Menstrual Health, Family Planning and Maternal Health

2



Women demonstrate contraceptive methods in Madagascar. Photo: Zoto Razanadratefa

KEY POINTS

- Five SADC countries have removed VAT from menstrual products and seven now provide menstrual ware in schools, mainly in rural and disadvantaged communities.
- Access to basic sanitation and handwashing facilities remains low in all countries except Mauritius and Seychelles.
- The regional average of the proportion of women of reproductive age with an unmet need for contraception is 19%, which is well above the global average of 9%. The lowest unmet need for contraception is Mauritius (10%) and the highest is 36% in Angola.
- Maternal mortality remains stubbornly high. Only Mauritius and Seychelles have met the SDG target of fewer than 70 deaths per 100,000 live births. DRC has the highest maternal mortality rate with 693 deaths per 100,000 live births.
- Eight countries in SADC have included Human Papillomavirus (HPV) in their national vaccination programme, though coverage varies across countries, from 97% in Seychelles to 53% in Botswana.
- The prevalence rate of cervical cancer per 100,000 women per year attributable to HPV is higher than the Africa average of 26 incidences in all countries except Mauritius.
- Nine SADC countries have national cervical cancer screening programmes. However, this has not necessarily resulted in large scale coverage, which ranges from 3% in Mozambique to 53% of women in South Africa ever being screened for cervical cancer.
- Expenditure on the health sector remains lower than the recommended Abuja Declaration goal of 15% of state's annual budget to improve the health sector in all countries in SADC. Namibia has the highest (13.6%) and Zambia the lowest (4.5%) annual expenditure on the health sector.


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RAPE MUST
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NASA
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Introduction

Sexual and reproductive health is a lifetime concern for both women and men, from infancy to old age, though it affects women disproportionately as the bearers and principle carers of children. From adolescence to old age women have needs for menstrual health and hygiene, contraception and family planning, antenatal, safe delivery care, post-natal care, services to prevent sexually transmitted infections including HPV, and services facilitating early diagnosis and treatment of reproductive health illnesses (including breast and cervical cancer).[1]

As far back as the International Conference on Population and Development (ICPD) in 1994, Sexual and Reproductive Health and Rights (SRHR) has been recognised as integral to human rights and dignity of women central to development. At the global level there has been remarkable progress. There has been a 25% increase in global contraceptive prevalence rate around the world. Adolescent births have declined steeply, and the global maternal mortality ratio has fallen. But progress has been slow and uneven. Hundreds of millions of women around the world are still not using modern contraceptives to prevent unwanted pregnancies, and global targets on reducing maternal and neonatal deaths have not been met.[2]

States re-recommitted themselves to advancing SRHR through the Sustainable Development Goals (SDGs) adopted in 2015 with a deadline of 2030. SRHR is comprehensively covered in three SDGs with eight indicators - SDG 3 Ensure healthy lives and promote well-being for all at all ages; SDG 5 Achieve gender equality and empower all women and girls and SDG 6 Ensure availability and sustainable management of water and sanitation for all.

At the regional level SADC heads of State adopted the SADC SRHR Strategy and Scorecard



Women on the Cape Flats sew reusable pads with the support of New Heritage, a Women Voice and Leadership grantee. Photo: Colleen Lowe Morna

2019-2030 aligned with the SDGs. SADC released the first milestone report in November 2021 reflecting progress and regression across 20 SRHR indicators. While there has been some progress, the region continues to shift the needle on SRH. Positive trends include the percentage reduction in new HIV and AIDS infections; Mother to Child Transmission Rate; Adolescents birth rate, as well as in the indicators related to comprehensive sexuality education and life skills. However, progress in other critical areas such as maternal and neonatal mortality, and women's unmet need for contraception has been slow. Budget resource allocations remain stagnant.

This chapter measures progress towards achieving women's SRHR using 20 indicators related to menstrual health, family planning and maternal health. The chapter shows that progress towards achieving the goals set out in the SDGs and SADC SRHR scorecard is not linear and that even where progress has been made there is always the danger of regression if states are not vigilant and fully committed to achieving the goals. Where states have regressed it is important to interrogate and understand the causes and to adopt new strategies that address the continued and new barriers to the realisation of SRHR.

[1] UNFPA, Sexual and reproductive health, https://www.unfpa.org/sexual-reproductive-health , accessed 3 September 2022.
[2] UNFPA, International Conference on Population and Development, https://www.unfpa.org/icpd , accessed 10 September 2022.

Table 2.1: SRH indicators in 2022

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Existence of SRHR policies/guidelines	No	Guide-lines	Yes	No	2013 Policy	2008 Policy	2017 Policy	2009 Policy	2007 Policy	2011 Policy	2001 Policy	2012 Policy	2019 Policy	2011 - 2015 Guide-lines	2008 Policy	2010 - 2015 Policy
Provision of free menstrual products in schools	No	Yes	No	No	No	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes
Removal of Value Added Tax (VAT) on menstrual products	No	No	No	No	No	Yes	No	No	Yes	No	Yes	Yes	**Yes**	No	No	Yes
Access to at least basic sanitation (%)[3] (2017 figures)	52 (50)	80 (77)	36	**15 (17)**	64 (62)	50 (45)	12 (11)	27 (26)	96	37 (32)	35 (35)	100	78 (76)	32 (29)	32 (31)	**35 (37)**
Access to basic handwashing facilities[4]	27	No data	16	19	24	6	27	8	No data	12	45	No data	44	48	18	42
Contraceptive preva-lence rate amongst all women aged 15-49 (%) any method[5]	16	57	20	26 (23)	54	**52 (53)**	42 (41)	49 (48)	43	27 (26)	52	No data	51 (50)	37 (36)	38 (37)	49
% women of reproductive age with unmet need for family planning[6]	36	17	32	28	15	18	19	16	10	22	12	No data	19	22	20	10
Females involved in decision-making for contraceptive use amongst women aged 15-49 (%)[7]	62	52	21	31	49	61	74	47	No data	49	71	No data	65	47	49	60
Age of access to contraception	16	12	TBA	18	15	No age stipu-lated	12	16	16	16	12	15	12	12	16	16
Maternal Mortality Ratio (per 100,000)[8] (2019 baseline)	**288 (241)**	**166 (143)**	172	693 (846)	452	618	335 (478)	349 (439)	61	**452 (408)**	385	**65 (62)**	121	556	252	462 (651)

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Antenatal Care Visits (At least one visit) %[9]	82	94	92	82	99	**92 (95)**	85 (82)	**97 (98)**	No data	94 (87)	97	No data	94	98	97	93
Antenatal Care Visits (At least four visits) %[10]	61	73	49	43	76	77	51	51	No data	51	63	No data	76	62	64	72 (76)
Births attended by skilled health staff (% of total)[11]	50	100	82	80	88	87 (78)	46 (44)	90	100	73 (54)	88	99	97	64	80	86 (78)
Postnatal care coverage %[12]	23	No data	49	50 (44)	88	84 (62)	72	84 (42)	No data	No data	69	No data	84	34	70 (54)	82 (57)
Neonatal mortality (per 1 000)[13] (2019 baseline)	24 (29)	18 (25)	24	27 (28)	20	34	20 (26)	20 (27)	**10 (9)**	29 (30)	20	9	21	25	27	31 (29)
Nursing and midwifery personnel per 10 000 of the population[14]	4	54	15 (6)	11	**25 (41)**	33	3	7 (4)	39 (35)	5	20	98	50 (39)	6	10	21 (19)
Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 13	No data	53	No data	No data	No data	No data	No data	89	74	No data	No data	97	63	59	60	96
Universal Health Coverage index (0 worst - 100 best)[15]	39	54	44	39	58	48	35	48	65	47	62	70	67	46	55	55
Health expenditure as proportion of GDP[16]	2,5	6 (5,8)	5,1 (4,5)	3,5 (3,3)	6,8 (6,5)	11,2 (9,2)	**3,7 (4,7)**	**7,4 (9,3)**	6,2 (5,8)	**7,9 (8,1)**	8,5 (8)	5,1 (3,9)	9,1 (8,2)	3,8 (3,6)	5,3 (4,9)	7,7 (4,7)
% annual budget allocated to health sector[17] (2019 baseline)	5,6 (2,9)	12,5 (16,2)	12 (10)	11,4 (11)	9,4	9,5 (13)	8	9,3 (10)	5,5	8,7	13,6 (14)	11,7	8,1	6,7 (10)	4,5 (8,9)	10 (10,7)

[3] https://data.worldbank.org/indicator/SH.STA.BASS.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ (2020 data), accessed 26 August 2022
[4] https://data.worldbank.org/indicator/SH.STA.HYGN.ZS?end=2020&locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ&start=2000 accessed 31 August 2022
[5] UNFPA, World Population Dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 29 August 2022
[6] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
[7] World Bank data - https://www.unfpa.org/data/world-population-dashboard, accessed 29 August 2022
[8] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/ , accessed 31 August 2022
[9] UNICEF, Maternal and Newborn health coverage database, https://data.unicef.org/topic/maternal-health/antenatal-care/ , Data as of May 2022, accessed 29 August 2022
[10] Ibid
[11] Ibid
[12] Ibid
[13] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
[14] 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 30 August 2022
[15] WHO indicators, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , accessed 29 August 2022
[16] World Bank, World Development Indicators, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ accesses 30 August 2022
[17] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022

Note about data

We have attempted to collect the most up to date data, however not all the indicators have updated 2022 data, and in some cases there is data missing for specific countries. Where we have been able to find updated data we have presented the last figure in brackets. Text in red shows regression.

SADC launched its first milestone scorecard with 2021 data. We have used data from the scorecard for the following indicators in this chapter:

- Maternal Mortality Ratio (per 100,000).
- Neonatal mortality (per 1 000).
- % women of reproductive age with unmet need for family planning.
- Proportion of females who have received the recommended number of doses of the HPV vaccine prior to age 13.
- % annual budget allocated to health sector.

We have triangulated the data with other sources. Discrepancies in data, specifically maternal mortality, will require further investigation.

Table 2.1 shows that:

- Five SADC countries (Lesotho, Mauritius, Namibia, Seychelles, South Africa and Zimbabwe) have now removed VAT on menstrual products. Seven countries (up from five in 2021) provide free sanitary ware in schools, this is up from five countries in 2021. These are: Botswana, Lesotho, Mauritius, Seychelles, South Africa, Zambia and Zimbabwe.
- Just one SADC country, Seychelles, provides basic sanitation to its entire population. All SADC countries except DRC and Zimbabwe have increased access to at least 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. Seven countries (Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe) are above the global average of 49%. All countries maintained or increased contraceptive prevalence, except Lesotho which decreased by one percentage point.
- No SADC country meets the global average for unmet need for family planning of 9%. Angola has the highest unmet need for family planning with 36% of women of reproductive age (15-49 years) having a need for family planning, but not having access to contraception. Mauritius has the lowest unmet need for 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.
- Maternal mortality remains stubbornly high. 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. DRC has the highest MMR with 693 deaths per 100 000 live births. Five other countries (Eswatini, Lesotho Mozambique, Tanzania and Zimbabwe) have more than 400 maternal deaths per 100 000 live births. The figures show that four countries registered an increase in maternal deaths between 2019 and 2021.
- 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. There have been marginal decreases in seven SADC countries and an increase in Mauritius.
- No country in SADC provides universal health care. Access to essential health services ranges from a score of 71 in Seychelles to 35 in Madagascar.
- Government expenditure remains lower than the recommended Abuja Declaration goal of 15% of annual expenditure on the health sector.

