Menstrual Health, Family Planning and Maternal Health 2

Piggs Peak maternal menstrual health campaign. Photo: Thandokuhle Dlamini

KEY POINTS

- While there has been good progress, the Maternal Mortality Rate (MMR) remains unacceptably high in SADC. Only two of the 16 SADC countries, Seychelles and Mauritius, have met SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100,000 live births, seven times higher than the SDG target.
- Neonatal deaths also remain high in the region. Only three SADC countries (Seychelles, Mauritius and South Africa) having achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.
- More countries understand the importance of women's menstrual hygiene to their overall health and wellbeing. Seven SADC countries have removed VAT on menstrual products. Seven countries now provide free sanitary ware in schools.
- Local government plays a key role in providing access to SRH services and should develop SRHR specific policies, including provisions on national health emergencies.
- Most pregnant women in the region have access to at least one antenatal visit, but women in rural areas have less access than those residing in urban areas.
- The COVID-19 pandemic has strained public health systems globally, interrupting and delaying many kinds of critical health care. A survey by the World Health Organization (WHO) of 105 countries across the globe, found that family planning and contraception were among the most frequently disrupted health services, with seven in ten countries experiencing disruptions.
- Health expenditure as a proportion of SADC budgets remains low. Only two countries, Eswatini and Malawi have met the recommended goal of 15% total government expenditure on health.

Introduction

Sexual and reproductive health rights (SRHR) are the basic rights of any individual, regardless of whether they are young or old; female, male, or any other sexual or gender identity, HIV positive or negative. All have the right to make their own choices regarding sexuality and reproduction, provided these respect the rights of others to bodily integrity. It also includes the right to access information and services that are needed, not only to support these choices but also to optimise their health.

> All have the right to make their own choices regarding sexuality and reproduction

The International Conference on Population and Development (ICPD) defines **reproductive health** as

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."[1]

Realising SRHR is integral to achieving gender equality, the United Nations Population Fund (UNFPA) draws a clear connection between reproductive health, human rights and sustainable development, highlighting that when SRH needs are not met, individuals are deprived of the right to make crucial choices about their own bodies and futures, which in turn impact on their families' welfare and future generations.[2]

Making the right choices - vaccinating our young in Lesotho.
Photo: Thandokuhle Dlamini

1 International Conference on Population and Development (ICPD), Programme of Action, Para 7.2 (2014)
2 UNFPA, Sexual & reproductive health https://www.unfpa.org/sexual-reproductive-health, accessed 13 July
3 Ibid

Sexual and reproductive health is a lifetime concern for both women and men, from infancy to old age. As the bearers and principal carers of children, SRHR is of particular importance to women. From adolescence to old age women have needs for comprehensive sexuality education, menstrual hygiene, and health, contraception and family planning, access to safe and legal abortion, antenatal, safe delivery care, post-natal care, services to prevent sexually transmitted infections (including HIV), and services facilitating early diagnosis and treatment of reproductive health illnesses (including breast and cervical cancer).[3]

SRHR is comprehensively covered in eight the Sustainable Development Goals targets through:

- SDG 3: Ensure healthy lives and promote well-being for all at all ages
  - Target 3.1 - By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
  - Target 3.2 - By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
  - Target 3.7 - By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
  - Target 3.8 - Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
  - Target 3.b - Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- SDG 5: Achieve gender equality and empower all women and girls
  - Target 5.6 - Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
- SDG 6: Ensure availability and sustainable management of water and sanitation for all
  - Target 6.1 - By 2030, achieve universal and equitable access to safe and affordable drinking water for all
  - Target 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[4]

[4] United Nations, Sustainable development goals, https://sdgs.un.org/goals accessed 14 July 2021

Table 2.1: SRH indicators in 2021

INDICATORS	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Existence of SRHR policies/guidelines	No	Guidelines	Yes	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2015 - 2019 Policy	2011 - 2015 Guidelines	2008 Policy	2010 - 2015 Policy
Existence of laws and policies that allow adolescents to access SRH services without third party authorisation	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 Strategy	No
Provision of free menstrual ware	No	Yes	No	No	No	Yes	Yes	No	No	No	Yes	Yes	No	No	Yes	No
Removal of Value Added Tax (VAT) on menstrual ware	No	No	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Basic drinking water status (%)[5]	56	99	80	43	69	69	54	69	100	56	83	96	93	57	60	64
Access to basic sanitation (%)[6]	50	77	36	21	58	43	11	26	96	29	35	100	76	30	26	36
Contraceptive prevalence rate amongst all women aged 15-49 (%) any method[7]	16	57	20	23	54	53	41	48	43	26	52	No data	50	36	37	49
Unmet need for contra-ception amongst all women aged 15-49 (%)[8]	27	8	19	21	10	11	15	13	8	19	10	No data	11	16	15	8
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[9]	62	No data	21	31	49	61	74	47	49	49	71	No data	65	47	47	60
Age of access to contraception	16	12	TBA	18	15	No age stipulated	12	16	16	16	12	15	12	12	16	16
Maternal Mortality Ratio (per 100,000)[10]	241	144	273	473	437	544	335	349	61	289	195	53	119	524	213	458
Antenatal Care Visits (At least one visit) %[11]	82	94	92	82	99	95	82	98	No data	87	97	No data	94	98	97	93
Antenatal Care Visits (At least four visits) %[12]	61	No data	No data	43	No data	77	51	51	No data	51	No data	No data	76	62	64	76
Skilled attendance at birth (%)[13]	50	100	82	80	88	78	44	90	100	54	88	99	97	64	80	78
Postnatal care coverage %[14]	23	No data	49	44	88	62	No data	42	No data	No data	69	No data	84	34	54	57
Neonatal mortality (per 1000)[15]	28	18	30	27	18	43	20	20	10	29	19	9	12	20	23	26
Nursing and midwifery personnel per 10 000 of the population[16]	4	54	6	11	41	33	3	4	35	5	20	98	13	6	10	19
Universal Health Coverage index (0 worst - 100 best)[17]	40	61	52	41	63	48	28	46	63	46	62	71	69	43	53	54
Health expenditure as proportion of GDP[18]	2,5	5,8	4,5	3,3	6,5	9,2	4,7	9,3	5,8	8,1	8	3.9	8,2	3,6	4,9	4,7
Health expenditure as proportion of total government expenditure[19]	5	8.8	8,6	11	16.5	13	10.1	16.7	10	8.8	13.8	9.7	14.2	12.3	11.3	8.4

[5] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles, accessed 7 July 2021
[6] Ibid
[7] UNFPA, World Population Dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 7 July 2021
[8] Ibid
[9] Ibid
[10] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles , accessed 6 July 20212
[11] World Bank Data, https://data.worldbank.org/indicator/SH.STA.ANVC.ZS?view=chart , accessed 6 July 2021
[12] UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , accessed 6 July 2021
[13] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles , accessed 7 July 2021
[14] WHO, The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/women-age-15-49-years-who-received-a-health-check-within-2-days-after-delivery-of-their-most-recent-live-birth-in-the-last-2-years-(-) , accessed 7 July 2021
[15] SDG Report 2021, Country profiles https://dashboards.sdgindex.org/profiles, accessed 6 July 2021
[16] WHO, The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nursing-and-midwifery-personnel-(per-10-000-population) ,accessed 7 July 2021
[17] SDG Report 2021, Country profiles , https://dashboards.sdgindex.org/profiles , accessed 7 July 2021
[18] World Bank, World Development Indicators, https://databank.worldbank.org/data/source/world-development-indicators#, accessed 7 July 2021
[19] Ibid

Table 2.1 shows that:

- Seven SADC countries (Lesotho, South Africa, Zimbabwe, Zambia, Seychelles, Mauritius and **Namibia**) have now removed VAT on menstrual products, Namibia being the latest country to do so. Seven countries (Lesotho, Zambia, Seychelles, Botswana and Madagascar, South Africa, Zimbabwe) provide free sanitary ware in schools; this is up from five countries in 2021.
- Mauritius is the only country that provides drinking water to 100% of the population. Of the other countries coverage ranges from 43% in DRC to Botswana at 99%.
- Just one SADC country, Seychelles, provides basic sanitation to its entire population. Madagascar has the lowest coverage with just 11% of the population having access to basic sanitation
- The contraceptive prevalence rate (CPR) for all women aged 15-49 using all methods ranges from 16% in Angola to 57% in Botswana. Just six countries (Botswana, Eswatini, Lesotho, Namibia, Zambia and Zimbabwe) are above the global average of 49%.
- Angola has the highest unmet need for contraception with 27% of women of reproductive age (15-49 years) having a need for family planning, but not having access to contraception.
- Women in SADC have limited control over decision-making on SRHR. This ranges from 21% in Comoros to 74% in Madagascar of women aged 15-49 and who make decisions on SRHR.
- Just two of 16 SADC countries, Seychelles and Mauritius have met the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100 000 live births.
- Just three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 neonatal deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.
- No country in SADC provides universal health care. Access to essential health services ranges from 71% in Seychelles to 28% in Madagascar.

This chapter focuses on three key areas of SRH - menstrual health, family planning and maternal health - measuring the progress countries in realising the targets set out in the 2016 SADC Protocol on Gender and Development, the Sustainable Development Goals (SDGs), and the SADC SRHR strategy. These are analysed against the backdrop of the COVID-19 pandemic and its profound effects on the sector, as well as the vaccine roll out and what this could portend.

SRH and the COVID-19 pandemic

At the start of the pandemic in 2019 much was being written about the potential effect that pandemic would have on women's SRHR[20]. While some global surveys have been conducted information on the impact on the pandemic on SRH is lacking at the country level.

Tracking access to essential health services during the pandemic is critical to achieving the optimal balance between fighting the COVID-19 pandemic and maintaining these services. As part of their response, countries need to have defined the set of essential services to be maintained during the pandemic, to assess how these services are being affected and to track any changes that may be occurring as the outbreak progresses along its various stages.[21]

National, regional and international data on the impact of the pandemic is urgently needed to advocate for resources for the most affected populations, and to help target efforts to maintain

[20] UNFPA, Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, Interim Technical Note, 27 April 2020
[21] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020

health services for the populations in greatest need.[22] This data will also be crucial in developing responses to other health emergencies.

The COVID-19 pandemic presented an opportunity for states to integrate SRHR into state of emergency responses. SADC countries with standalone policies and guidelines should find it easier to do this as part of their COVID-19 response. A local council in Zimbabwe showed how this can be done.

Murehwa Rural District acts on SRHR amidst the COVID-19 pandemic

Early on in the COVID-19 outbreak Murehwa District Council in Zimbabwe recognised the risks that COVID-19 posed to SRHR. Together with key stakeholders the Council developed a COVID-19 and Sexual Reproductive Health and Rights Response Plan. Murehwa RDC is also a key member of the Murehwa COVID-19 Gender Sub-Committee.

The plan included seven strategic priorities:

- Personal Protective Equipment (PPE) at Council Rural Health Centres.
- Ensuring access to contraceptives and reproductive health services.
- Ensuring that menstrual education and sanitary ware is accessible to women and girls.
- Making sure that maternal health services (including waiting mothers homes) are accessible to Murehwa community.
- To ensure that cervical cancer screening, STI treatments and HIV/AIDS services exist during the period.
- Ensuring continuity of public awareness on SRHR and GBV issues.
- Rapid response services for GBV cases and provision of shelter to victims.

