmed infections, and deaths. There is need to be sensitive to gender throughout any government's response to COVID-19.[59]

Figure 2.10: Percentage of the population receiving essential health services



Source: http://apps.who.int/gho/data/view.main.INDEXOFESSENTIALSERVICECOVERAGEv. Accessed 15 May 2020.

Figure 2.10 shows that nine countries provide essential health services to at least 50% of their citizens. A majority of citizens in Angola, DRC, Lesotho, Madagascar, Malawi, Mozambique, and Tanzania do not receive essential health services. As the COVID-19 pandemic ravages the region, these findings should worry leaders in these countries and will hopefully lead to new action for a concerted push to meet the political commitments made to bring in UHC. UHC coverage must include SRHR services, including during the COVID-19 pandemic. Covering SRHR indicates progress towards achieving UHC commitments as well as the SDGs.

[57] United Nations Resolution 74/2, October 2019, Political declaration on Universal Health Coverage
[58] Ibid
[59] World Bank, April 2020, Universal Health Coverage in times of COVID-19 accessed on 6 July 2020 from https://blogs.worldbank.org/health/covid-19-coronavirus-universal-health-coverage-times-crisis

Zambia: Sounding the alarm on chronic SRH constraints

Zambian mothers have been speaking out about the dismal state of healthcare in the country as their leaders look to meet SDG targets linked to health and wellbeing.

Expectant mothers in Lusaka recently told Radio Lusaka, an adult contemporary station that hosts SRHR programming, that while government has improved some services, the country has a long way still to go.

One report found that some clinics do not have medical supplies, and another highlighted the issue of travel in a country where many women must walk long distances to reach a hospital or health centre.

The women interviewed said they want easier access to health services, something they know will prevent maternal deaths. They also noted the inhabitable state of many existing shelters for expectant mothers at hospitals and clinics.

The report comes during a time when Zambia's leaders look to pave the way for attainment of the SDGs by 2030, especially the goals linked to ensuring health and wellbeing for all and achieving universal health coverage.

Women from Luangwa District in Zambia attend a neonatal class in October 2019. Photo: Albert Ngosa

Many women in Zambia still die from preventable causes while giving birth. The WHO indicates that 99% of all maternal deaths worldwide occur in Africa.

Maternal health problems in Zambia range from negligence of health personnel to a lack of advancement in health technology. Poor road networks add to the problem, causing lengthy delays when transporting women to clinics.

Story by Christopher Chisi - A Journalist with Chawama Catholic Church, Regina Pacis Parish - as an entry into the GL Zambia 2020 Summit Media Entry

Fertility

Fertility is one of the least talked about SRH subjects. Deeply entrenched patriarchy in Southern Africa often blames the woman when families do not have biological children when in fact biologically this is usually caused by men. The economic situation of many SADC countries limits expensive fertility treatment for most citizens.

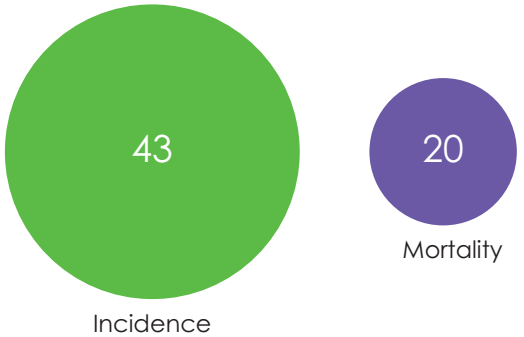
Health insurance seldom covers these trial and error treatments. So far, scientific studies have not proven the efficacy of traditional fertility treatments. Infertility has ripple effects on one's mental wellbeing. Stigmatisation associated with infertility leaves women more vulnerable to polygamy, abuse, and harmful practices.