This chapter focuses on four key areas of SRHR - menstrual health, family planning and maternal health and cervical cancer - 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.

SRH and the COVID-19 pandemic

SDG Target 3.7 aims to ensure universal access to sexual and reproductive health-care services, including for family planning.

While not as severe as predicted, the COVID-19 pandemic, and the subsequent lockdowns in almost all countries across the globe, had an impact on women's SRHR, especially in low-and middle-income countries. At the beginning of the pandemic measures such as social distancing, lockdown and mobility restrictions, and fear of travelling to health facilities, raised concerns about women's ability to continue using contraception. Disrupted global manufacturing and supply chains and overwhelmed health facilities also threatened to reduce the availability of family planning supplies and services.

However, data from United Nations Population Fund (UNFPA) shows that the disruptions in family planning services were smaller and shorter than initially projected, largely concentrated in April and May 2020. This can be attributed to the resilience of health systems that continued to provide services. Partners also doubled down to support access to reproductive health supplies and services.[18]

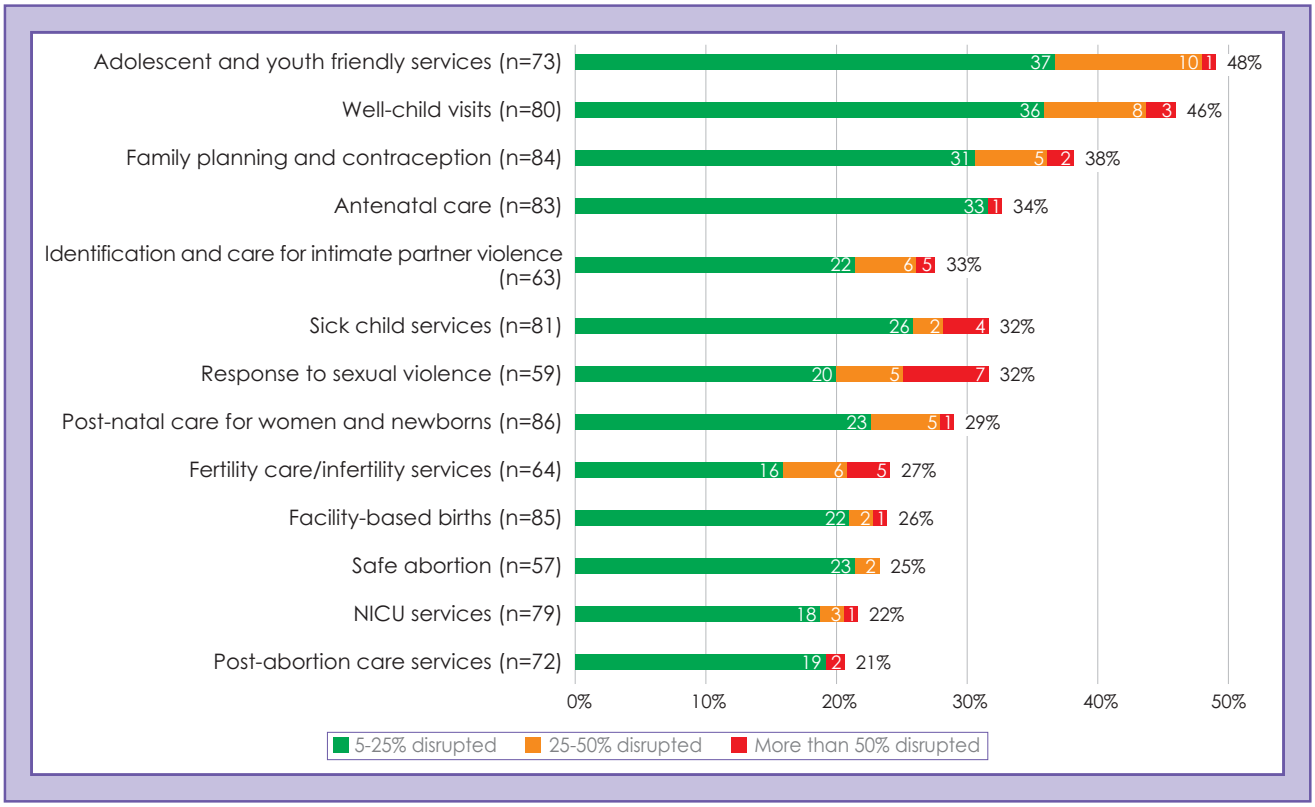
The third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic for the period November to December 2021 shows that despite early evidence of service recovery, nearly all countries are still affected by the COVID-19 pandemic. Of the 129 participating countries 92% report some kind of disruption to services during the preceding six months from the date of survey submission (June-November 2021).[19]

The survey shows that there has been a decrease in service disruptions between Q1 of 2020 and Q4 of 2021. In the first quarter of 2020, over half of the countries surveyed (55%) reported 5-50% disruptions in sexual, reproductive, maternal, new-born, child and adolescent health services. This reduced to 33% in Q4 of 2021.[20]

While not as severe as predicted, the COVID-19 pandemic, and the subsequent lockdowns in almost all countries across the globe, had an impact on women's SRHR

[18] UNFPA Technical Note Impact of COVID-19 on Family Planning: What we know one year into the pandemic
[19] Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November to December 2021, February 2022
[20] Ibid.

Figure 2.1: Percentage of countries reporting disruptions in sexual, reproductive, maternal, newborn, child and adolescent health services in Q4 2021



Source: Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November to December 2021, February 2022.

Figure 2.1. Shows that the most disrupted services were youth friendly services (49%), followed by child visits (46%) and family planning and contraception (38%).

SRHR policy and legislative framework

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.

The vision of the SADC SRHR strategy 2019-2030 is to "ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realise and exercise their SRH

rights, as an integral component of sustainable human development in the SADC region." The strategy is aligned with the SDG, and aims to achieve ten SRHR 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 realisation of SRHR in the region removed (SDGs 5.1 and 5c)."[21]

Southern African Development Community (SADC) Ministers of Health developed a **SADC Scorecard on sexual and reproductive health and rights (SRHR)** in 2018, to track progress on achieving the targets of the SADC SRHR strategy and the SDGs. It is a high-level peer review accountability tool that consists of 20 key indicators that reflect areas for accelerated action if the 10 outcomes of the strategy are to be met. Four of the indicators relate to maternal health, family planning and reproductive cancers. The scorecard also measures proportion of annual budgets allocated to the health sector as well as proportion of population accessing integrated SRH services and the proportion of services within the essential package of SRHR services covered by the public health system Unfortunately there is almost no information on the last two indicators.

SADC countries developed a baseline scorecard in 2019. The milestone scorecards measure progress by countries against the baseline data and show whether the SADC region and Member States are on track to meet the SADC SRHR Strategy and SRHR SDG targets by 2030. Member States report every two years on progress (2021, 2023, 2025, 2027 and 2029).

SADC launched the 2021 Milestone Scorecard in November 2021. The tool is available online and visually presents how states are progressing in achieving the targets by indicating upward or downward movement and by colour coding to show where targets or milestones have been achieved or not. The scorecard shows country and regional trends over time against the indicators. This will help to inform member states' strategies for reviewing and increasing efforts to achieve the targets.

Status of SRHR policies in SADC

Over the last 20 years 14 of the 16 SADC countries have developed stand-alone SRHR policies or guidelines on SRHR, though many of these are now outdated.

[21] 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
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
Updated/ adopted in the past five years		
Madagascar	Reproductive Health and Family Planning Law	2017
Malawi	National Reproductive Health and Rights Policy	2013-2022
South Africa	National integrated SRHR Policy , ED 1	2019
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		
DRC	Comprehensive Public Health Bill (Including SRHR)	2018
Angola	Included in the Constitution	1975

Source: Audit of SRHR policies and laws, Gender Links (2019), additional online research.

Table 2.2 shows that 14 SADC countries have either stand-alone SRHR laws and policies or SRHR guidelines, however most of these are outdated. Ten countries adopted these five to ten years ago, Madagascar, Malawi and South Africa have SRHR laws and policies less than five years old. Angola and the DRC are the two countries that have no standalone SRHR policy or guidelines.

Role of local government

As the level of government closest to the people, local government is an important entry point for women. Local council offices are geographically closer to communities than national offices. Councillors are more accessible than parliamentarians. In many SADC countries 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 Gender Links (GL) Centres of Excellence for gender in local government is the most far-reaching, systematic and sustained effort to



Local authorities in Zimbabwe Centres of Excellence for Gender in local government have developed progressive messages on meeting SRHR needs.
Photo: Colleen Lowe Morna

promote gender mainstreaming in Local Government in SADC. Over the last decade, GL has worked with 380 local councils in ten countries - Botswana, Eswatini, Lesotho, Madagascar, Mauritius, Mozambique, Namibia, South Africa, Zambia and Zimbabwe. Councils have developed Gender, GBV and SRHR strategies and action plans aligned with the SADC Gender Protocol, which was updated in 2016 in line with the Sustainable Development Goals. Since then many councils have started to develop and implement programmes that directly address women's SRH needs, with increasing focus on vulnerable groups including sex workers.



City of Harare extends SRHR services to all

Walking down the Avenues of Harare at night, one is greeted by a host of sex workers of all ages going about their business. AS in many SADC countries, sex work is illegal in SADC. But the City of Harare has decided not to turn a blind eye on the SRHR needs of any of its residents. The metropole provides multiple SRH services through three dedicated health institutions: Wilkins Hospital, Edith Opperman (Mbare[22]) and the Mbare Clinic (mainly providing SRH services to sex workers).

With support from the Centre for Sexual Health & HIV/AIDS Research (CeSHHAR), the services provided to sex workers include voluntary counselling and testing; treatment of STIs; provision of contraceptives; access to information, and a plethora of SRHR services. "We come here all the time to access services because the health staff here do not stigmatise us compared to other health institutions. We are also free to talk about any issues SRH issues that are affecting us as we have all the confidentiality and privacy we need", said one of the sex workers, who preferred to remain anonymous.

Edith Opperman offers SRH services to adolescents. This includes access to information, access to contraception, and treatment for sexually transmitted infections, and HIV and AIDS testing among other services. Medecins Sans Frontieres (Doctors without Borders) supported the programme from 2015-2020. Between 2019 and 2020 the uptake of contraceptive services by female clients increased from 6.4% to 43%.[23] HIV prevalence among adolescents dropped to 2.3%.

Since the Medecins Sans Frontieres funding came to an end, the City of Harare Health Department has continued providing SRH services at the clinic though at a much lower scale. In addition to the distribution of contraceptives (both female and male condoms) to adolescents, the clinic is popularising the menstrual cup and menstrual pants as alternatives to sanitary pads. These have been readily accepted in the community; however, their uptake has been low.



Health Personnel at Edith Opperman Clinic demonstrating the use of the menstrual cup.
Photo: Tapiwa Zvaraya

Edith Opperman Clinic also serves as a referral centre for sexual gender-based violence (SGBV) cases in Harare. Health practitioners assist survivors of SGBV with the necessary services including provision of pre-exposure prophylaxis (PREP), HIV counselling and testing, and legal advice for those who need to report cases to the police.

Source: By Tapiwa Zvaraya, from a report on a study visit to SRHR services with Amplify Change facilitated by the City of Harare, a COE "hub" in March 2022.

[23] Mbare is one of the oldest suburbs of Harare, the capital city of Zimbabwe.
[24] MSF, https://www.msf.org.za/sites/default/files/2021-08/evaluation_adolescents_sexual_reproductive_health_project_zimbabwe.pdf

Menstrual health

According UNICEF: "Every month, 1.8 billion people across the world menstruate. Millions of these girls, women, transgender men and non-binary persons are unable to manage their menstrual cycle in a dignified, healthy way."[24] Menstrual health is a fundamental right for every girl and woman to live a healthy life during menstruation. Gender inequality, discriminatory social norms, cultural taboos, poverty and lack of basic services like toilets and sanitary products can all cause menstrual health and hygiene needs to go unmet.

Harmful practices and inadequate facilities to help women and girls deal with their periods continue to deny them their rights to health and dignity; limit or exclude them from productive activities such as attending school, going to work and/ or participating in sports and community activities. Many girls and young women do not have easy access to a supply of quality sanitary materials.

The **African Coalition for Menstrual Health Management (ACMHM)**, established at the 2018 African Symposium on Menstrual Health Management reported 'great progress" for menstrual health in Africa in 2021. The Coalition hosted by UNFPA East and Southern Africa Regional Office (ESARO) now has a membership of about 600 organisations and individuals from governments, CSOs, social entrepreneurs, academia, faith leaders and youth from across the continent. Its mission is to advance and sustain a collaborative platform for a diverse range of Africa-based actors working on menstrual health management.

The ACMHM positions MHM as a key development and multi-sectoral issue and work collectively to advance the ACMHM agenda globally. It aims to enhance MHM documentation and knowledge management, as well as research. They also contribute to the development, harmonisation and implementation of MHM products, standards and value chains.

Sanitary products are expensive and taxed in most countries, so many resort to using materials that are ineffective, unhygienic and uncomfortable, such as reusing rags, leaves and other safe methods of menstruation management.

Removing VAT is an important first step towards providing affordable menstrual products and governments can show their commitment to addressing women's menstrual health needs by scrapping value-added tax (VAT) on sanitary products. Providing free sanitary products to all school girls, particularly in rural areas will improve educational performance and advance their overall health. There are a growing number of countries in the SADC region that have removed VAT on sanitary products.



Learners from various school in Windhoek commemorating menstrual Health and Hygiene.
Photo: Gender Links

[24] UNICEF Menstrual Hygiene, https://www.unicef.org/wash/menstrual-hygiene accessed 31 August 2022.

Table 2.3: VAT exempted and free menstrual products in SADC

Country	NO VAT on sanitary ware	Free sanitary ware in schools[25]
Mauritius	Yes (2017)[26]	Yes (2018)[27]
Lesotho	Yes (2019)[28]	Yes (2021)[29]
South Africa	Yes (2019)[30]	Yes (2019)[31]
Zimbabwe	Yes (2020)[32]	Yes (2020)[33]
Namibia	Yes (2021)[34]	No
Seychelles	No	Yes (2022)[35]
Zambia	No	Yes (2019)[36]
Botswana	No	Yes (2017)[37]
Angola	No	No
Comoros	No	No
DRC	No	No
Eswatini	No	No
Madagascar	No	No
Malawi	No	No
Mozambique	No	No
Tanzania	No	No

Source: Constructed by Gender Links from sources in footnotes.

Table 2.3 shows that five SADC countries (Lesotho, Mauritius, Namibia, South Africa and Zimbabwe) have now removed VAT on menstrual products. Seychelles is the latest country to do so. Seven countries (Mauritius, Lesotho, South Africa, Zimbabwe, Zambia, Seychelles and Botswana) provide free sanitary ware in schools.



Belinda Groeneveldt, Principal of Cedar High School, is working with New Heritage on a new pilot project for ASRHR in schools. Photo: Colleen Lowe Morna

[25] Largely of rural schools and indigent populations
[26] The Daily Vox, ,accessed 3 September 2022
[27] Change.org accessed 3 September 2022
[28] Gender Links accessed 3 September 2022
[29] Menstrual Hygiene Day, accessed 3 September 2022
[30] Global Citizen accessed 3 September 2022
[31] Department of Women MH Day speech accessed 3 September 2022
[32] BDO Global accessed 3 September 2022
[33] Fair Planet accessed 3 September 2022
[34] Epf Web accessed 3 September 2022
[35] ZAWYA accessed 3 September 2022
[36] MH Day accessed 3 September 2022
[37] AfricaNews accessed 3 September 2022



Seychelles became the seventh country in SADC to provide free sanitary ware to all school girls at all state and private schools, as well as in professional centres across the island in January 2022. The Government took the decision to launch the national programme following a motion tabled by the Member for the National Assembly for Glacis (also the Chairperson of the Women's Parliamentary Caucus) Regina Esparon. Her intervention before the National Assembly declared menstruation a "normal health related process for women and girls." She called on Government and stakeholders to start discussions on making sanitary products tax free, more affordable and accessible for women and girls.



Zimbabwe allocated USD 12,5 million, starting in January 2020, for the provision of sanitary pads to all adolescent schoolgirls in rural areas. But young women still struggle to access sanitary ware. Young women in schools and communities are leading the cause for improving access to sanitary products.



South Africa: New Heritage Foundation - Western Cape, a Women Voice and Leadership grantee, started its ending period poverty campaign by handing out sanitary pads which was not sustainable. The organisation is now teaching girls how to make reusable sanitary pads and continues with the education around menstruation. In this phase, New Heritage will work with Cedar High School on the Cape Flats in an integrated programme of Adolescent Sexual and Reproductive Health including menstrual health with a view to replicating this programme in other schools. During the Sixteen Days of Activism, New Heritage collaborated with SAWID in the WVL-SA Sixteen Days Period Poverty Dialogue in Cape Town in December 2021. The strong message sent out in the dialogue is that period poverty is a form of gender violence.



Providing sanitary ware to girls in Umguza

Young people constitute close to 60% of the population of the SADC population. They face the most challenges in accessing Sexual Reproductive Health (SRHR) services, sanitary ware being one of them. In rural Zimbabwe, close to 60% of women and girls in rural areas including young girls have no access to sanitaryware largely due to cost.

A packet of pads costs an average of between USD$1.50 to USD$2 despite the fact Zimbabwe has exempted value-added tax on sanitary ware.

This has prompted school girls from Mahlothova Secondary School in Umguza to embark on a reusable sanitary pad production project. Initiated by the School Girls League Club in 2019, the project seeks to provide access to pads to vulnerable girls in the Umguza community. It also aims to reduce incidences of absenteeism which leads to poor academic performance. The Girls League Club consists of approximately 25 young girls both in and out of school who come from diverse backgrounds including being the sole breadwinners in their families.

Core to their activities is the production of reusable sanitary pads. These are largely distributed amongst their peers in school, other out-of-school youths, and women in the community who have no access to these products. This project has seen an improvement in the attendance of girls in school. Some girls are actively participating in extra-curricular activities. As the project grows the Club is starting to enlist boys an indication of a change in mindset.



Umguza students making reusable sanitary pads. Photo: Tapiwa Zvaraya

While their successes have contributed to an improvement in the access to sanitary ware for girls in the school, they have not gone without their challenges which include a turnover in membership, and the soaring cost of materials to produce the sanitary pads. In addition, due to their school commitments, the group barely finds time to make pads regularly which sometimes affects the beneficiaries of the project negatively. By and large, the project has proved to be a sustainable model, more so in other rural communities like Lupane, and Murehwa where such projects are being implemented.

The project seeks to secure more funding and establish an online presence that will not only market their products but also lure prospective sponsors. There is no doubt that the institutionalization of the project has been a beacon of hope for both Mahlothova school and the communities surrounding it.

Source: Gender Links News Service.

Period stigma

Period or menstruation stigma refers broadly to the discrimination people who menstruate face. From physical issues such a lack of access to sanitation supplies, to the verbal shaming of menstruating people as "dirty" or "unclean," period stigma results in a lower quality of life for those who are faced with it. In developing nations, this can be even more harmful.[39]

[39] https://www.verywellmind.com/what-is-period-stigma-5116231



Challenging menstruation stigma and taboos in Malawi

Ulemu Kupakasa wanted to give up her aspiration of being the vice president of the student's union in a higher education institution in Malawi because of the shame, stigma and ridicule she endured. Men said that the first woman candidate for the post could not be Vice President because she menstruates. Students at the university, however, proved the opposing group wrong by voting for Kupakasa as the Vice President of the students union.

This is just one example of how stigma and taboos around menstruation impact on women's participation at all levels of decision-making. Various organisations are trying to tackle this issue in Malawi.

According to Executive Director for the Coalition of Empowerment of Women and Girls (CEWAG), Beatrice Mateyu: "The negative comments are unfortunate in as far as gender equality is concerned because they are deliberately linking one's leadership capabilities to menstruation. With several legal instruments on the table aimed at ending discrimination against women, we should be moving away from looking at leadership qualities based on one's sex. We need to look at qualities and capabilities of the person to lead us neither their sex nor their gender."

CEWAG is implementing several projects targeting adolescent girls in order to demystify stigma that comes with menstruation. "Social stigma in regards to menstruation is a long-standing issue and mostly a woman is looked at as dirty, unclean and impure when menstruating. If you add poverty to it where girls and women do not have proper menstrual facilities, running water and sanitary pads things get worse and the issue of uncleanliness which has been talked about is more physical in nature rather than just imaginary social stigma," says Mateyu.

There is also a need to create dialogue and teach boys and men issues to do with menstruation and gender. "To build a more equal and just society we need to educate men and boys to view monthly periods as a natural process not a weakness or a limitation," she said.

SHRH trainer and champion for Sex Rights Africa Network, James Mamalira says inclusion of women in students' unions matters most because it is one way of mentoring them into leadership in the society adding such comments are more colonised, repugnant and a misleading patriarchal mindset. He bemoans lack of open platforms to discuss menstruation from within families to the entire community and inadequate access to menstrual hygiene products, which force women to resort to rags as some of contributing factors of menstrual induced social stigma.

"Social stigma in regards to menstruation is a long-standing issue..."

Malawi Girls Guide Association (MAGGA), executive director for MAGGA, Mphatso Baluwa Jim says their message is "Let's stop discussing issues to do with menstruation under closed doors as it allows negative myths to proliferate that usually leave girls less confident about their bodies."

Jim adds, "Menstruation is part of being a woman and should not be a taboo subject. Families and communities should create spaces where these issues can be discussed openly and give young women a chance to negotiate safe, hygienic and dignified monthly period hence ending the stigma."

Source: Malawi: End the stigma. Period by Jenipher Changwanda and Ziliro Mchulu. This story is part of the GL News Service.[40]

[40] https://genderlinks.org.za/news/malawi-end-the-stigma-period/

The discrimination faced by someone menstruating comes in a range of forms from joke or the perpetuation of a belief that is not true. From accusations of 'PSM-ing' if a person who menstruates is behaving in a sensitive, sharp, or aggressive manner, politicians claiming that menstruating people do not function well at work.

Addressing period stigma requires normalising menstruation including openly discussing periods without shame and putting in place school and workplace policies that are explicit about women not being separated or discriminated against during their period.

Sanitation and hygiene

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.

The Southern African region represents an area with huge gaps on access to basic water and basic sanitation services. According to the United Nations Children's Fund (UNICEF), more than 70 per cent of the population in Eastern and Southern Africa (340 million people) have no access to basic sanitation services[41].



Kariba REDD+ Project members fetching water from the borehole Hurungwe RDC. Photo: Tapiwa Zvaraya

Safe water, sanitation and hygiene are basic human rights and critical to human health, and welfare, as well as to the economic and social development of communities and nations, yet millions of people across the globe do not have access to these basic services. Women are particularly affected as those who often bear the primary responsibility for collecting water and managing household hygiene. Women are also directly impacted by the lack of adequate sanitation facilities because of their reproductive roles and their complex WASH related needs across their life course.

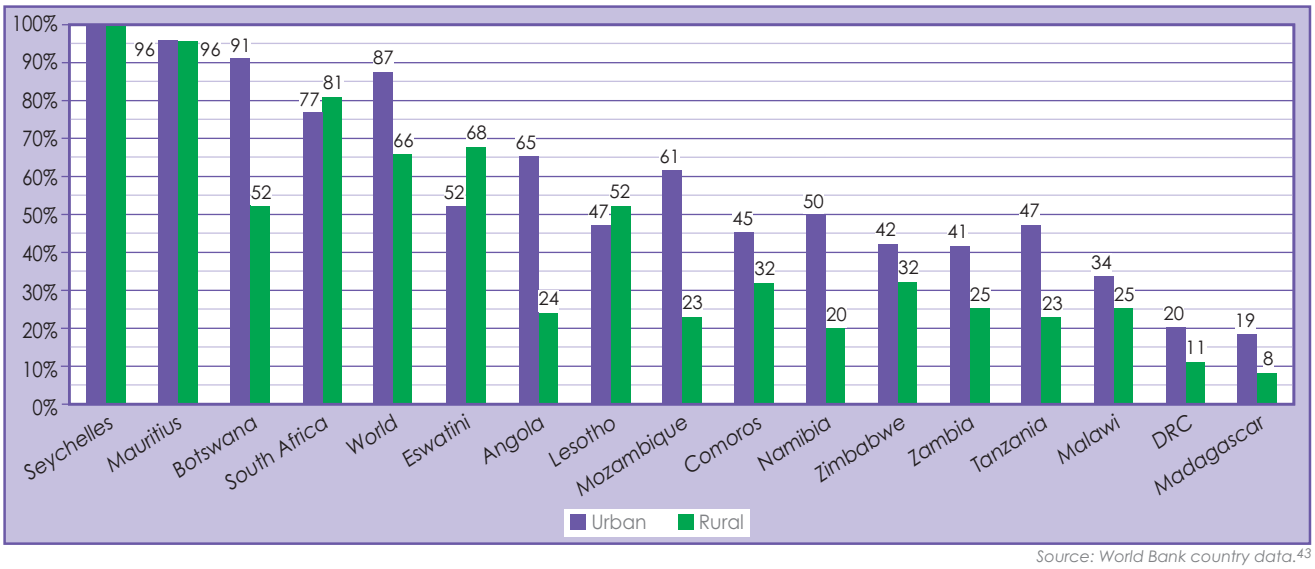
Poor access to WASH facilities also increases women and girls' vulnerability to violence[42]. Harassment, abuse, rape and other forms of violence are very real threats when travelling long distances to access water or latrines or having to use unsafe public facilities.

[41] UNICEF, Sanitation and hygiene. Available at: https://www.unicef.org/esa/sanitation-and-hygiene, accessed: 13 July 2022.
[42] House, S., Suzanne Ferron, Marni Sommer and Sue Cavill (2014) Violence, Gender & WASH: A practioner's toolkit. Making water, sanitation and hygiene safer through improved programming and services, SHARE Consortium, http://violence-wash.lboro.ac.uk/

Access to basic sanitation

There has been progress in increasing access to WASH services in the region, however progress has been sluggish in most countries. While the data is not disaggregated by sex it shows the discrepancies between urban and rural access, where it is predominantly women who are responsible for sourcing and providing water for the household.

Figure 2.2: Proportion using at least basic sanitation services - Urban/Rural



Source: World Bank country data.[43]

Figure 2.2 shows a discrepancy between urban and rural coverage in all countries except Seychelles and Mauritius where there is almost universal access. However, there is a large disparity in access for those living in urban and rural areas, where in most countries rural coverage is lower. In Lesotho, Eswatini and South Africa, on the other hand, those living in rural areas have greater coverage. In ten countries (Botswana, Angola, Mozambique, Comoros, Namibia, Zimbabwe, Zambia, Tanzania, Malawi, Madagascar and DRC) less than half the population living in rural areas have access to at least basic sanitation.

Coverage of sanitation in primary and secondary schools in SADC is patchy. The SADC Hygiene strategy presents data for just four countries - Madagascar, Malawi, Mauritius and Seychelles. Mauritius and Seychelles are the only countries with universal access in both primary and secondary schools. Coverage is lower in Madagascar and Malawi with coverage of 62% and 75% respectively, in primary schools. Coverage is even lower in secondary schools with 52% coverage in Madagascar and 56% in Malawi.[44] States need to address the gaps in access to basic sanitation facilities in schools, especially in secondary schools where adolescent girls require access to sanitation facilities to be able to manage their menstruation in a safe and dignified manner. Lack of access to these facilities prevents adolescent girls from attending school during their period, resulting in them missing up to five days of school per month.

[43] https://data.worldbank.org/indicator/SH.STA.HYGN.ZS
[44] SADC Hygiene Strategy 2021-2025.

Access to hygiene

The World Health Organisation (WHO) estimates that a new-born in low- and middle-income countries dies every minute from infections related to lack of clean water and an unclean environment. Providing adequate water, toilets and hygiene in homes and health facilities help to reduce preventable new-born and maternal deaths due to sepsis and other infections due to unhygienic conditions.[45]

Progress towards the SDG target on hygiene is monitored through indicator 6.2.1b, 'the proportion of the population with handwashing facilities with soap and water at home. Data on access to basic handwashing facilities including soap and water only started being recorded from 2010 and it is not available for all countries or years. The data show that progress has been exceptionally slow, and coverage remains low.

Figure 2.3: Proportion with basic handwashing facilities including soap and water

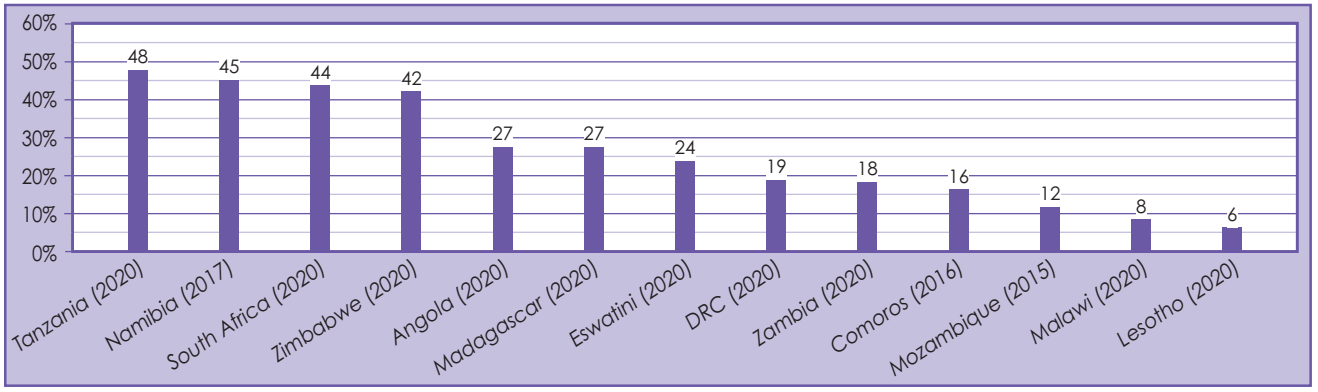


Figure 2.3 shows that with less than half of the population, in the 13 countries for which there is data, having access to these at least basic handwashing facilities including soap. There is no accurate data on the breakdown of access to basic hygiene in urban and rural areas.

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

Access to voluntary family planning and reproductive health (FP/RH) services is vital for safe motherhood and healthy families. Having a choice of modern contraceptives allows couples to plan and space births, ensuring families have the means to properly care for their children.

[45] Ibid.



Male and Female Condoms, Antananarivo, Madagascar.
Photo: Zoto Razanadratefa

Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies. 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 recognised 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.

The proportion of the need for family planning satisfied by modern methods, Sustainable Development Goals (SDG) indicator 3.7.1, has plateaued globally at around 77% from 2015 to 2020. In the Africa region the need for family planning met by modern methods grew from 55% to 58%.[46] Among the 1.9 billion women of reproductive age group (15-49 years) worldwide in 2019, 1.1 billion have a need for family planning; of these, 842 million are using contraceptive methods, and 270 million have an unmet need for contraception.[47]

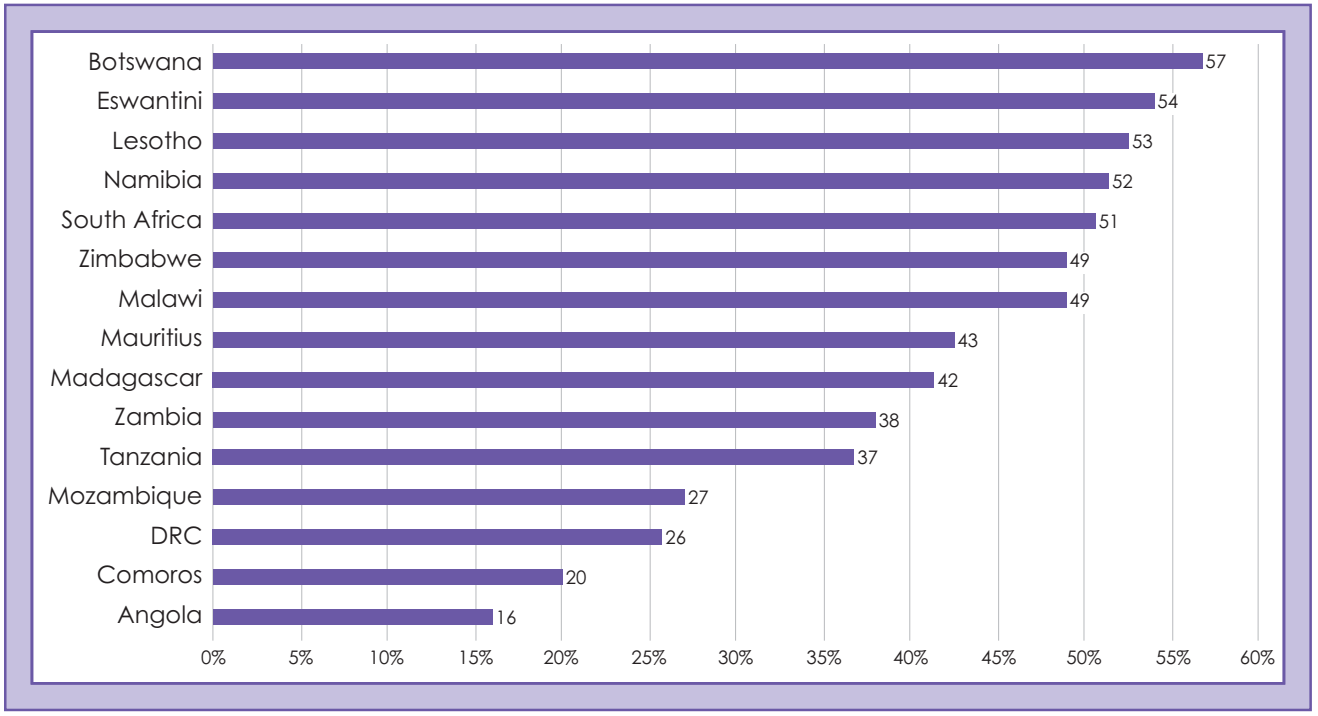
Contraceptive prevalence rates (CPR)

Contraceptive prevalence rate in this report, refers to the percentage of all women[48] 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.[49] In East and Southern Africa the contraceptive prevalence rate is low, with just 35% of all women aged 15-using any method of contraception.[50] This is lower than the global average of 49%.[51]

> Contraception is a lifesaver for women trying to prevent unplanned or unwanted pregnancies

[46] https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception
[47] Ibid
[48] 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.
[49] WHO, Sexual and Reproductive Health, https://www.who.int/reproductivehealth/topics/family_planning/contraceptive_prevalence/en/ accessed 27 July 2021
[50] UNFPA dashboard, https://www.unfpa.org/data/world-population-dashboard, accessed 8 September 2022
[51] https://www.unfpa.org/data/world-population-dashboard, accessed 8 September 2022

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



Source: UNFPA, World Population Dashboard, 2022.[52]

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.

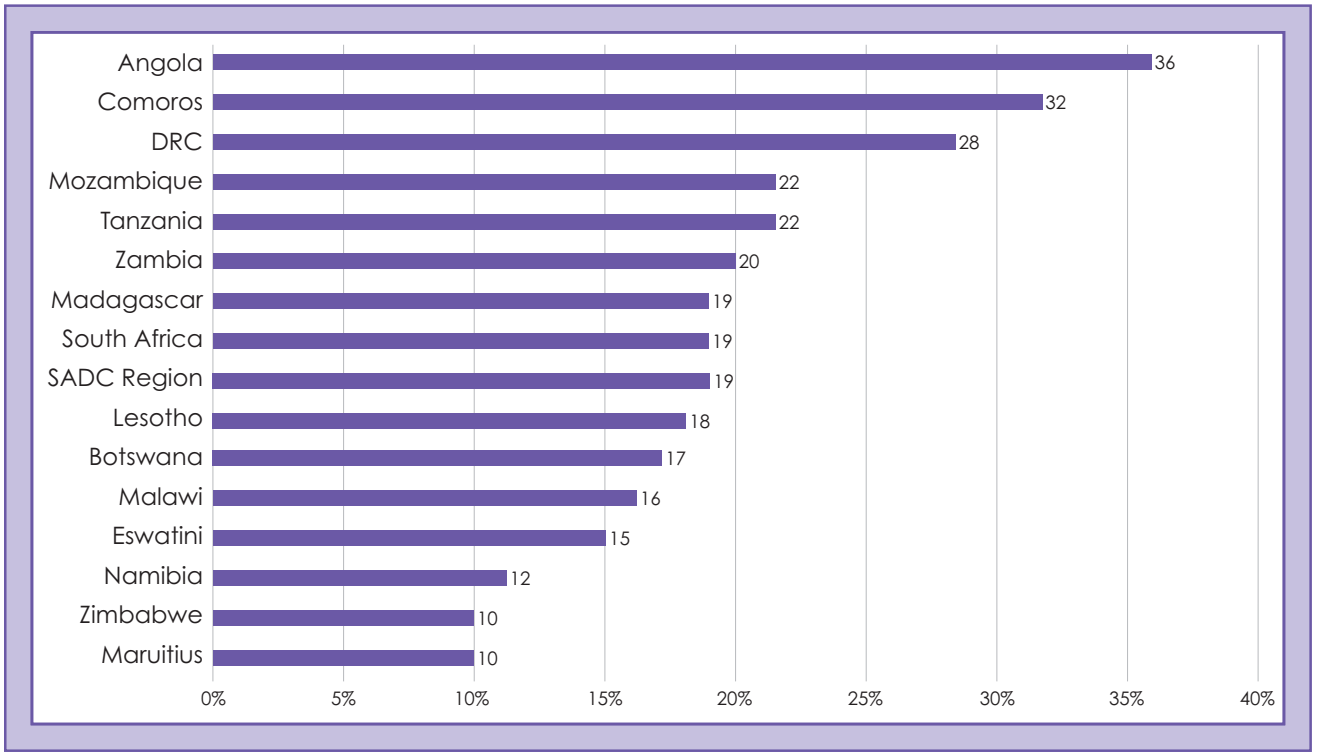
More than one out of every ten married women in the world, and one out of every five women in Africa, have unmet family planning needs. Despite this, studies concerning sub-Saharan Africa as well as the community-level factors that may influence the unmet need for family planning are scarce.[53] One study was conducted using data between 2015 and 2020 to assess factors associated with unmet need for family planning in sub-Saharan Africa.[54]

The study identified individual and community factors. "Women's age, education, age at co-habitation, heard about family planning through media, parity, number of under-five children, and knowledge about modern contraceptive methods were among the individual-level factors that were associated with both the unmet need for spacing and limiting. Place of residence, community level of women illiteracy, and region

[52] https://www.unfpa.org/data/world-population-dashboard accessed 31 August 2022
[53] Teshale AB (2022) Factors associated with unmet need for family planning in sub-Saharan Africa: A multilevel multinomial logistic regression analysis. PLOS ONE 17(2): e0263885. https://doi.org/10.1371/journal.pone.0263885, accessed 9 September 2022
[54] Ibid.

were among the community-level factors that were associated with both unmet needs for spacing and limiting. Household size and visiting the health facility in the last 12 months were associated with unmet need for spacing only and husband education was associated with unmet need for limiting only."[55]

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



Source: SADC SRHR scorecard, 2021.[56]

Figure 2.5 shows the proportion of women who have unmet needs for contraception. Angola has the highest unmet need with 36% of women of reproductive age (15-49 years) having a need for family planning not met. Two countries (Mauritius and Zimbabwe) are below the global average of 10%. Seven countries equal or are less than the SADC average of 19%. These are Madagascar, South Africa, Lesotho, Malawi, Eswatini, Namibia, Zimbabwe and Mauritius.

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

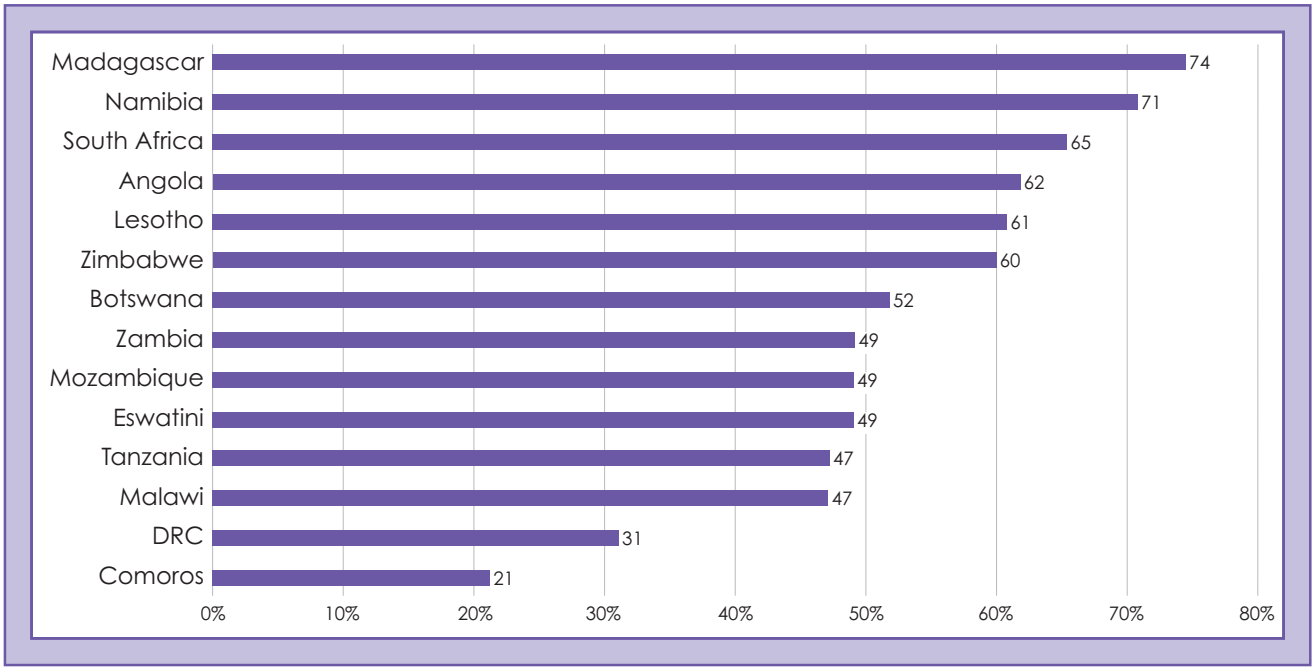
[55] Ibid.
[56] https://dev-www.sadc.int/srhrscorecard/ accessed 31 August 2022

Female decision making on SRHR

SDG Indicator 5.6.1: Proportion of women, aged 15-49 years, who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

Women's right to make decisions about their own bodies is pivotal to gender equality and universal access to sexual and reproductive health and rights in three areas. There are three main considerations for women to be empowered to exercise their reproductive rights - seeking reproductive health care for themselves, contraceptive use, and consensual sexual relations.

Figure 2.6 : Female decision-making on SRHR (%)



Source: UNFPA, World Population Dashboard, 2007-2020.[57]

Figure 2.6 shows that there is no country in which all women have control over decision-making on SRHR. Eight countries are below the global average of 57% and seven below the average for East and Southern Africa of 52%. 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.

[57] https://www.unfpa.org/data/world-population-dashboard Accessed 31 August 2022.

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.

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.

Maternal mortality

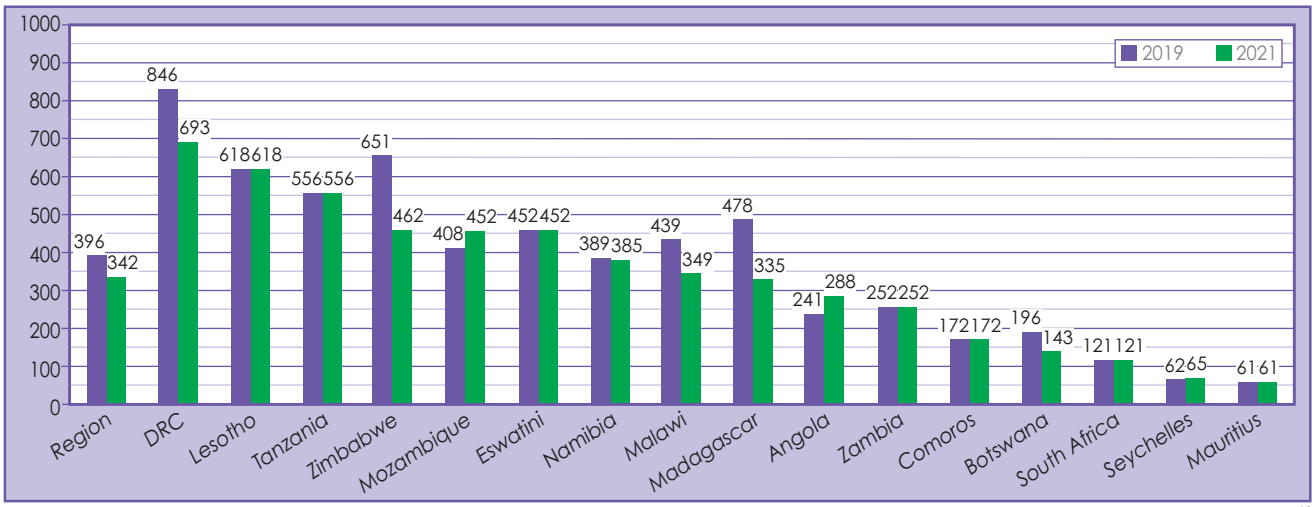
Maternal mortality refers to deaths due to complications from pregnancy or childbirth. Most maternal deaths are preventable with timely management by a skilled health professional working in a supportive environment. The most common direct causes of maternal injury and death are excessive blood loss, infection, high blood pressure, unsafe abortion, and obstructed labour, as well as indirect causes such as anaemia, malaria, and heart disease.[58]

Globally there has been a significant decrease in maternal deaths over the last 20 years. Globally maternal mortality dropped from 342 deaths per 100,000 live births in 2000 to 152 deaths per 100,000 live births in 2020.[59] Low income countries have a significantly higher maternal mortality rate (462 per 100,000) compared to 11 per 100,000 in high income countries.[60]

Most countries in the SADC region are still far from reaching the SDG target 3.1 by 2030. There are a range of factors contributing to this including high unmet need for contraception and early and unintended pregnancies, poor access to maternal health services and standard of care, as well as socio-economic and demographics factors such as geographical location, poverty, age and gender inequality.

[58] Ibid
[59] UNICEF maternal mortality database https://data.unicef.org/topic/maternal-health/maternal-mortality/ accessed 14 July 2021
[60] https://theconversation.com/most-maternal-deaths-are-preventable-how-to-improve-outcomes-in-south-africa-181282#:~:text=The%20past%2020%20years%20have,of%20these%20deaths%20are%20preventable

Figure 2.7: Maternal Mortality ratio per 100,000 deliveries



Source: SADC SRHR Scorecard.[61]

Note: The figures here have been extracted from the SADC SRHR milestone scorecard. It should be noted that some of the figures differ from those published by UNICEF on trends between 2000 and 2017, and in most cases the SADC scorecard figure are higher than those published by UNICEF.

Figure 2.7 shows progress in reducing maternal deaths in SADC since the completion of the SADC SRHR scorecard in 2019 and the first-year milestone 2021. Maternal mortality remains stubbornly high in SADC. The regional average is 396 deaths per 100 000 deliveries. 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. Maternal mortality decreased in DRC and Zimbabwe but increased in Mozambique and Angola. It is not clear if these marked differences are due to real changes, or better data collection. Overall, maternal mortality remains a major concern in the region, as illustrated in the case study that follows from Lesotho.

High rate of maternal mortality a cause for concern[62]



The high rate of maternal mortality particularly among young girls aged between 15-24 due to complications of unwanted pregnancies, often results in them dropping out of school. This is of great concern to UNFPA, the United Nations Population Fund in Lesotho.

UNFPA Lesotho seeks to prevent unwanted pregnancies through contraception, giving women an opportunity to decide when to become pregnant and spacing of their pregnancies. Safe motherhood is the second pillar while the third pillar is, midwifery, particularly skilled midwives who are able to perform life-saving interventions and deal with complications.

UNFPA has supported the Government of Lesotho through the Ministry of Health to change the midwifery curriculum. With the new curriculum training has been upgraded from a 12 months' diploma course to an 18 months post basic diploma.

According to the most recent State of the World's Midwifery report, well-trained midwives could help avert roughly two thirds of all maternal and new-born deaths globally and also deliver 87 per cent of all essential sexual, reproductive, maternal and new-born health services.

[61] https://dev-www.sadc.int/srhrscorecard/ accessed 1 September 2022
[62] UNFPA, https://lesotho.unfpa.org/en/news/high-maternal-mortality-great-concern-unfpa-0

Access to maternal health services

Table 2.5: Provision of antenatal and postnatal care

Country	Antenatal care coverage: at least one visit %	Antenatal care coverage: at least four visits %	Post-natal check-up for mothers %
Angola	82	61	**23**
Botswana	94	73	No data
Comoros	92	**49**	**49**
DRC	82	**43**	**50**
Eswatini	99	76	88
Lesotho	91	77	84
Madagascar	85	51	72
Malawi	97	51	84
Mozambique	94	51	No data
Namibia	97	63	69
South Africa	94	76	84
Tanzania	98	62	34
Zambia	97	64	70
Zimbabwe	93	72	82

Source: Maternal and Newborn Health Coverage Database updated May 2022.

Table 2.5 shows that 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 a skilled health worker, with just 82% of pregnant women having access to this health service. Eswatini has the highest proportion of women attending at least one visit.

A much lower proportion of women have at least four antenatal visits. 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.

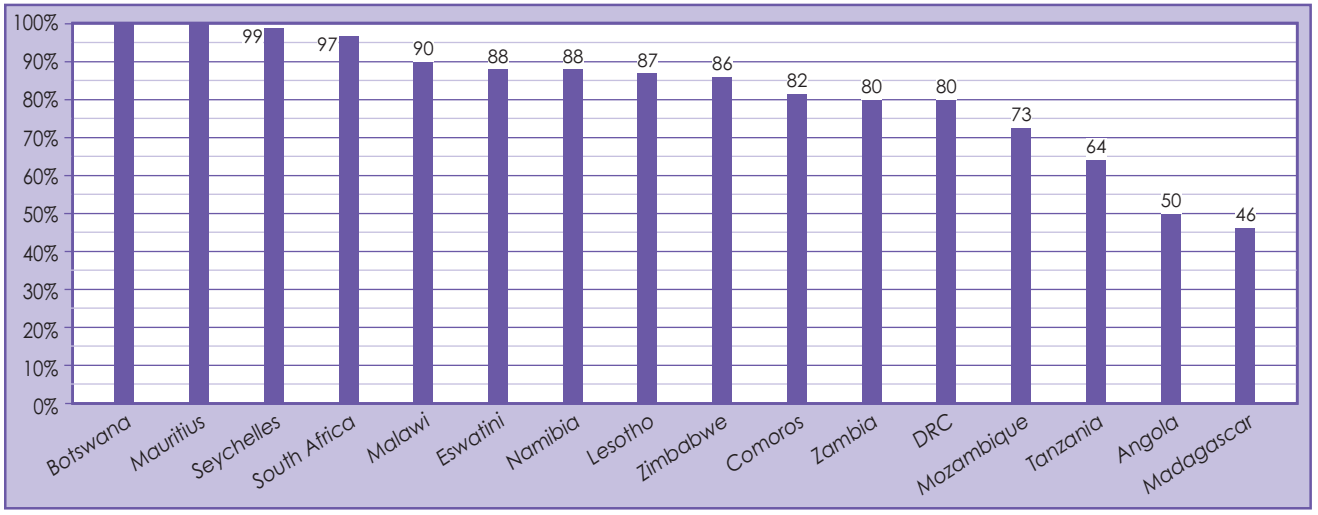


Maternity ward in Befelatanana, Madagascar. Photo: Zoto Razanadratefa

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 and Tanzania) less than half the women who have given birth receive postnatal care.

There is no data for antenatal and postnatal care for Mauritius and Seychelles.

Figure 2.8: Percentage of births delivered by a skilled health personnel (typically doctor, midwife and/or nurse)



Source: Maternal and Newborn Health Coverage Database updated May 2022.[63]

Figure 2.8 shows that only in Mauritius and Botswana do all women have access to skilled birth attendants during delivery. Angola and Madagascar have exceptionally low proportions of pregnant women having a skilled attendant during delivery, with just 50% and 46%, respectively.

Neonatal mortality

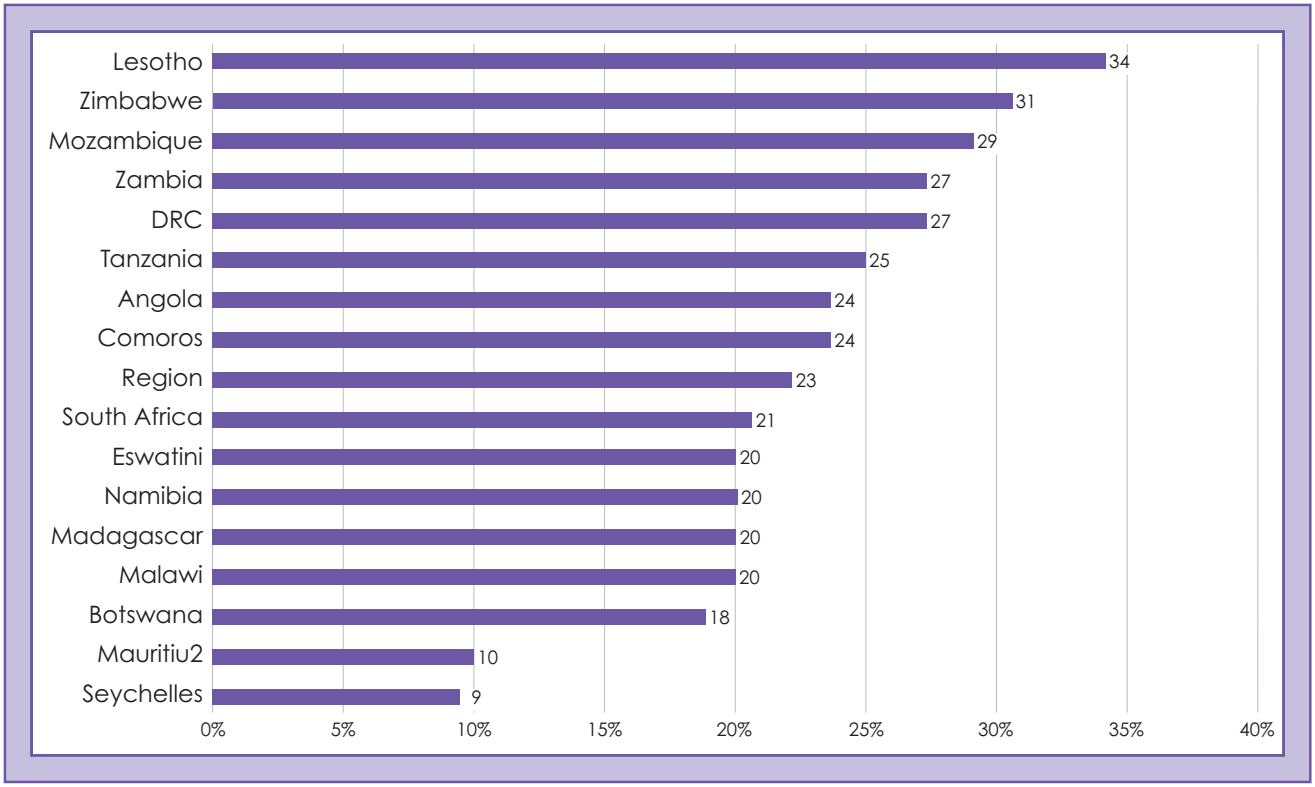
SDG Target 3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

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]

By 2030, end preventable deaths of new-borns and children under 5 years of age

[63] https://data.unicef.org/topic/maternal-health/newborn-care/ , accessed 2 September 2022
[64] https://www.who.int/whosis/whostat2006NeonatalMortalityRate.pdf , accessed 2 September 2022
[65] https://data.unicef.org/topic/child-survival/neonatal-mortality/ , accessed 2 September 2022

Figure 2.9: Neonatal mortality rate per 1000 live births



Source: SADC SRHR Scorecard.[66]

Figure 2.9 shows that the regional average for neonatal deaths is 23 per 1000. Just two SADC countries (Seychelles and Mauritius) have achieved the SDG target 3.2 of 12 deaths per 1,000 live births. Lesotho has the highest neonatal mortality rate with 34 deaths per 1,000 live births.

Human papillomavirus (HPV) and Cervical cancer

Human papillomavirus (HPV) is the most common sexually transmissible infection (STI). In their lifetime, sexually active women and men will be infected at least once without necessarily developing any pathologies. HPV infection is now a well-established cause of cervical cancer. There is growing evidence of HPV being a relevant factor in other anogenital cancers (anus, vulva, vagina and penis) as well as head and neck cancers. More than 42 million people globally are currently infected with HPV types that cause disease.[67]

Risk factors for HPV include a history of tobacco use, lack of condom use at high risk sex and HIV infection. Male circumcision and the use of condoms have shown a significant protective effect against HPV transmission.

HPV types 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide. HPV vaccines that prevent HPV 16 and 18 infections are now available and have the potential to reduce the incidence of cervical and other anogenital cancers[68].

[66] https://dev-www.sadc.int/srhrscorecard/ accessed 2 September 2022
[67] https://www.cdc.gov/hpv/parents/about-hpv.html
[68] Ibid.

Cancer of the cervix uteri is the 4th most common cancer among women worldwide, with an estimated 604,127 new cases and 341,831 deaths in 2020. This is an increase from 570,00 cases and 311,00 deaths: an incidence rate of approximately 13 per 100,000 women. Current estimates indicate that every year 117,316 women are diagnosed with cervical cancer and 76,745 die from the disease in Africa.[69]

The WHO has launched a Global Initiative to scale up preventive, screening, and treatment interventions to eliminate cervical cancer as a public health challenge in the 21st century. WHO Cervical Cancer Elimination Strategy Targets for 2030 include:

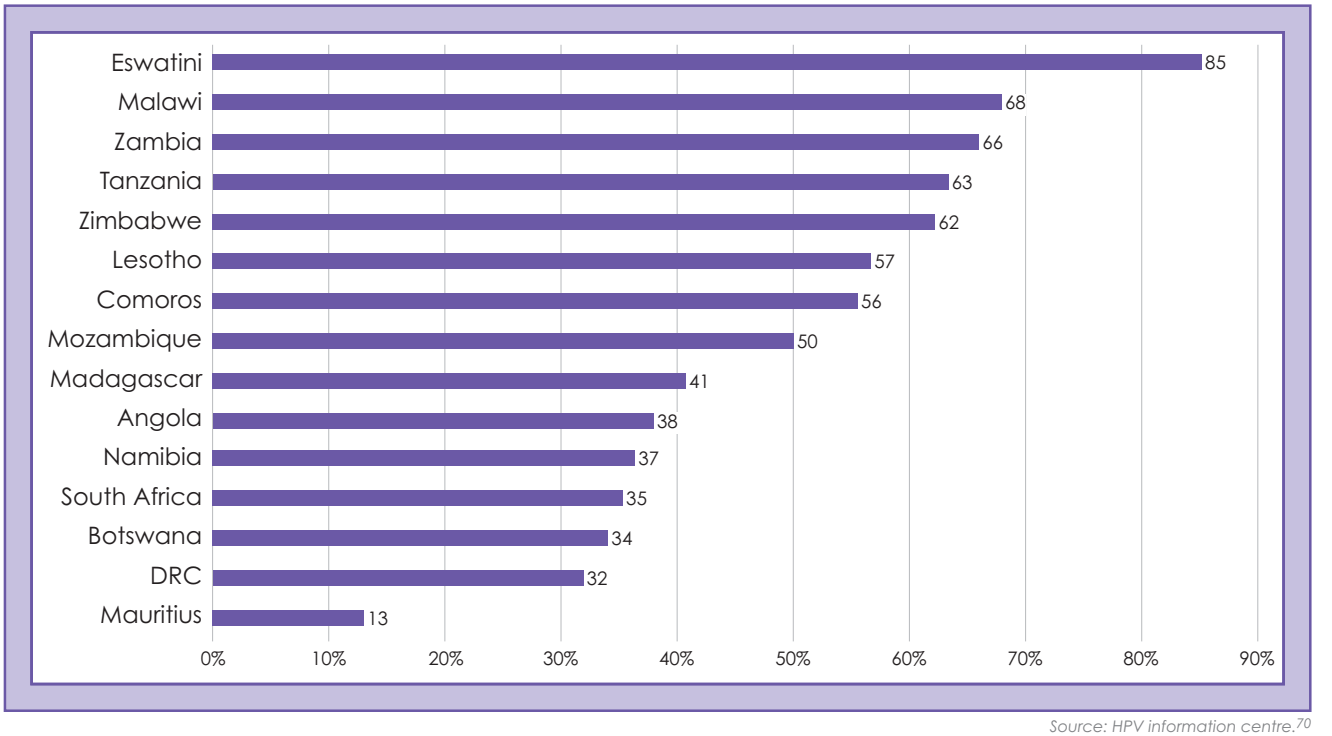
- 90% of girls fully vaccinated with the HPV vaccine by the age of 15.



Primary School girls in Hwange being vaccinated for Human Papiloma Virus (HPV). Photo: Tapiwa Zvaraya

- 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age.
- 90% of women identified with cervical disease receive treatment.

Figure 2.10: Incidence of cervical cancer due to HPV in SADC (2020 estimates)



Source: HPV information centre.[70]

The incidence of cervical cancer attributable to HPV is extremely high in many SADC countries. Figure 2.10 shows that the prevalence rate of cervical cancer per 100,000 women per year, attributable to HPV is higher than the African average of 26 incidences in all countries except

[69] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, G_mez D, Mu_oz J, Bosch FX, de Sanjos_ S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 22 October 2021.

[70] Bruni L, Albero G, Serrano B, Mena M, Collado JJ, G_mez D, Mu_oz J, Bosch FX, de Sanjos_ S. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Africa. Summary Report 22 October 2021.

Mauritius. Of the 10 countries in Africa with the highest cervical cancer prevalence rate seven are in SADC (Eswatini, Malawi, Zambia, Tanzania, Lesotho, Comoros and Mozambique). Mauritius is the only country with a prevalence rate equal to the global average of 13.

Eight SADC countries rate in the top ten of the incidence of cervical cancer cases attributable to HPV. Effective primary (HPV vaccination) and secondary prevention approaches (screening for, and treating precancerous lesions) will prevent most cervical cancer cases. When diagnosed, cervical cancer is one of the most successfully treatable forms of cancer, as long as it is detected early and managed effectively. However, 84% of new cases occur in low-and-middle income countries due to poor access to all three prevention strategies. Cancers diagnosed in late stages can also be controlled with appropriate treatment and palliative care.

Primary prevention: HPV Vaccination

The World Health Organization (WHO) recommends a two-dose schedule of the HPV vaccine administered 6-12 months apart to girls aged 9-14 years as the primary target for prevention of cervical cancer. WHO has set a target 90% of girls fully vaccinated with the HPV vaccine by the age of 15.[71] One of the recommendations of the WHO is for states to include the HPV vaccination as part of the national vaccination programme. Only Seychelles and Zimbabwe have achieve the WHO goal target 90% of girls fully vaccinated with the HPV vaccine by the age of 15.The SADC SRHR scorecard includes an indicator to prevent HPV - Proportion female received recommended does by age 15.

Table 2.6 shows that eight countries in SADC have included HPV in their national vaccination programme, though coverage varies across countries. Seychelles, which started the vaccination programme in 2014 has the highest coverage (97%) whereas Botswana which started in 2015 has the lowest coverage (53%. Zimbabwe and Malawi have performed best starting their programmes in 2018 and 2019 and have a coverage of 96% and 89% respectively. With two of the highest incidences of cervical cancer attributed to HPV this is an important step towards eliminating cervical cancer as a public health problem. Eswatini, which has the highest prevalence of cervical cancer attributable to HPV is among the eight SADC countries that have not included HPV in their national vaccination programme.

Table 2.6: HPV vaccination programmes

Country	HPV included in national vaccination programme:	Proportion female received recommended does by age 15
Seychelles	Yes (2014)	97%
Zimbabwe	Yes (2018)	96%
Malawi	Yes (2019)	89%
Mauritius	Yes (2016)	74%
South Africa	Yes (2014)	63%
Zambia	Yes (2019)	60%
SADC region		60%
Tanzania	Yes (2018)	59%
Botswana	Yes (2015)	53%
Angola	No	No data
Comoros	No	No data
DRC	No	No data
Eswatini	No	No data
Lesotho	No	No data
Madagascar	No	No data
Mozambique	No	No data
Namibia	No	No data

Source: SADC SRHR Scorecard, Cervical Cancer profiles.

[71] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8841655/

Secondary prevention: Cervical cancer screening

Cervical cancer screening is the secondary prevention strategy for cervical cancer. This is yet to be fully integrated into existing reproductive health and HIV care services. The result is low coverage of cervical cancer screening and treatment. Other factors contributing to the low uptake of the screening services are long distances to health facilities, lack of awareness of the disease and the role of screening; failure of women to avail themselves for screening; low budget allocation for screening purposes; the demands of competing health needs such as HIV infection, tuberculosis and other common diseases and no consumer demand and therefore no political will to establish screening programmes.[72]

Table 2.7 shows that nine SADC countries have national cervical cancer screening programmes but coverage is patchy especially in Madagascar and Mozambique where just 8% and 3% of women have ever been screened for cervical cancer. No country in SADC is near to the WHO target of 70% of women are screened with a high-performance test by 35 years of age and again by 45 years of age.

Table 2.7: Screening for cervical cancer

Country	National Screening programme exists	Screened ever	Screened in last five years
South Africa	Yes	53%	43%
Botswana	Yes	50%	39%
DRC	Yes	42%	36%
Zambia	Yes	20%	17%
Zimbabwe	Yes	20%	19%
Eswatini	Yes	19%	15%
Malawi	Yes	19%	15%
Madagascar	Yes	8%	5%
Mozambique	Yes	3%	3%
Mauritius	No	42%	25%
Namibia	No	39%	29%
Seychelles	No	32%	26%
Angola	No	25%	20%
Lesotho	No	17%	14%
Tanzania	No	13%	11%
Comoros	No	10%	10%

Source: WHO cervical cancer country profiles.[73]

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."[74] Sexual and reproductive health services are considered essential and are therefore included in this definition. Protecting people from the financial

[72] SA Journal of Gynaecological Oncology 2009 Vol 1 No 1, Cervical cancer in Southern Africa: The challenges
[73] Ibid.
[74] WHO, Fact Sheet: Universal Health Coverage, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) accessed 12 July 2021

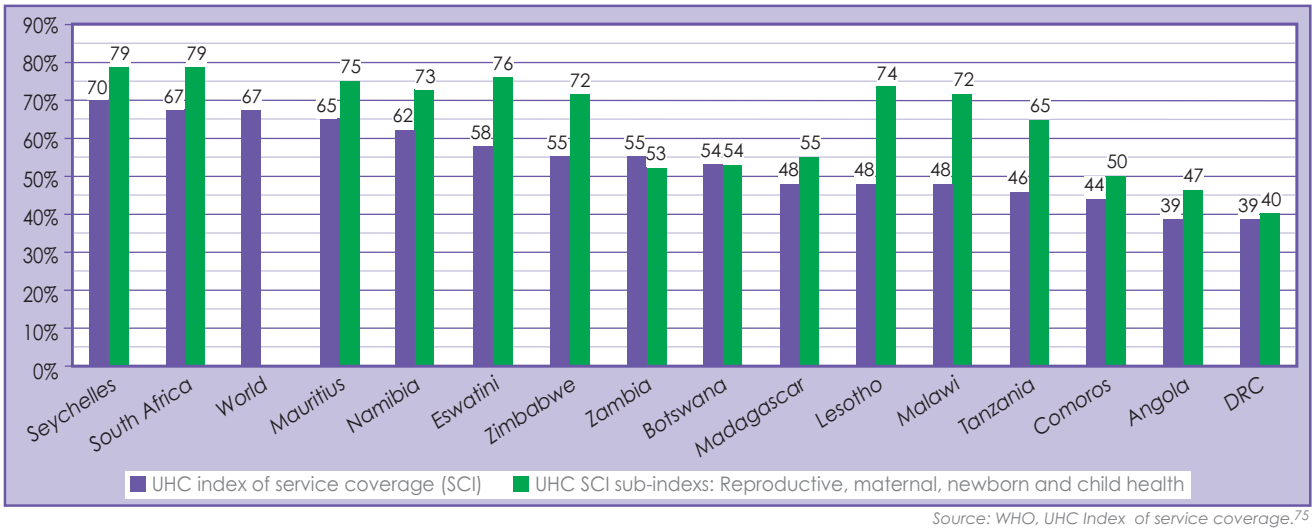
consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow - destroying their futures and often those of their children.

Monitoring progress towards UHC should focus on:

- The proportion of a population that can access essential quality health services (SDG 3.8.1).
- The proportion of the population that spends a large amount of household income on health (SDG 3.8.2).

The Universal Health Coverage (UHC) Index is measured on a scale from 0 (worst) to 100 (best) based on the average coverage of essential services including reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access.

Figure 2.11: Universal Health Coverage



Source: WHO, UHC Index of service coverage.[75]

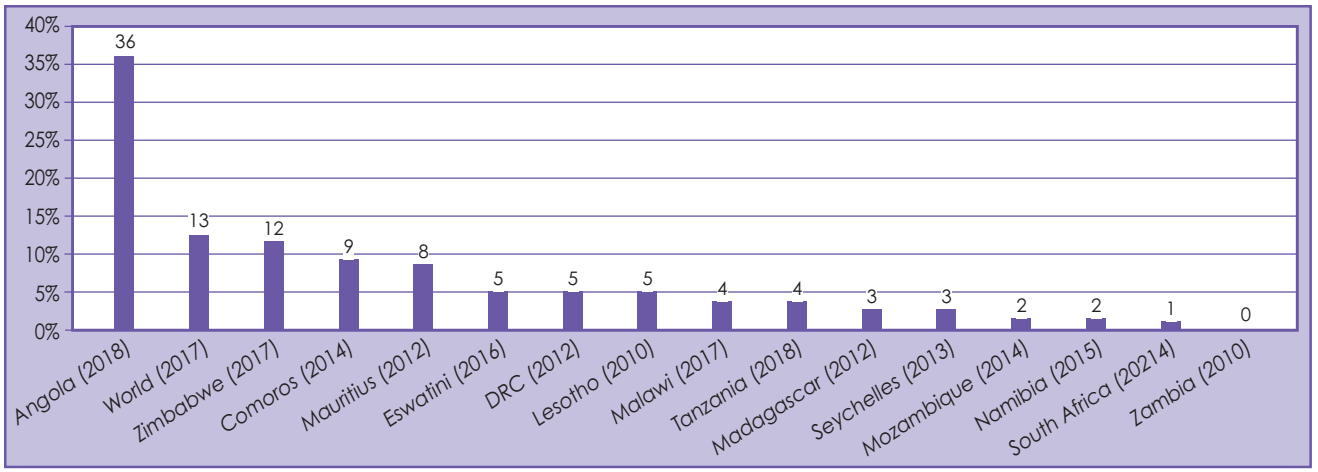
Figure 2.11 shows that no country in SADC provides universal health care. The universal health coverage index ranges from 71 in Seychelles to 39 in DRC. Only Seychelles and South Africa are above the global average of 67. Mauritius and Namibia have between rate between 60 and 65 while Madagascar, Lesotho, Malawi, Tanzania, Comoros, Angola and DRC rate below 50 on the UHC index.

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

UHC means that all individuals and communities receive the health services they need without suffering financial hardship

[75] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage , Accessed 3 September 2022.

Figure 2.12: Proportion of population spending more than 10% of household consumption or income on out-of-pocket health care expenditure (%)



Source: World Bank data.[76]

Figure 2.12 shows that all countries are lower than the world average of 13%, except Angola where an exceptionally high proportion of the population (35%) are spending more than 10% of household consumption or income on health care. However the year of data collection ranges from 2010 to 2018. Figures could be higher based on more recent data.

Health expenditure on health sector

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.

There are 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.[77]

Health expenditure is an important indicator of a government's commitment to the health and wellbeing of citizens. Increasing expenditure on health is associated with better health outcomes, especially in low-income countries. When a government attributes proportionately less of its total expenditure on health, this may indicate that health, including nutrition, is not regarded as a priority.

[76] https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-MZ-NA-SC-TZ-ZM-ZW-1W
[77] https://www.thebalance.com/what-is-gdp-definition-of-gross-domestic-product-3306038

Table 2.8: Health financing analysis

Country	% annual budget allocated to the health sector[78]	Health expenditure as % of GDP[79]
Namibia	13.6	8.5
Botswana	12.5	6
Comoros	12	5.1
Seychelles	11.7	5.1
DRC	11.4	3.5
Zimbabwe	10	7.7
Lesotho	9.5	11.2
Eswatini	9.5	6.8
Malawi	9.3	7.4
Mozambique	8.7	7.9
South Africa	8.1	9.1
Madagascar	8	3.7
Tanzania	6.7	3.8
Angola	5.6	2.5
Mauritius	5.5	6.2
Zambia	4.5	5.3

Source: SADC SRHR Scorecard, World Bank Data.

Table 2.8 shows that no SADC countries have met the recommended Abuja Declaration goal of 15% of state's annual budget to improve the health sector.[80] Namibia has the highest annual expenditure with 13.6% of the annual budget being allocated to the health sector. Six countries spend between 10% and 14% on health; seven countries spend between 6% and 10% and four countries spend less than 6% of the annual budget on the health sector. Only Lesotho spends more than 10% of its GDP on health.

More worrying, however, is that health spending in six countries (Botswana, Lesotho, Malawi, Namibia, Zambia and Zimbabwe) has regressed between 2019 and 2021. The biggest cut is in Botswana, where expenditure decreased from 16.2% to 12.5% of annual budget expenditure.



Hwange students received free menstrual health products. Photo: Tapiwa Zvaraya

[78] SADC SHR scorecard, https://dev-www.sadc.int/srhrscorecard/, accessed 31 August 2022
[79] World Bank, World Development Indicators, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=AO-BW-KM-CD-SZ-LS-MG-MW-MU-NA-SC-ZA-TZ-ZM-ZW-MZ accesses 30 August 2022
[80] 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 take steps to improve the SRHR of their populations including:

Polices and frameworks

- Update dated policies in line with international standards on SRHR and the SADC SRHR strategy and scorecard.
- Improve implementation and monitoring of frameworks and policies and hold governments accountable.

Menstrual health

- Scrap VAT on menstrual products and provide free sanitary ware in schools, especially in rural and underprivileged areas.
- Commit to investing more in water, sanitation and hygiene in all settings, including household, communities, schools and health care facilities, with a particular focus on rural areas, where access to these services is substantially lower than in urban areas.

Maternal health

- Explore the reasons for the persistently high levels of maternal mortality and address these through policy and practice.
- Implement programmes to increase access to maternal health services such as antenatal care, skilled birth attendance and neonatal care especially in rural areas.

Contraception and family planning

Identify areas and communities where women have a high unmet need for family planning and develop access and provision strategies.

HPV and cervical cancer

- Include the HPV vaccine in the national vaccination programme; conduct education and awareness programmes on HPV, and step up the rate of vaccination especially in schools.
- Implement the cervical cancer programme in schools; develop strategies to speed up coverage of screening, including allocating budgets and raising awareness about cervical cancer and how it can be prevented.

Universal health care coverage

Invest in and develop partnerships to facilitate roll out of UHC including SRHR services.

Investment and expenditure

Recommit to increasing investment in the health sector to 15% of their annual budget in line Abuja Declaration goal.

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