Murehwa RDC junior Councillors and youth campaign on SRHR and ending child marriages. Photo: Tapiwa Zvaraya

A COVID-19 gender committee at district level is responsible for implementation, making use of the provisions in the Council Gender and other committees' budget. Councillors who have close links to the community, assist with continued awareness to the public on SRHR issues and the council will seek to partner with development partners and Government Ministries in the district.

Source: Murehwa Rural District Council SRHR Strategy

[22] Ibid

The need for sex disaggregated data

Sex-disaggregated data from testing through to vaccinations is critical to understanding the differential impact the virus is having on women, men and gender non-conforming people. Disaggregating data on who is being tested, confirmed cases, hospitalisation, ICU admissions, deaths and vaccinations will help to inform response. This information is, however, completely lacking in some countries. At the very least countries should be disaggregating data on confirmed case, deaths and now vaccinations to ensure there is equal access.

According to the COVID-19 Sex disaggregated data tracker, which tracks sex disaggregated data across the globe, "very few countries are reporting this data in its entirety."[23] Of 198 countries, only 139 disaggregate data on confirmed cases and only 107 on deaths. South Africa is the only country that has reported disaggregated data on cases and deaths in the past month, and Mozambique has reported disaggregated data on confirmed cases in the past month. No other SADC countries have reported on sex disaggregated data.[24] Globally only 16 countries disaggregate data on testing and 42 on vaccinations,[25] no SADC countries are reporting sex-disaggregated data on vaccinations.

Biological sex is relevant and sex-disaggregated analysis important for a range of different reasons. A growing body of research highlights the influence of biological sex in clinically relevant health outcomes, including sex-specific differences in immunity, pharmacology, and vaccines outcomes (side-effects and efficacy). In vaccine studies, cisgender females tend to develop higher antibody response and, relatedly, higher efficacy and more side-effects, suggesting the need for sex-differentiated dosing regimens.[26]

It is for these reasons that it is essential for researchers and regulatory agencies to include biological sex as a variable in trial data analysis and reporting, to inform policies and programmes to address the impact of the pandemic on SRHRs.

Sex-disaggregated data from testing through to vaccinations is critical in assessing the impact of COVID-19

As we are still in the very early stages of the vaccination roll-out there are still many unknowns in terms of the side-effects of the vaccine. More research is needed but reports from women who have been vaccinated should be an important identifier of potential side-effects. For example, there have been concerns relating to the vaccine's impact on reproductive health after some women reported getting heavier periods after the first dose of the vaccine. Women took to Twitter to share their experiences about excessive bleeding following being vaccinated. While medical practitioners have cautioned against associating these symptoms with the vaccine because there is no conclusive evidence to show this,[27] it is imperative that this evidence be gathered so that women can make informed choices about their bodies.

[23] Global Health 50/50, The COVID-19 Sex-Disaggregated Data Tracker, https://globalhealth5050.org/the-sex-gender-and-covid-19-project/the-data-tracker/ accessed 28 June 2021
[24] Ibid
[25] Ibid
[26] Lancet, Sex-disaggregated data in COVID-19 vaccine trials, Published Online March 5, 2021, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00384-6/fulltext, accessed 10 July 2021
[27] Halima Zoha Ansari, The Global COVID-19 Vaccine Roll-Out Shows The Lack Of Research On Women's Biology, 5 May 2021, https://feminisminindia.com/2021/05/05/the-global-covid-19-vaccine-roll-women-health/ , accessed 20 July 2021

SRHR policy and legislative framework in SADC

Article 6.1 (a) of the SADC SRHR Strategy obliges member states to establish a multi-sector 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.

SDG 3.7 call on states to integrate reproductive health into national strategies and programmes. Stand-alone policies on SRHR are a marker of political commitment to realising the SRHR of women and girls and the will to domesticate regional, continental, and global SRHR instruments.

Status of national SRHR policies and laws in SADC

The vision of the SADC SRHR strategy 2019-2020 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 realize and exercise their SRH rights, as an integral component of sustainable human development in the SADC region. The strategy is aligned with the SDG, and aims to achieve ten outcomes:

1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG3.1.);
2. New-born mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2.);
3. HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3);
5. Rates of unplanned pregnancies and unsafe abortion reduced;
6. Rates of teenage pregnancies reduced;
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6);
8. Health systems, including community health systems, strengthened to respond to SRH needs; (SDG 5.6);
9. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6);
10. Barriers - including policy, cultural, social and economic - that serve as an impediment to the realization of SRHR in the region removed (SDGs 5.1 and 5c)."[28]

Over the last 17 years, 14 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines.

[28] SADC Secretariat, Strategy for Sexual and Reproductive Health Rights in the SADC Region 2019-2030, p12, 2019

Table 2.2: Status of SRHR policies in SADC

Country	Policies/guidelines	Year
SRHR policies		
Older than ten 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
Older than five years		
Seychelles	Reproductive Health Policy for Seychelles	2012
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
Adopted in the past five years		
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 policies and laws, Gender Links, 2019.

Table 2.2 shows, of the 14 SADC countries that have either stand-alone SRHR policies or SRHR guidelines, ten countries adopted these between 2001 to 2015. Madagascar is the only country with a policy less than five years old. Some of these policies are for reproductive health only, while SRHR is broader including sexual rights, this points to the need for countries to update their policies to align with international standards on SRHR.

Countries need to update their policies to align with international standards on SRHR

Angola and the DRC are the two countries that have no standalone policy or guidelines.

While the DRC does not have a standalone policy, its parliament signed a revised comprehensive public health bill into law in 2018. The law creates a new legal environment favourable to family planning and reproductive health, repealing and replacing a colonial law from 1920 prohibiting any form of action against or preventing procreation. The family planning provisions contained in the law enable access to family planning services for all women, including adolescents and young people, and legally protect a women's ability to choose to use family planning even if her spouse objects. The law officially took effect on March 13, 2019.[29]

[29] https://www.advancefamilyplanning.org/drc-passes-new-public-health-law-provisions-family-planning

Role of local government

Local government, is responsible for primary healthcare services, including maternal health and family planning services; have HIV and AIDS policies, and take responsibility for ARV treatment.

The Centres of Excellence (COE) in local government programme, is the most far-reaching systematic and sustained effort to promote gender mainstreaming in local government in SADC. Gender Links is working with 380 local councils in ten countries - Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe covering a population of 99 810 806 people. GL has worked with councils to developed gender, GBV and SRHR strategies and action plans aligned with the SADC Gender Protocol, updated in 2016 in line with the Sustainable Development Goals. As a result many councils are implementing specific programmes on SRHR.

Local authorities in Zimbabwe have been actively involved in maternal health. All council clinics in Zimbabwe provide maternal health services. These include access to contraception, provision of waiting mothers' shelters for pregnant girls and mothers.

All 92 local authorities in Zimbabwe are reviewing their Sexual Reproductive Health and Rights action plans. Most of the local authorities including Chinhoyi Municipality, Epworth Local Board, Murehwa Rural District Council, Bulawayo City Council, Guruve Rural District Council, Bikita Rural District Council, and Umguza Rural District Council are conducting SRHR youth-led campaigns and dialogues. The campaigns focus on, menstrual health, child marriages, gender-based violence, child sexual abuse, and teenage pregnancies.

In rural local authorities where most pregnant women have to walk long distances to clinics, there has been a deliberate attempt by local authorities like Murehwa RDC, Umguza RDC, Guruve RDC, Nyanga RDC and Mutoko RDC to construct Waiting Mothers' Shelters so that pregnant women can have a place to stay prior to giving birth as well as after giving birth before they can go back to their places of residence.

Source: GL Zimbabwe Office

Menstrual health

Menstrual health relates to human dignity, and it is a fundamental right for every girl and woman to live a healthy life during menstruation. Menstruation is a monthly occurrence for every woman and girl, yet stigma based on myth and cultural beliefs continue to exclude them from public and family life during this period. Unaffordable sanitary products drive desperate women and girls to improvise sanitary pads, using leaves, cloth, and other unsafe methods of menstruation management. UNICEF estimates that 1.8 billion girls, women, and non-binary persons menstruate, yet millions of them across the world cannot manage their monthly cycle in a dignified, healthy way.[30]

[30] UNICEF, WASH: Mentrual hygiene, https://www.unicef.org/wash/menstrual-hygiene, accessed 16 July 2021

Aside from health and hygiene risks, this causes adolescent girls and young women (AGYW) to miss school activities including lessons and sports activities, due to lack of sanitary pads, which affects their performance at school.

COVID-19 posed many challenges for menstruating AGYW. Lock-downs, border closures and supply disruptions have limited access to menstrual hygiene products and increased price of sanitary products as a result. According to Plan International, "With the pandemic significantly affecting livelihoods and household incomes, it is harder now for people, including adolescent girls, to afford to buy sanitary products than before the COVID-19 pandemic began, even when products are available."[31] In addition, lock-downs have affected access to reliable information and support around menstrual health and hygiene, access to clean water to maintain good menstrual hygiene and less hygienic environment for disposal of products and waste-management.[32] This highlights the urgent need for safe water and sanitation facilities, and safe and effective means of managing menstruation.

Eswatini - Lavumisa menstrual health campaign. Photo: Thandokuhle Dlamini

Governments can show their commitment to addressing women's menstrual health needs by scrapping value-added tax (VAT) on sanitary ware, also known as "tampon tax", and by providing free sanitary products to all school girls, particularly in rural areas. Improving access to sanitary ware for schoolgirls will ensure improved educational performance of AGYW. Safe menstruation management will advance their overall health.

Table 2.3: Menstrual products in SADC

Country	NO VAT on sanitary ware	Free sanitary ware in schools[33]
Lesotho	Yes	Yes
South Africa	Yes	Yes
Zimbabwe	Yes	Yes
Zambia	Yes	Yes
Seychelles	Yes	Yes
Namibia	Yes	No
Mauritius	Yes	No
Botswana	No	Yes
Madagascar	No	Yes
Angola	No	No
Comoros	No	No
DRC	No	No
Eswatini	No	No
Malawi	No	No
Mozambique	No	No
Tanzania	No	No

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

Table 2.3 shows that

- Five SADC countries have removed VAT on sanitary ware and provide free sanitary ware in schools. These are: Lesotho, South Africa, Zimbabwe, Zambia and Seychelles.
- Two countries (Namibia and Mauritius) have removed VAT on sanitary ware but do not provide free sanitary ware in schools.
- Two countries (Botswana and Madagascar) provide free sanitary ware in schools but have not removed VAT on sanitary ware.
- Seven SADC countries have neither removed VAT on sanitary ware nor provide free sanitary ware in schools.

[31] Plan International, Periods in a Pandemic - Menstrual hygiene management in the time of COVID-19, 2020
[32] Ibid
[33] Largely of rural schools and indigent populations

Woman at forefront of scrapping 'tampon tax' in Namibia[34]

Emma Theofelus.
Photo courtesy of Shelleygan Petersen, The Namibian

On 3 March 2021 Deputy Minister of Information and Communication Technology in Namibia, Emma Theofelus, tabled a motion in the National Assembly for a tax exemption on menstrual products. "I ask that this matter be referred to the relevant standing committee and for the finance ministry to consider bringing an amendment to the tax laws relevant to this motion," she said.

Theofelus, an advocate for young women to be safe during their menstrual cycle told *The Namibian* that "Period poverty is one of the undignified processes women and young ladies have to experience. Your period is such a natural process and not something they can opt out of. There are not enough social and economic circumstances to create safety for young women," she said.

Following the motion being tabled at the beginning of March, the Namibian government eliminated VAT on sanitary products, on 17 March 2020 meaning that women and girls in Namibia will no longer be charged a luxury tax rate of 15% of VAT on sanitary products.

The exemption will take effect in the 2022/2023 financial year, according to Finance Minister Iipumbu Shiimi. "I wish to announce this to enhance affordability by the girl child and urge suppliers and retailers to pass on this relief to consumers once enacted," Shiimi told The Namibian.

Theofelus, at 25, is one of the youngest cabinet members in the region. She was appointed as Namibia's information, communication and technology deputy minister in April 2020. One of her key roles since coming into office has been to help lead communication to the public on preventative steps against the COVID-19 pandemic, which hit Namibia in March.

Hygiene Day at Coastal Resources Center in KwaZulu-Natal, 2020.
Photo courtesy of Coastal Resources Center

While menstrual health and hygiene is something that affects women of all ages, AGYW experi-ence the biggest challenges. Local councils are working with partners to raise awareness around menstrual health and to raise funds for sanitary products for AGYW, especially those in rural areas, as illustrated in the case study that follows:

[34] Adapted from an article in The Namibian, 'Theofelus puts sanitary pads in spotlight' , 5 March 2021, https://www.namibian.com.na/209330/archive-read/Theofelus-puts-sanitary-pads-in-spotlight accessed 24 July 2021

Zambia: Council works to 'Keep a Girl Child in School'

Kabwe Municipal Council Dreams project. Photo: Albert Ngosa

Kitwe City Council has allocated $3036 towards provision of reusable sanitary pads and face masks to adolescent girls in peri-urban areas (Mwekera, Kamfinsa, Miyombo, Garneton) in Kitwe district. Girls in this area walk 5km to 10km to get to school. The Local Participation in Governance (LoPaGo project is a partnership with Gesellschaft für Internationale Zusammenarbeit (GIZ)) The District Education Board Secretary (DEBS) identified schools and assisted in information dissemination.

The project found that girls in these areas use unhygienic materials during their menstrual periods such as like old clothes, *chitenge* materials and papers. They are often absent from school during their menstrual period. This distribution of reusable sanitary pads took place from 15th October to 30th November 2020. During the distribution schoolgirls were sensitised on myths and misconceptions surrounding menstrual health.

The goal of the initiative is to empower vulnerable girls through provision of reusable sanitary pads and capacity building on menstrual hygiene management and reproductive health for improved self-esteem. By acquiring knowledge on menstrual hygiene management, the overall health status of the girls is enhanced. One packet of reusable sanitary pads distributed through this project is sufficient to meet the sanitary needs of a girl for three years at a cost of less than one dollar.

Source: Regina Musa, SRHR Most Significant Result 2021

In addition to AGYW there are other at-risk groups, including women in prisons who are not able to manage their menstruation in a dignified and hygienic way. Special efforts need to be made to ensure that all women and girls everywhere have access to menstrual products and hygiene.

Special efforts needed to ensure all women and girls everywhere have access to menstrual products and hygiene

Malawi: Promoting menstrual health in prison

Kabwe Municipal Council Dreams project. Photo: Albert Ngosa

Activists in Malawi have applauded the allocation of funds to cater for Menstrual Hygiene Management (MHM) for women and girls in detention saying it will improve their wellbeing.

The Malawi Parliament approved a K30 million ($36,896) increase in the Malawi Prison Service health budgetary allocation in the 2019/2020 national budget after the Centre for Human Rights Education Advice and Assistance (CHREAA) with funding from Amplify Change advocated for allocation of funds to cater for Menstrual Hygiene Management in Prison.

Executive Director for CHREAA, Victor Mhango said the move will improve the wellbeing and dignity of female inmates as enshrined in Malawi Constitution. Section 42 (1) of the Constitution which stipulates that "every detained person be held under conditions consistent with human dignity, which shall include at least access adequate nutrition and medical treatment at the expense of the state."

Women in prisons have no income to buy basic necessities including sanitary pads, under wear and soap, making them prone to infections as a result of poor menstrual health. " A lot of them suffer from candidiasis," says Annie Kitalo an official at Chichiri Prison.

"The Government should also remove VAT on sanitary pads so that a lot of women can afford to buy sanitary pads as it is a basic need for all girls," Mhango says. There is also a need to support women and girls in rural areas who cannot afford to buy sanitary pads because they are expensive. Pressure is mounting in Malawi for Government to remove VAT on sanitary pads and support groups to make reusable sanitary napkins for schools.

Excerpt from article by Jenipher Changwanda GL 16 Days SRHR News Service[35]

[35] Additional reporting by the Center for Human Rights Education Advice and Assistance (CHREAA). Picture courtesy of CHREAA.

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 6.1: By 2030, achieve universal and equitable access to safe and affordable drinking water for all

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.

In early July 2021 the World Health Organisation's (WHO) Joint Monitoring Programme (JMP) released a report - Progress on household drinking water, sanitation and hygiene 2000 - 2020, presenting estimates on household access to safely managed drinking water, sanitation and hygiene services over the past five years. The report assesses progress toward achieving the sixth Sustainable Development Goal (SDG) to "ensure availability and sustainable management of water and sanitation for all by 2030." The report notes that billions of people around the world will be unable to access safely managed household drinking water, sanitation and hygiene services in 2030 unless the rate of progress quadruples, according to a new report from WHO and UNICEF.[36]

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

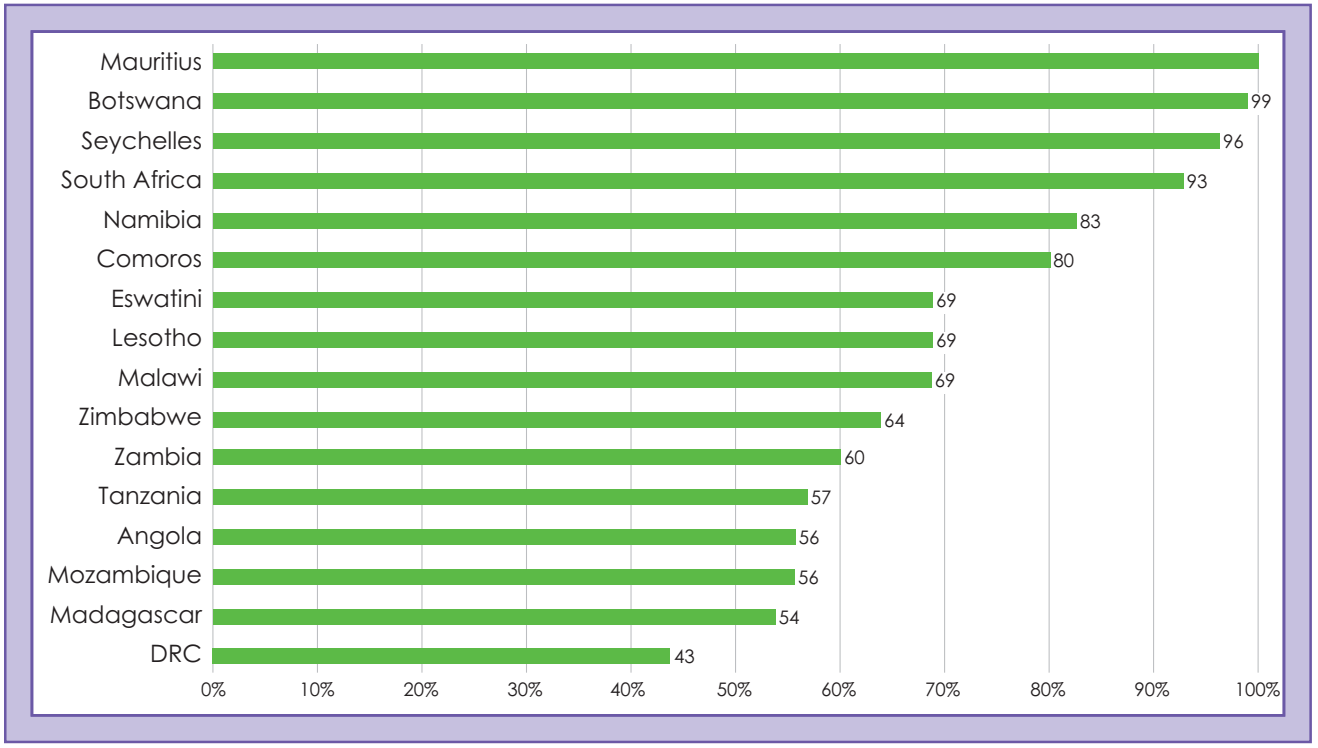
In 2020, around one in four people lacked safely-managed drinking water in their homes. Nearly half the world's population lacked safely managed sanitation. COVID-19 has highlighted the urgent need to ensure everyone can access good hand hygiene. At the onset of the pandemic, 3 in 10 people worldwide could not wash their hands with soap and water within their homes. While there has been progress over the last five years since the SDGs were adopted, there are still millions of people who lack access to basic water and sanitation.

Safely managed sanitation services reached 62% of the world's urban population, but only 44% of its rural population. Sub-Saharan Africa is experiencing the slowest rate of progress in the world, with only 54% of people using safe drinking water.[37]

[36] WHO, Billions of people will lack access to safe water, sanitation and hygiene in 2030 unless progress quadruples - warn WHO, UNICEF, 1 July 2021 https://www.who.int/news/item/01-07-2021-billions-of-people-will-lack-access-to-safe-water-sanitation-and-hygiene-in-2030-unless-progress-quadruples-warn-who-unicef accessed 16 July 2021

[37] Ibid

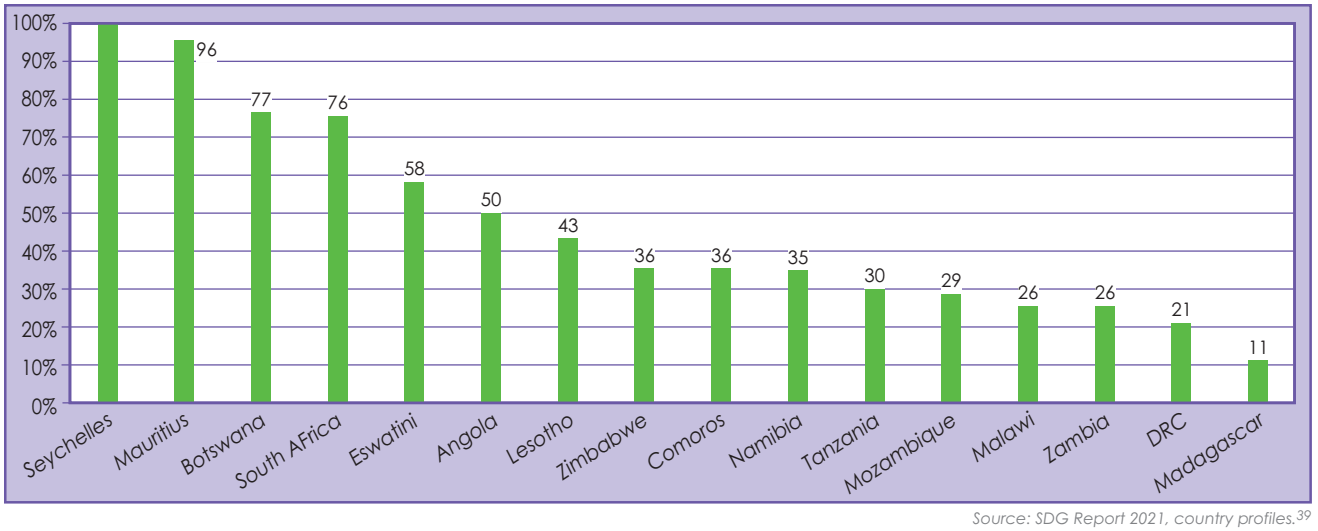
Figure 2.1: Access to basic drinking water in SADC



Source: SDG Report 2021, country profiles.[38]

Figure 2.1 shows that Mauritius is the only country that provides basic drinking water to 100% of the population. Botswana (99%), Seychelles (96%) and South Africa (93%) are close to achieving universal coverage, but still fall short. Most countries have between 54% - 83% coverage. The DRC has just 43% coverage.

Figure 2.2: Percentage population using basic sanitation



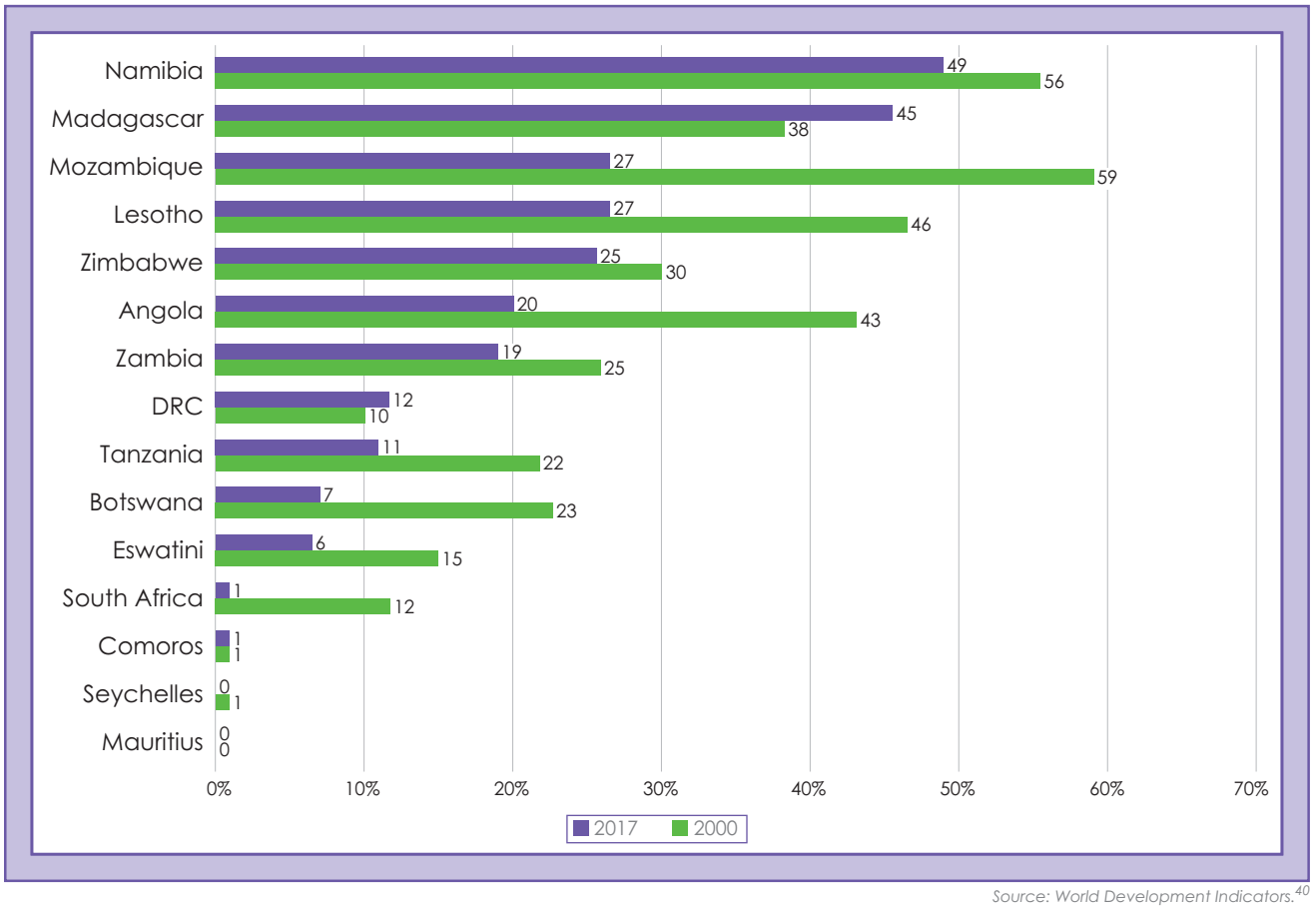
Source: SDG Report 2021, country profiles.[39]

[38] https://dashboards.sdgindex.org/profiles accessed 12 July 2021
[39] https://dashboards.sdgindex.org/profiles accessed 12 July 2021

Figure 2.2 shows that only one SADC country, Seychelles, provides basic sanitation to its entire population. Mauritius is close to achieving universal coverage. Botswana (77%) and South Africa (76%) are three quarters of the way to this target. Eswatini (58%) and Angola (50%) are half way or further. The other ten countries are lower than 50%, with Madagascar (11%) having the lowest coverage.

People practicing open defecation refers to the percentage of the population defecating in the open, such as in fields, forest, bushes, open bodies of water, on beaches, in other open spaces or disposed of with solid waste. There is a correlation between access to sanitation and percentage of the population practising open defecation.

Figure 2.3: Percentage of population practicing open defecation 2000-2017



Source: World Development Indicators.[40]

Figure 2.3 shows that just two (Mauritius and Seychelles) of the 16 SADC countries have eradicated the practise of open defecation. There has, however, been marked progress in most countries over the last 17 years.

Madagascar, DRC and Tanzania all recorded an increase in the proportion of the population practicing open defecation. Namibia still has the highest prevalence of this practise.

Marked progress of open defaecation has been made in most countries over the last 17 years

[40] https://data.worldbank.org/indicator/SH.STA.ODFC.ZS Accessed 14 July 2020.

Access to Family Planning (FP) Services

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.

CEDAW: Article 14 (b): To have access to adequate health care facilities, including information, counselling and services in family planning.

Access to contraception is a universal human right that dramatically improves the lives of women and children in poor countries. Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies. When women can exercise their right to bodily autonomy, by deciding when and how many children they want have, they are able to make informed choices about their lives and wellbeing. Access to contraception improves maternal health and child survival, reduces the number of abortions overall, especially unsafe abortions and it empowers women and promotes social and economic development and security.

The 2030 Agenda for Sustainable Development reaffirms the commitments made in the Programme of Action of the International Conference on Population and Development (ICPD), adopted by 179 governments in Cairo, Egypt in 1994. The ICPD Programme of Action recognized the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. While much progress has been achieved in expanding access to contraception since 1994, significant challenges persist.

Of the 1.9 billion women of reproductive age (15-49 years) living in the world in 2019, 1.1 billion have a need for family planning, meaning that they are either current users of contraceptives or have an unmet need for family planning. Worldwide, in 2019, 49% of all women in the reproductive age range (15-49 years) were using some form of contraception, an increase from 42% in 1990.[41] The proportion of women with unmet need for family planning stands currently at 9%, a proportion that has remained unchanged since 2000.

Zimbabwe - Contraceptive shots at Gweru City Council, Zimbabwe.
Photo: Gender Links

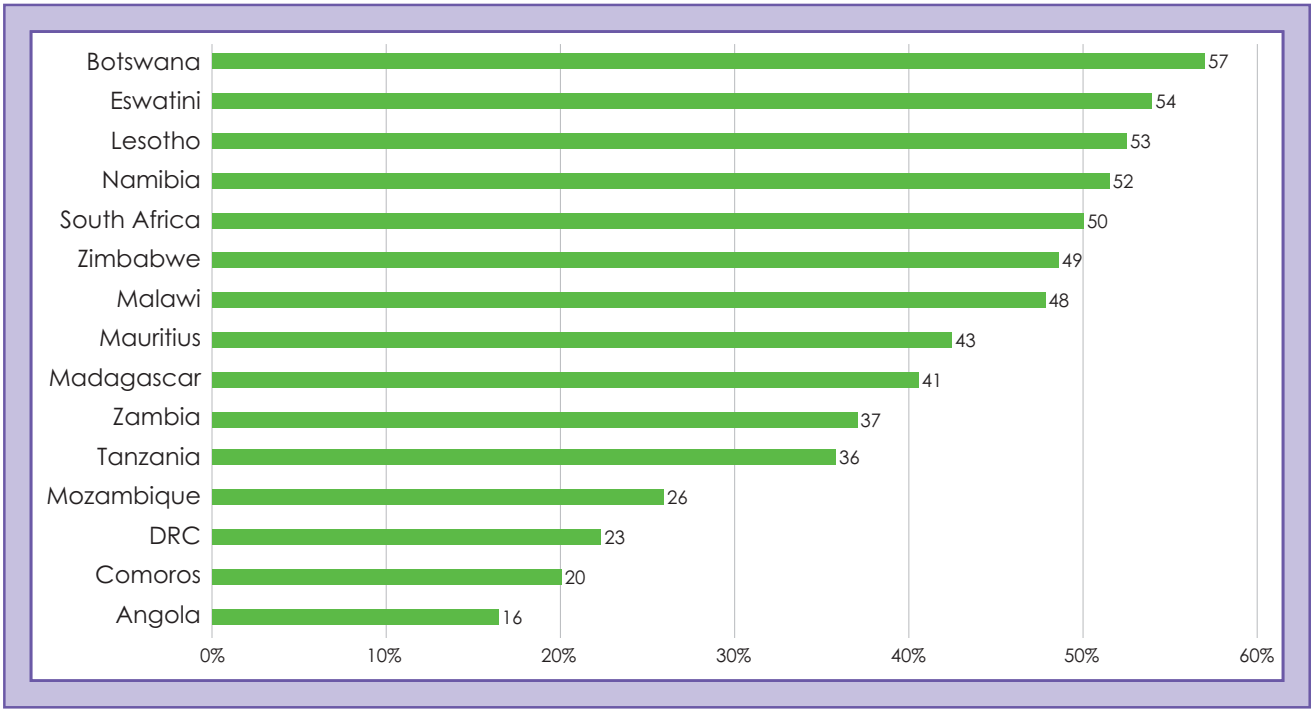
There are a number of reasons why women are not able to control their fertility, including high levels of GBV and women's inability to negotiate safe sex, customary laws and culture and lack of access to modern contraceptive methods.

[41] United Nations Department of Economic and Social Affairs, Population Division (2020). World Fertility and Family Planning 2020: Highlights pp.13

Contraceptive prevalence rates (CPR)

Contraceptive prevalence rate in this report refers to the percentage of all women[42] of reproductive age (15-49) who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used.[43]

Figure 2.4: Contraceptive prevalence (CPR) amongst all women aged 15-49 (%) any method



Source: UNFPA, World Population Dashboard.[44]

Figure 2.4 shows that the CPR in the SADC region ranges from 57% in Botswana to a low 16% in Angola. Six countries (Botswana, Eswatini, Lesotho, Namibia, South Africa and Zimbabwe) meet or exceed the global average of 49%.

Unmet contraception need

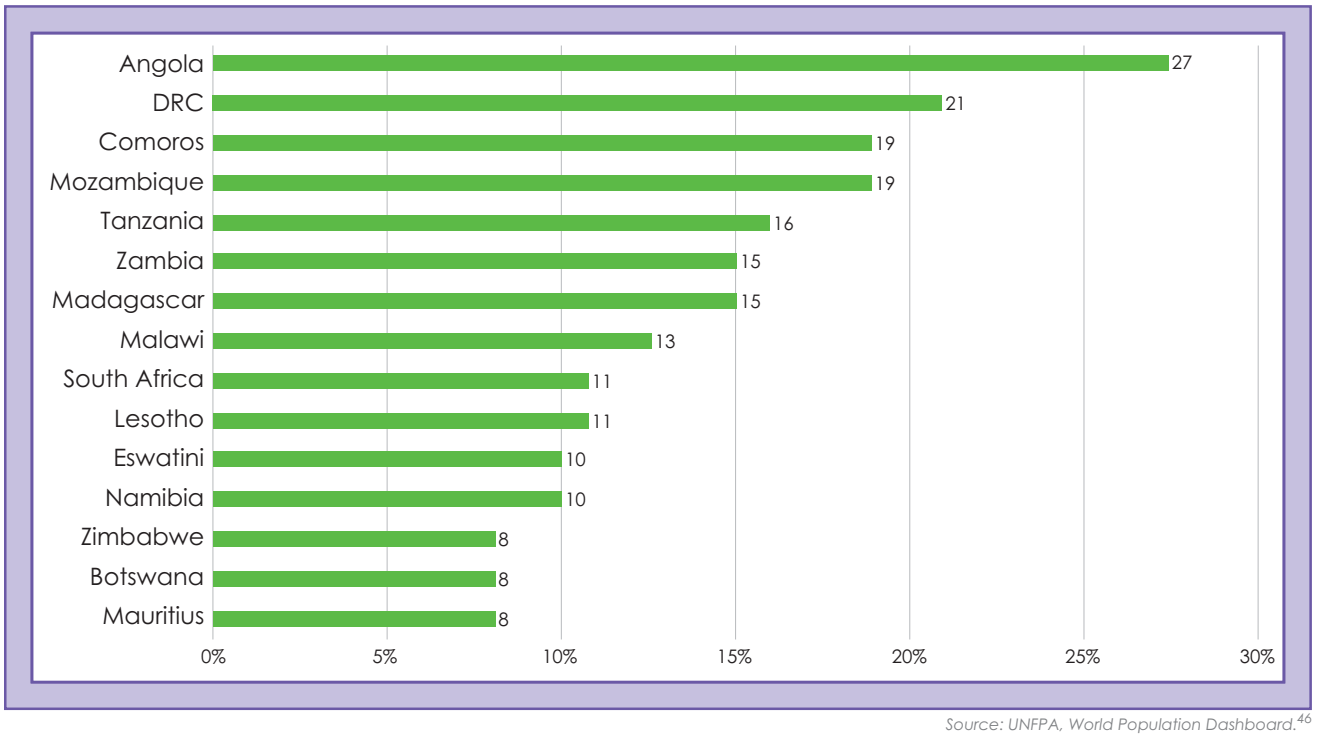
Women with unmet need are those who are sexually active, but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. This unmet need for family planning points to the gap between women's reproductive desire to avoid pregnancy and contraceptive behaviour.

The reasons for this are complex but anecdotal testimony of field workers shows that "the obstacles to contraception go well beyond access to services that are of good quality and affordable. Non-access barriers include fear of health side effects, normative acceptability (including religious concerns), social accept-

[42] This is often reported for married/in union women only, which is how we have reported on it previously. In this report we use the broader definition, which includes all women of reproductive age using any method of contraception.
[43] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 27 July 2021
[44] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021

ability (including the important matter of the partner's approval), and various possible informational and other cultural factors. Uncertainty and ambivalence about the desire to avoid pregnancy can also figure in, as can perceptions of the actual risk of becoming pregnant.[45]

Figure 2.5: Unmet need for family planning rate women aged 15-49, all women (%) 2021



Source: UNFPA, World Population Dashboard.[46]

Figure 2.5 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 27% of women of reproductive age (15-49 years) having a need for family planning, but not having that need met. Three countries (Mauritius, Botswana and Zimbabwe) are below the global average of 10%, and Namibia and Eswatini are both at 10%.

The rest of the countries range from 11% in South Africa in Lesotho, to 27% in Angola.

There is a correlation between low CPR and high unmet needs for contraception. The seven countries with the lowest CPR (Angola, DRC, Comoros, Mozambique, Madagascar, Tanzania and Zambia) have the highest proportion of women with an unmet need for contraception.

The effects of COVID-19 on Family Planning (FP)

At the start of the pandemic, UNFPA, Avenir Health, Johns Hopkins University and Victoria University modelled the potential impact of the pandemic on family planning services. They found that six months of severe health system disruptions in 114 low- and middle-income countries could lead to 47 million women unable to use contraceptives, leading to 7 million unplanned pregnancies.

[45] Machiyama, K., Casterline, J.B., Mumah, J.N. et al. Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. Reprod Health 14, 23 (2017)
[46] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021

Reasons for the disruption include:

- Clinical staff occupied with the COVID-19 response may not have time to provide services, or may lack personal protective equipment to provide services safely.
- Health facilities in many places closing or limiting services.
- Women refraining from visiting health facilities due to fears about COVID-19 exposure or due to movement restrictions.
- Supply chain disruptions limiting availability of contraceptives and stock-outs of many contraceptive methods were anticipated.
- Product shortages and lack of access to trained providers or clinics mean that women may be unable to use their preferred method of contraception, may instead use a less effective short-term method, or may discontinue contraceptive use entirely.[47]

As predicted, the pandemic has strained public health systems globally, interrupting and delaying many kinds of critical health care. The World Health Organization (WHO), conducted two surveys on the continuity of essential health services during the COVID-19 pandemic. The first covers the period January-March 2020 in 105 countries and the second the period June-March included responses from 135 countries. In the second survey all SADC countries were included except Tanzania and Zimbabwe.

The first survey found that family planning and contraception were among the most frequently disrupted health services, with 7 in 10 countries experiencing disruptions.[48] The results showed that most countries reported some disruption in reproductive, maternal, new-born, child and adolescent health (RMNCAH) and nutrition services. Family planning services were disrupted in 68% of countries (59% partially disrupted and 9% reporting severe/complete disruption.)[49] The number of countries reporting disruptions in family planning services decreased in the second survey, to 44%, indicating that services have improved as the pandemic has progressed showing resilience in health systems to ensure continuity of health care services.

A regional survey conducted by the WHO that included responses for 17 African countries - including DRC, Madagascar, South Africa, Tanzania and Zimbabwe - found that 59% of the countries that participated in the survey reported a reduction in the use of FP since the beginning of the pandemic. Twelve (71%) countries reported a reduction in uptake of FP commodities, showing the need to continuously educate the public on health seeking behaviour even during the pandemic. Eight (47%) countries reported stock out of FP commodities, most reporting implants and IUDs as the major stock outs.[50]

Evidence and data needs to be continuously gathered in each country to assess the overall impact on women accessing SRH services. This data is crucial to informing policy and practise now and to learn for future health emergencies or disasters. The case study that follows is one example of innovative strategies.

COVID-19 has strained public health systems globally, interrupting and delaying many kinds of critical health care

[45] Machiyama, K., Casterline, J.B., Mumah, J.N. et al. Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. Reprod Health 14, 23 (2017)
[46] https://www.unfpa.org/data/world-population-dashboard accessed 12 July 2021
[47] UNFPA, Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage, Interim Technical Note, 27 April 2020
[48] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020
[49] Ibid, p 8
[50] Continuity of Essential Sexual and Reproductive Health Services During Covid-19 Pandemic In The WHO African Region, pp4

Mbabane, Eswatini - Once a month, Nolwazi Myeni receives a message on her mobile phone notifying her that family planning services are available despite the pandemic-related lockdown. "I felt very encouraged to be assured that I could visit any clinic amid COVID-19 for my contraceptive needs," the 24-year-old said.

This service has encouraged thousands of women in Eswatini to access contraceptives, and also provided welcome monthly reminders lest they forget.

"With the lockdown movement restrictions, it's easy to forget the date to return to the health facility. These [messages], beyond encouraging us to go for the service, also act as a reminder," Myeni said.

Myeni is the mother of a 6 year old and a mentor to dozens of adolescent girls in her community. She hopes to continue her youth-empowerment efforts by becoming a teacher. Family planning will help her realize this dream, she says, by helping her avoid pregnancy so she can complete her studies and receive a primary teacher's diploma.

The short message service (SMS) programme is part of a partnership between UNFPA, the World Food Programme (WFP) and the health ministry's Sexual Reproductive Health Unit.

The programme not only encourages recipients to learn about family planning services, it also provides information about food relief. The campaign aims to reach 80,000 young women receiving assistance through the WFP COVID-19 relief project in Eswatini.

Experts are concerned the COVID-19 pandemic may be undermining women's ability to choose whether and when to have children. In April, UNFPA and partners projected that 6 months of lockdown-related service disruptions could result in at least 47 million women around the world unable to use modern contraceptives.

Women in Eswatini get SMS reminders on family planning.
Photo: Thandokuhle Dlamini

There are some indications this may be happening in Eswatini. The country saw a 47 per cent drop in use of family planning services between January and May compared to the previous year, according to a recent report by the Social Protection Cluster Partners.

An increase in unintended pregnancies will not only disrupt women's and girls' ability to achieve their full potential, it will also endanger their lives by exposing them to possible pregnancy complications in an uncertain time.

Some health facilities, especially those in rural areas of the country, are already reporting a decline in women attending antenatal clinics and an increase in home deliveries.

"Since the start of the lockdown, we have noted an increase in incidents of women delivering babies either at home or on their way to the facility," midwife Lobesutfu Nkambule told UNFPA.

"Ensuring that women continue accessing these services is one way we can mitigate COVID-19's impact on the health of vulnerable groups like women and girls," said Margaret Thwala-Tembe, UNFPA's acting head of office in Eswatini.

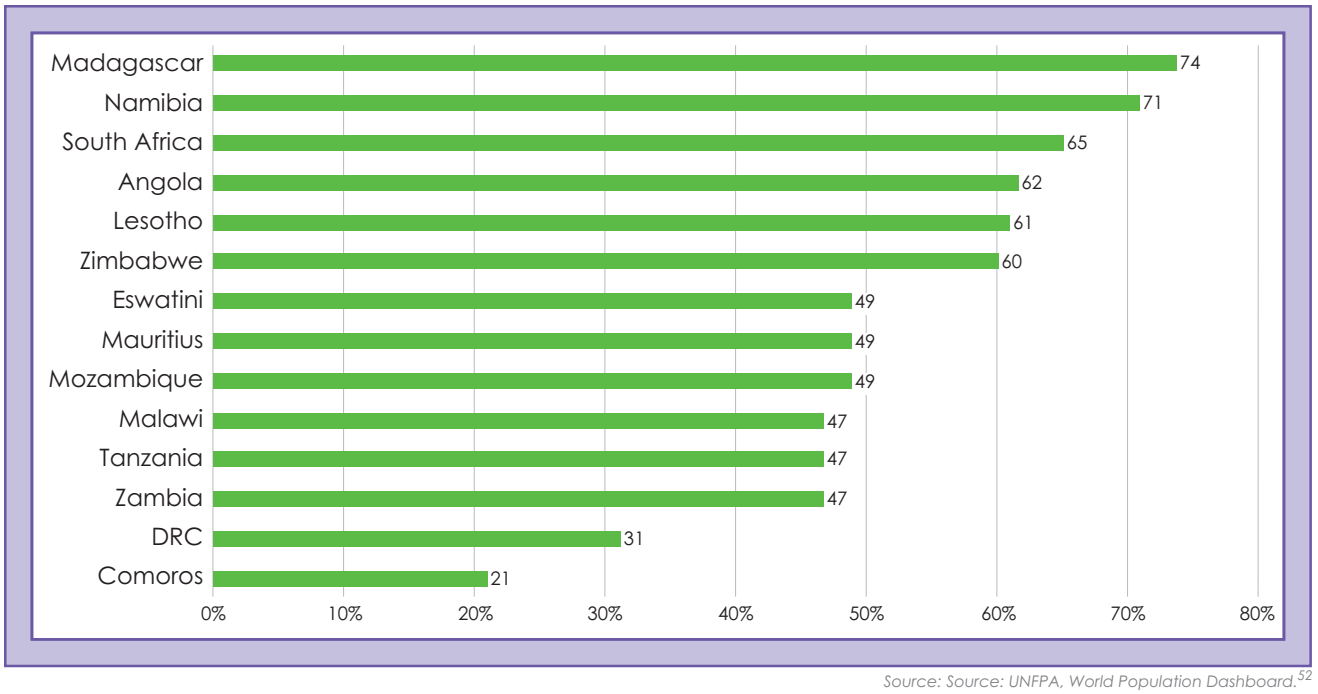
Source: UNFPA, Eswatini SMS service helps women access family planning, food amid pandemic, 30 July 2020[51]

[51] https://www.unfpa.org/news/eswatini-sms-service-helps-women-access-family-planning-food-amid-pandemic accessed 16 July 2021

Female decision making on SRHR

Overall, the right to bodily autonomy and women's right to make decision about their own bodies is remarkably low throughout SADC.

Figure 2.6:Female decision making on SRHR 2021



Source: Source: UNFPA, World Population Dashboard.[52]

Figure 2.6 shows that there is no country in which all women have control over decision-making on SRHR. Madagascar has the highest proportion of women involved in decision-making on SRHR at 74%, followed by Namibia (71%), South Africa (65%), Angola (62%), Lesotho (61%) and Zimbabwe (60%). In eight countries less than 50% of women are involved in decision-making on SRHR, with DRC and Comoros well below 50% at 31% and 21% respectively.

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, appropriate and affordable quality health care, in particular, to:

SDG 3.1: By 2030, Reduce maternal mortality to fewer than 70 deaths per 100 000 live births

[52] https://www.unfpa.org/data/world-population-dashboard Accessed 14 July 2021

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 health refers to the health of women during pregnancy, childbirth and the postnatal period. Each stage should be a positive experience, ensuring women and their babies reach their full potential for health and well-being. Although important progress has been made in the last two decades, about 295 000 women died during and following pregnancy and childbirth in 2017. This number is unacceptably high.[53]

Maternal mortality

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anaemia, malaria, and heart disease. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment.[54]

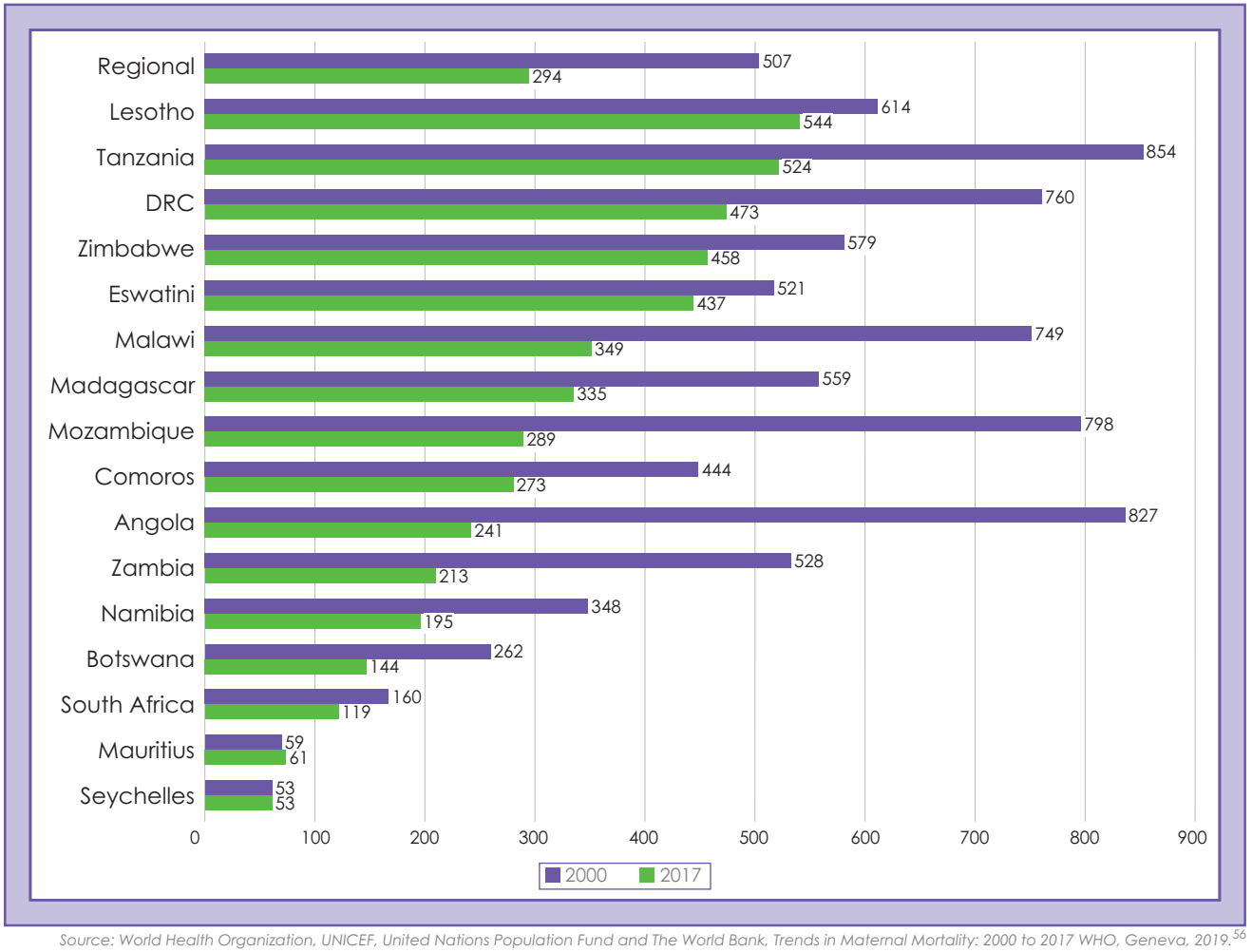
There has been progress globally from 2000 to 2017 by reducing maternal deaths 38% from 342 deaths to 211 deaths per 100,000 live births, which is an average annual rate of reduction of 2.9%. This is less than half the 6.4% annual rate needed to achieve the Sustainable Development global goal of 70 maternal deaths per 100,000 live births.[55] But MMR stills remain high in many parts of the world.

Most countries in Southern Africa are still far from reaching the SDG target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births by 2030.

Health professionals in Botswana are committed to saving the lives of women. Photo: Gender Links

[53] https://www.who.int/health-topics/maternal-health#tab=tab_1
[54] Ibid
[55] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 14 July 2021

Figure2.7: MMR per 100,000 in SADC 2000-2017



Source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 2000 to 2017 WHO, Geneva, 2019.[56]

Figure 2.8 shows that just two SADC countries, Seychelles and Mauritius have met SDG Target 3.1 of reducing maternal mortality to fewer than 70 deaths per 100 000 live births. Lesotho has the highest MMR with 544 deaths per 100 000 live births. Eleven countries have a MMR in excess of 200 deaths per 100 000 live births.

However, comparative figures from 2000 show tremendous progress. Overall, the regional average has improved from 507 to 294 deaths per 100,000 over the last 17 years. All countries except Seychelles and Mauritius have experienced a reduction. This is most pronounced in Angola (from 827 to 141 deaths per 100,000) and Mozambique (from 798 to 189 per 100,000).

Global progress has been made from 2000 to 2017 by reducing maternal deaths by 38%

[56] https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 12 July 2021

Table 2.4: Rate of MMR decrease in SADC 2000-2017

Country	2000	2017	Decrease	% decrease	Decrease/year		Reduction needed to achieve SDG 3.1 of 70 by 2030
Lesotho	614	544	70	11%	4	1%	474
Tanzania	854	524	330	39%	19	2%	454
DRC	760	473	287	38%	17	2%	403
Zimbabwe	579	458	121	21%	7	1%	388
Eswatini	521	437	84	16%	5	1%	367
Malawi	749	349	400	53%	24	3%	279
Madagascar	559	335	224	40%	13	2%	265
Region	507	294	213	42%	13	2%	224
Mozambique	798	289	509	64%	30	4%	219
Comoros	444	273	171	39%	10	2%	203
Angola	827	241	586	71%	34	4%	171
Zambia	528	213	315	40%	19	4%	143
Namibia	348	195	153	44%	9	3%	125
Botswana	262	144	118	45%	7	3%	74
South Africa	160	119	41	26%	2	2%	49
Seychelles	53	53	0		0	0%	Met
Mauritius	59	61	-2		0	0%	Met

Source: World Health Organization, UNICEF, United Nations Population Fund and The World Bank, Trends in Maternal Mortality: 2000 to 2017 WHO, Geneva, 2019.[57]

Table 2.4 shows the progress that has been made in SADC countries over the last seventeen year and how far they still have to go to reach SDG Target 3.1. Overall, the MMR in SADC has decreased by 42%, over 17 years. At this rate (a decrease of 13 deaths every year) it will take the region 17 years to achieve the target of 70 deaths per 100 000 live births. With just nine years to go to 2030, countries will need to bolster their efforts to reduce maternal mortality. Lesotho, Tanzania, and DRC face the greatest challenge. Namibia, Botswana and South Africa are within reach of this goal.

Access to maternal health services

Table 2.5: Antenatal care coverage rural and urban

Country	Year	ANC at least one visit			ANC at least four visits		
		National	Area		National	Area	
			Rural	Urban		Rural	Urban
Angola	2016	82	63	92	61	39	74
Botswana	2007	94	94	94	73	70	76
Comoros	2012	92	91	95	49	49	50
DRC	2018	82	77	90	43	38	51
Eswatini	2014	99	98	99	76	74	82
Lesotho	2018	91	91	92	77	74	80
Madagascar	2018	85	84	92	51	47	66
Malawi	2017	98	98	98	51	49	59
Mozambique	2018	94	93	97	51	45	65
Namibia	2013	97	97	97	63	61	64
South Africa	2016	94	96	92	76	80	73
Tanzania	2017	98	97	99	62	57	76
Zambia	2019	97	96	99	64	65	61
Zimbabwe	2019	93	92	96	72	73	68

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[58]

[57] https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 12 July 2021
[58] https://data.unicef.org/topic/maternal-health/newborn-care/ accessed 16 July 2021

Table 2.5 shows antenatal coverage in SADC at the national and rural and urban areas. No country in the region has all women being attended at least once during pregnancy by skilled health personnel. Angola has the lowest proportion of mothers having at least one visit to skilled health worker, with 82% of pregnant women having access to this health service. Eswatini has the highest proportion of women attending at least one visit. The table shows that in most countries women in rural areas have less access than those residing in urban areas.

A much lower proportion of women have at least four antenatal visits. It is encouraging to see that in five countries (Botswana, Lesotho, Eswatini, South Africa and Zimbabwe) over 70% of pregnant women have at least four antenatal visits. In almost all countries the urban/rural divide is bigger, partly as a result of access to clinics and the distances that pregnant women have to travel to get to them.

The WHO Pulse Surveys on the continuity of health services during the COVID-19 pandemic, found in the first survey (July to August 2020) that antenatal and especially delivery care services were rarely severely disrupted during the pandemic. However, 53% of countries reported partial disruptions in antenatal care services and 32% in facility-based birth services.[59] As with family planning services, the countries reporting disruptions decreased in the second survey period January to March 2021 with 39% reporting disruption to antenatal services and 25% in facility-based births.

Table 2.6: Percentage of births delivered by a skilled health personnel[60]

Country	Year	National	Area	
			Rural	Urban
Botswana	2017	100		
Mauritius	2019	100		
Seychelles	2012	99		
South Africa	2016	97	95	98
Malawi	2016	90	89	95
Eswatini	2014	88	86	93
Namibia	2013	88	82	95
Lesotho	2018	87	84	90
Mozambique	2018	87		
Zimbabwe	2019	86	82	94
DRC	2018	85	79	95
Comoros	2012	82	79	92
Zambia	2019	80	73	93
Tanzania	2016	64	55	87
Angola	2016	50	21	68
Madagascar	2018	46	40	72

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[61]

Table 2.6 shows that only in Mauritius and Botswana do all women have access to skilled birth attendants during delivery. Angola (50%) and Madagascar (46%) have exceptionally low proportions of pregnant women with a skilled attendant during delivery. The table shows that as in the cases of other maternal health services the urban/rural divide is marked, highlighting challenges for women in rural areas to access such services.

[59] World Health Organisation, Pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report, 2020
[60] Typically doctor, midwife and/or nurse
[61] https://data.unicef.org/topic/maternal-health/newborn-care/

Table 2.7: Postnatal care coverage per country, national, urban and rural

Country	Year	National	Area	
			Rural	Urban
Eswatini	2014	88	85	94
Lesotho	2018	84	82	87
South Africa	2016	84	81	85
Madagascar	2018	72	70	79
Zambia	2019	70	64	82
Namibia	2013	69	69	69
Zimbabwe	2015	57	53	67
DRC	2018	50	41	63
Comoros	2012	49	46	56
Malawi	2016	42	41	52
Tanzania	2016	34	29	48
Angola	2016	23	12	31

Source: UNICEF global databases, 2021, of antenatal care, based on MICS, DHS and other nationally representative household survey data.[62]

Table 2.7 shows that the proportion of women (age 15-49) who received postnatal care within two days after birth is low, with no country achieving 100% coverage. Coverage of these services ranges from 23% in Angola to 88% in Eswatini. In four countries (Angola, Comoros, Malawi and Tanzania) less than half the women who have given birth receive postnatal care. There is no data for Botswana, Mauritius, Mozambique and Seychelles.

COVID-19 affecting maternal health in DRC

For many women who are pregnant during this time of corona virus this journey in their lives has been uncertain.

Arlette Mali Mungu Bahati, resident of Kinshasa city, is just a month away from the birth of her second child, but her anxiety has remained constant feature of her pregnancy since COVID-19 was reported in the Democratic Republic of Congo (DRC) in March. At one time when Bahati was feverish, she refused seeking medical attention owing to her anxiety and the risk of exposure to COVID-19 in hospitals.

Since March Bahati, who at the time was five months pregnant has witnessed several restrictions, including shutdown of the market where she makes an income from a clothing store. It was inevitable, her shop was located in one of the most frequented places in Kinshasa and government had to enforce social distance, an important protocol of curbing the spread of the virus.

With her livelihood affected, and her anxiety reaching new levels, Bahati says her pregnancy makes her more of prisoner than fulfilled."I have limited my outings because of the coronavirus, I hardly go out anymore for fear of being contaminated," the expectant mother said.

Afraid of being infected, Bahati decided to change hospitals. Her previous hospital located in Gombe municipality in Kinshasa City, the epicentre of Coronavirus, was one of 8 hospitals designated by the government to receive

[62] https://data.unicef.org/topic/maternal-health/newborn-care/

COVID-19 patients. and she could not risk it despite assurances of care against contracting the disease. She could no longer continue to be examined by her usual gynaecologist at Ngaliema Hospital, with whom she had established a good relationship since her last pregnancy. The change is also costing her dearly. She now has to pay $10 per consultation and $20 whenever she requires the attention of a gynaecologist, compared to the free care she received before.

UNFPA celebrating midwives in the time of COVID-19.
Photo courtesy of Junior Mayindu, UNFPA

"At my former hospital, I was very used to my gynaecologist because he understood me better. I could call him at any time in case of discomfort but now I consult a general practitioner doctor just to check the evolution of my health," she said. "If I have to see a gynaecologist, I must pay $20," she said. "It's true that they're all doctors and I trust them, but the problem is that I'm not used to them and have to start all over again. I have a lot of self-restraint and I'm anxious because I don't even know the health status of the doctor who consults me and the nurses who welcomes me, the situation is just complicated, but I trust God, he is in control, I will deliver my baby without complication."

Coronavirus pandemic caught the world unaware, affecting all facets of human lives and motherhood is not spared. Fear, anxiety and uncertainty are disrupting this normally happy period for expectant mothers. Pregnant women are increasingly changing their places of consultation with a large number of them stopping prenatal consultations and care.

Dr. Kabongo Kanyanya Jessy, Head of Programme at AFIA MAMA, a non-governmental organisation (NGO) working on promotion of women's rights and gender in Kinshasa City, noted that pregnancy itself is a period of anxiety for women. COVID-19 has added to the anxiety. He said the government should put in place a policy to take care of pregnant women at this critical time.

"The government should develop a policy for the management not only of COVID-19, but also to consider other associated pathologies and above all to capitalize more on the follow-up of pregnant women because they are much more exposed," he said.

Dr. Mukendi Richard, a gynaecologist at the University Hospital in Lubumbashi added, "to date there is no scientific evidence to indicate that pregnant women are more vulnerable to COVID-19. Pregnancy is, however, accompanied by physical changes, and pregnant women may sometimes be more exposed to viral respiratory infections insofar as there is a physiological decrease in natural immunity during pregnancy to enable the pregnant women to support the father's foreign cells present in the foetus."

Physical distancing is impossible in the management of delivery. Bahati, who is in her third trimester, finds it inconvenient to wear a mask as it prevents her from breathing well - an observation made by many pregnant women. This may account for the decline in prenatal care with more pregnant women reportedly relying on home and traditional care."In fact, we are seeing a significant drop in the number of pregnant women attending public hospitals because of the fear of easily contracting the virus. But also because of the fear of being held in isolation in case of suspicious symptoms or a positive COVID-19 result," Dr. Mukendi said.

By Gabrielle Nina Mitch. This story is part of the GL News Service Gender and COVID-19 series[63]

[63] https://genderlinks.org.za/news/covid-19-affecting-maternal-health-in-drc/ accessed on 8 August, 2021

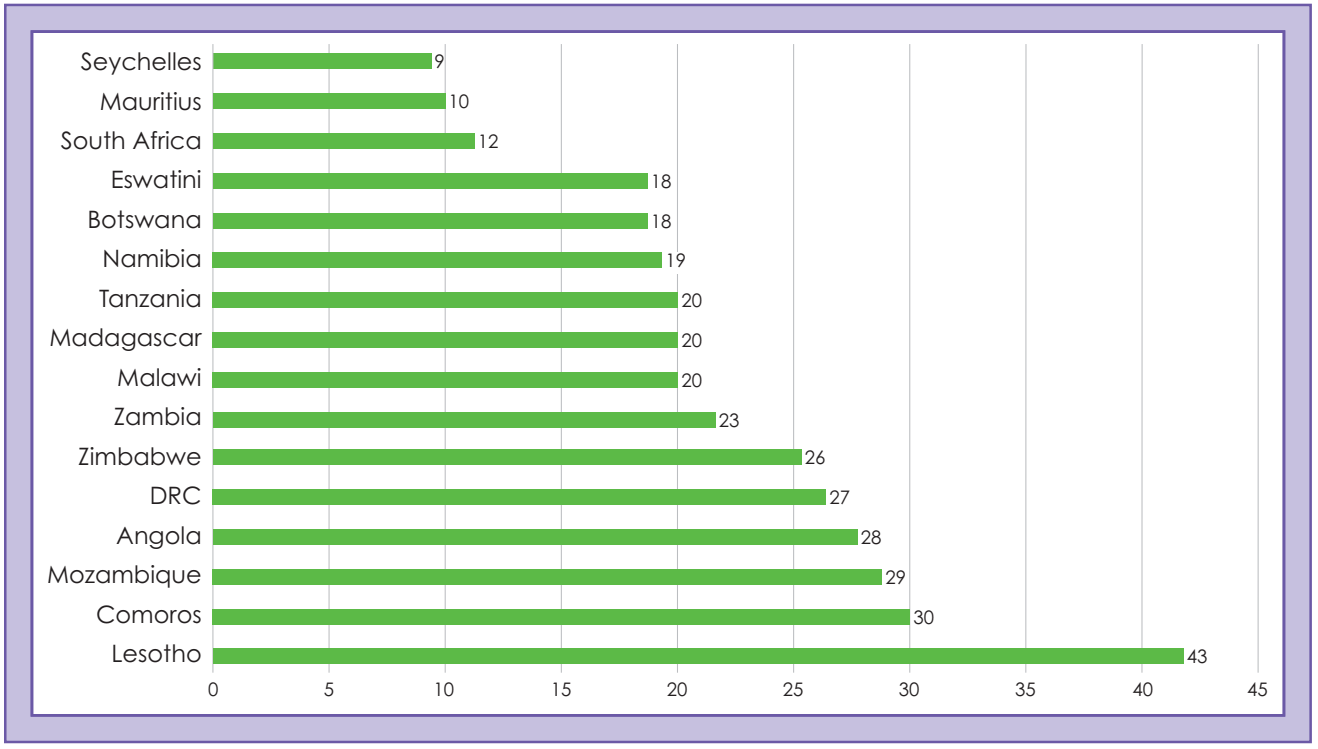
Neonatal mortality

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.[64] About a third of all neonatal deaths occurring within the first day after birth, and close to three-quarters occurring within the first week of life.[65]

SDG Target 3.2 reads: "by 2030, end preventable deaths of new-borns and children under 5 years of age." All countries aim to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

The first 28 days of life - the neonatal period - is the most vulnerable time for a child's survival. Children face the highest risk of dying in their first month of life at an average global rate of 17 deaths per 1,000 live births in 2019, down by 52 per cent from 37 deaths per 1,000 in 1990,[66] but still short of the SDG target 2.2 of at least 12 deaths per 1,000 live births.

Figure 2.8: Neonatal Mortality Rate per 1,000 by country 2021



Source: Sustainable Development Report 2021, Country profiles.[67]

Figure 2.8 shows that just three SADC countries (Seychelles, Mauritius and South Africa) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 43 deaths per 1,000 live births.

[64] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf
[65] https://data.unicef.org/topic/child-survival/neonatal-mortality/
[66] https://data.unicef.org/topic/child-survival/neonatal-mortality/
[67] https://dashboards.sdgindex.org/profiles accessed 12 July 2021

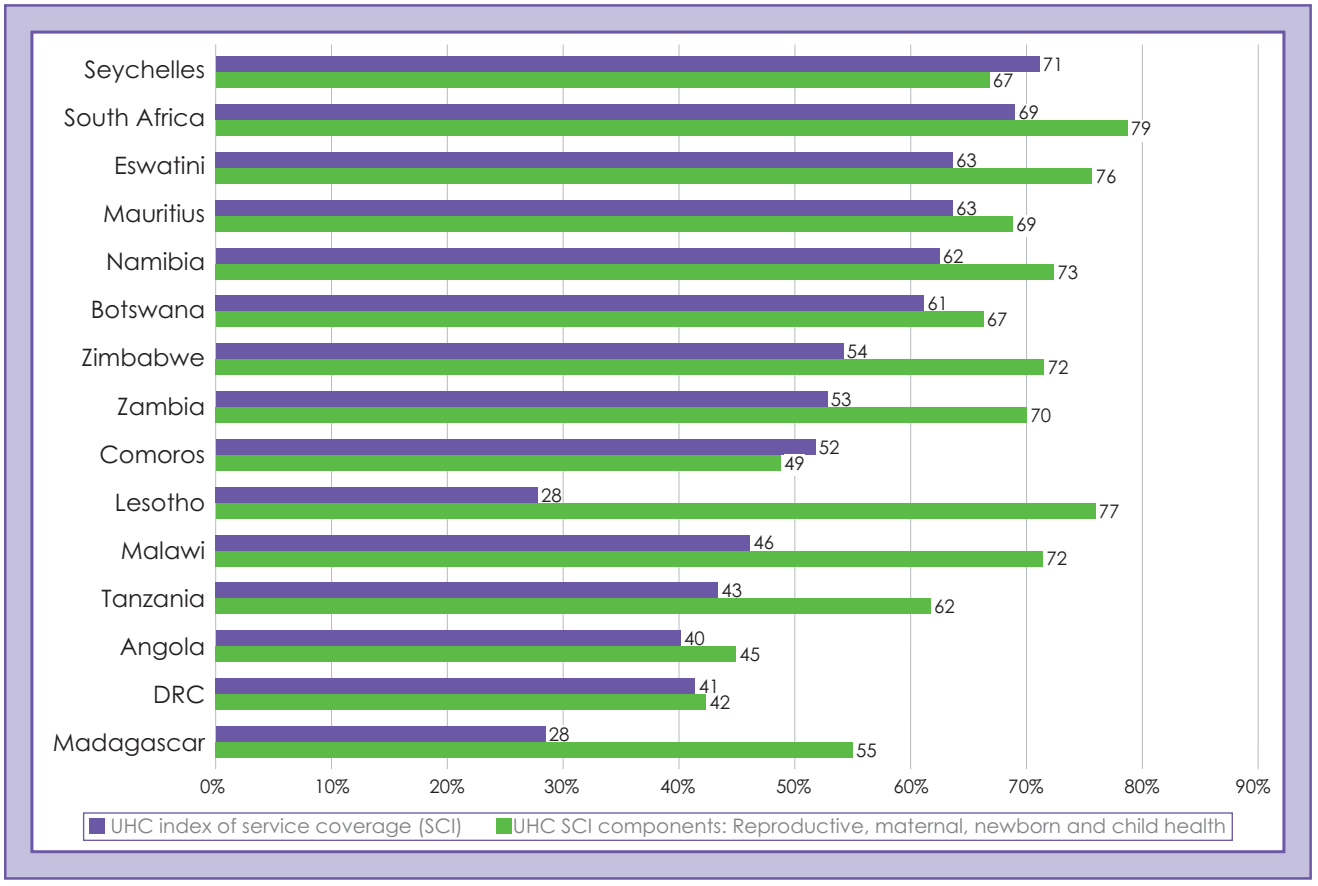
Universal health care (UHC)

SDG 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

According to the WHO "UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."[68] Sexual and reproductive health services are considered essential and are therefore included in this definition.

Currently, at least half of the people in the world do not receive the health services they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health.[69]

Figure 2.10: % population receiving essential health services



Source: WHO, UHC Index of service coverage.[70]

[68] WHO, Fact Sgeet: Universal Health Cobverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021
[69] WHO, Universal health coverage, https://www.who.int/health-topics/universal-health-coverage#tab=tab_1 accessed 13 July 2021
[70] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , accessed 15 July 2021.

Figure 2.9 shows that no country in SADC provides universal health care. Access to essential health services ranges from 71% in Seychelles to 28% in Madagascar. South Africa, Eswatini, Mauritius and Namibia have between 60% and 69% coverage, while Lesotho, Tanzania, Angola, DRC and Madagascar have less than 50% coverage.

It is encouraging that as a component of UHC of service coverage, access to reproductive, maternal, new-born and child health services is higher in than the overall coverage in all countries except Seychelles, with the highest coverage in South Africa (79%) and Lesotho (77%).

Cervical cancer

Human papillomavirus (HPV) is the most common sexually transmitted disease. While it is it usually harmless some types cause long term health problems. HPV is one of the main causes of cervical cancer. Globally there were about 43 million HPV infections in 2018, many among people in their late teens and early 20s. There are vaccines to prevent HPV infection and HPV assays that detect nucleic acids of the virus. WHO has launched a Global Initiative to scale up preventive, screening, and treatment interventions to eliminate cervical cancer as a public health problem during the 21st century.

Cervical cancer continues to be a major public health problem affecting middle-aged women, particularly in less-resourced countries. The global scale-up of HPV vaccination and HPV-based screening has the potential to make cervical cancer a rare disease in the decades to come.[71]

Cervical cancer continues to be a major public health problem affecting middle-aged women

Approximately 570,000 cases of cervical cancer and 311,000 deaths from the disease occurred in 2018: a rate of 13 per 100,000 women globally. This varies widely between countries, with rates ranging from less than 2 to 75 per 100,000 women. Cervical cancer was the leading cause of cancer-related death in women in eastern, western, middle, and southern Africa.

Figure 2.11: Cervical cancer incidence and mortality rates per 100 000 in SADC

Source: The Lancet, Burden of Cervical Cancer Incidence.[72]

Figure 2.10 shows that the incidence of cervical cancer in the SADC region, at 43 per 100,000, is well above the global average of 13 per 100,000, The mortality rate is also high at 20 per 100,000. With approximately 65 per 100 000 women developing cervical cancer before age 75 years, Eswatini has the highest rate of cervical cancer in the region.

SADC countries must start rolling out vaccines as well as conducting education and awareness programmes on HPV, to increase the rate of vaccination. States should consider starting to roll out the vaccines as part of the inoculation regime.

[71] Marc Arbyn, et al. Estimates of incidence and mortality of cervical cancer in 2018: a worldwide analysis, 4 December 2019
[72] https://www.thelancet.com/action/showFullTableHTML?isHtml=true&tableId=tbl1&pii=S2214-109X%2819%2930482-6 , accessed 16 July 2021

Health expenditure analysis

Health expenditure includes all expenditures for the provision of health services, family planning activities, nutrition activities and emergency aid designated for health, but it excludes the provision of drinking water and sanitation. Health financing is a critical component of health systems.

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.[73] Health expenditures are an important indicator of a government's commitment to UHC.

Table 2.8: Health financing analysis in SADC countries

Country	Health expenditure as % of total government expenditure	Health expenditure as % of GDP
Eswatini	16.5	6.5
Malawi	16.7	9.3
South Africa	14.2	8.2
Namibia	13.8	7.9
Tanzania	12.3	3.6
Zambia	11.3	4.9
Madagascar	10.1	4.7
Mauritius	10.0	5.8
Seychelles	9.7	3.9
Botswana	8.8	5.8
Mozambique	8.8	8.1
Comoros	8.6	4.5
Zimbabwe	8.4	4.7
Lesotho	13	9.2
DRC	11	3.3
Angola	5	2.5

Source: World Bank Data, World Development Indicators.[74]

Table 2.8 shows that only Eswatini and Malawi meet the recommended Abuja Declaration Goal of 15% of states annual budget to improve the health sector.[75] South Africa comes close with 14.2%. Namibia, Tanzania, Zambia, Madagascar and Mauritius spend between 10% and 14% on health. All other countries spend less than 10% of their GDP on health. DRC and Angola spend the least on health at 11% and 5% of total government expenditure. This poses a regional challenge to realising SRHR and achieving universal health coverage.

[73] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038
[74] https://databank.worldbank.org/data/source/world-development-indicators#. Accessed 15 July 2020
[75] WHO, Abuja Declaration - Ten years on https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf

Next steps

If states are to reach the targets set in the SADC gender Protocol and the SDGs they will need to takes steps to improve the SRHR of their populations including:

- **Updating guidelines and policies** - Of the 14 SADC countries that have either stand-alone SRHR policies or SRHR guidelines ten countries adopted these between 2001 to 2015. These policies need to be updated to align with international standards on SRHR. Angola and the DRC should prioritise developing stand-alone SRHR policies or guidelines. Policies must include responses to health emergencies.
- **Focus on maternal health care** - Maternal mortality remains unacceptably high in region, while progress has been made, in order to reduce maternal mortality to 70 deaths per 100,000 governments need to spend more on maternal health, including to improves access to antenatal care, to a skilled health care professional for delivery and postnatal care. Women in rural areas should be prioritised.
- **Addressing period poverty** - Governments should scrap VAT on menstrual products and provide free sanitary ware in schools, especially in rural areas.
- **Prioritising investment in clean water and sanitation** to ensure that they meet SDG targets 6.1 and 6.2 of achieving universal access to water and sanitation by 2030 states. Rural areas should be a priority. The government states should raise public awareness on sanitation, including building the capacity of community-led sanitation coverage.
- **Reducing women's unmet need for contraception** which is higher than the global average of 10% governments should work with civil society and suppliers to ensure that every woman who has a need for contraception has that need met.
- **Providing sex disaggregated data** Without sex disaggregated data we cannot understand the differential impact of the pandemic on women and men and ensure fair and equal access to vaccinations and treatment for all
  - There is a dire lack of country data on COVID pandemic from testing through to vaccination. States should collect and disaggregate data on who is being tested, confirmed cases, hospitalisation, ICU admissions, deaths and importantly vaccinations.
  - There is currently no country data on the impact of the pandemic on women's SRHR. States should prioritise collecting this data so that response strategies and programmes address the needs of the most vulnerable.
- **Strategies to reduce cervical cancer** in line with WHO initiative, states must start rolling out HPV vaccines as well as conducting education and awareness programmes on HPV, to increase the rate of vaccination, and should consider starting to roll out the vaccines as part of the inoculation regime.