COVID-19 has significantly impacted availability of fertility treatment around SADC. The Southern African Society of Reproductive Medicine and Gynaecological Endoscopy (SASREG) provides the following guidelines on fertility and COVID-19:[60]

- Undergoing fertility treatment does not increase the risk of contracting COVID-19 (beyond the risk that any individual takes by venturing into public space);
- For women who are trying to conceive, or who are in early pregnancy, there is no evidence to suggest an increased risk of miscarriage with COVID-19;
- At the moment, pregnant women do not appear to be more severely unwell if they develop COVID-19 infection than the general population;
- Women who have severe COVID-19 infection during pregnancy could be at increased risk of miscarriage or early labour;
- There is no evidence that the virus can pass to the developing foetus (vertical transmission); and
- Newborn babies and infants do not appear to be at increased risk of complications from the infection.

Knowing that COVID-19 poses no special risk to women undergoing fertility treatment, to the developing foetus, or to newborn babies will certainly provide peace of mind for those seeking these services. Women everywhere should have an affordable choice of fertility treatment free from fear of stigmatisation.

Figure 2.11: 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 15 May 2020

Youth lead on SRHR campaigns in Zimbabwe.
Photo courtesy of Women's Coalition of Zimbabwe

Figure 2.11 shows the current incidence rates of cervical and uterine cancer at 43 per 100 000 women of all ages. These cancers have emerged as a leading cause of death amongst women. The mortality rate for these cancers in SADC sits at 20%. It is critical to raise awareness of these cancers even during COVID-19. Governments must ensure accessible and affordable testing. UHC provides for relevant cancer treatments and testing.

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 a country's Gross Domestic Product (GDP). The GDP represents the total value of everything produced in the country. It does not matter if citizens or foreigners produce it - if they operate within a country's boundaries, research includes this production in GDP.[61] Health experts view health expenditures as an important indication of a government's commitment to UHC.

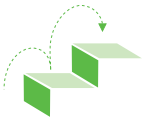
[60] SASREG COVID-19 and COVID-19 Guidelines, April 2020
[61] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038

Table 2.7: Health financing analysis

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Madagascar	17.8	6.0
Eswatini	15.25	7.7
Zimbabwe	14.5	9.4
Namibia	13.8	9.1
South Africa	13.3	8.1
Lesotho	10.1	8.1
Seychelles	10.0	3.9
Malawi	9.8	9.8
Mauritius	10.0	5.7
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	7.6
Comoros	3.6	3.9

Source: https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 15 May 2020.

Table 2.7 shows that only Eswatini and Madagascar meet the recommended Abuja Declaration goal of 15% expenditure on health.[62] Zimbabwe comes close at 14.5%. DRC and Comoros allocate the least to health at 3.7% and 3.6% of their respective budgets. All SADC countries spend less than 10% of their GDP on health. This poses a regional challenge to realising SRHR and achieving universal health coverage. Most countries will have increased health expenditures during the COVID-19 pandemic. It would be wise for governments maintain these higher allocations in years to come.



Next steps

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

- Develop and review national SRHR policies and guidelines to align to global, continental, and regional instruments on SRHR. The review of policies must include health disasters.
- Mainstream SRHR in all COVID-19 responses, including policy and guideline development.
- Ensure that price increases do not offset gains made in removing VAT from sanitary pads. Governments must make sanitary pads essential commodities, removing barriers to manufacturing and supply.
- Prioritise investment in clean water provision for both urban and rural areas.
- Raise public awareness on sanitation, including building the capacity of community-led sanitation coverage.
- Support continuity of WASH services in the home when possible or ensure regular deliveries of essential WASH supplies during the COVID-19 pandemic.
- Support health workers' menstrual health and WASH needs to prevent heightened risk of COVID-19 infection and other infections.
- Improve access to contraception for women and girls, including during the COVID-19 pandemic and other health disasters.
- Build capacity in communities to expand pools of health workers to achieve UHC, which is especially critical in emergencies such as the COVID-19 crisis.
- Keep sex disaggregated data on access to SRHR services, including during national health disasters such as COVID-19.
- Develop programmes and policies on reproductive cancers and share these with different target groups at community level.
- Prioritise investment in health systems in national budgets and plans to achieve the Abuja Declaration commitments.

Doctor Angele Mabiala distributes menstrual hygiene products to adolescents in Boma, DRC, in February 2020. Photo: Anna Mayimona Ngemba

[62] https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf