# CHAPTER 6

# Sexual and Reproductive Health and Rights

## Articles 26

A group of interns at work at a hospital in Antananarivo, Madagascar, in 2018.
*Photo: Zotonantenaina Razanandrateta*

### KEY POINTS

- The SheDecides movement has drawn renewed focus to the imperative of enabling women, and particularly young women, to have control over their own sexual and reproductive health and wellbeing.
- Maternal mortality across most of SADC, except for Mauritius and Seychelles, remains unacceptably high and it is declining too slowly to meet even the SDG target of 70 per 100 000 live births.
- Only South Africa and Mozambique have legislation that allows abortions on request. In late 2017, Madagascar passed the Reproductive Health and Family Planning Law after a clause that would have legalised abortion had been removed, and Angola has withdrawn a bill that legislators there passed in early 2018 that would have made abortion illegal after women marched in the streets against it.
- Leaders in SADC must address the differentials in access to all sexual and reproductive health services and maternal health services between rural and urban and across wealth quintiles to achieve the goals of the SADC Protocol.
- Stakeholders have been focusing on menstrual health and hygiene for the first time, especially for young women. But there is an acknowledgement that these issues also affect older women.
- Though SADC has seen some progress in reducing child marriage (e.g. Malawi and Zambia), teenage pregnancy remains an issue in several countries in the region.
- There is an urgent need for massive investment in expanding access to improved water and sanitation services, especially in countries such as Madagascar, Tanzania, Mozambique, Angola and the DRC.

**Teenage** pregnancy remains an **issue** in several countries in the region

## Key trends

| Table 6.1: Trends in health since 2009[1] | | | | |
|---|---|---|---|---|
| | Target 2030 | Baseline 2009 | Progress 2018 | Variance (Progress minus 2030 target) |
| **CONTRACEPTIVE USE AMONG SEXUALLY ACTIVE WOMEN** | | | | |
| Highest proportion of women | 100% | South Africa (65%) | Mauritius (76%) | 24% |
| Lowest proportion of women | 100% | Angola (6%) | Mozambique (12%) | 88% |
| **CURRENT MATERNAL MORTALITY RATE (MATERNAL DEATHS PER 100 000 BIRTHS)** | | | | |
| Highest | 0 | Angola (1400) | DRC (693) | 693 |
| Lowest | 0 | Mauritius (13) | Seychelles (0) | 0 |
| **BIRTHS ATTENDED BY SKILLED PERSONNEL** | | | | |
| Highest | 100% | Mauritius (100%) | Mauritius<br>Seychelles (100%) | 0<br>46% |
| Lowest | 100% | Angola<br>Tanzania (46%) | Madagascar (44%) | |
| **% WHO SAY A WOMAN SHOULD BE ABLE TO CHOOSE TO TERMINATE A PREGNANCY IN THE FIRST THREE MONTHS OF HER PREGNANCY** | | | | |
| Highest | 100% | | Angola (52%) | N/A |
| Lowest | 100% | | Madagascar (13%) | N/A |
| **TOTAL COVERAGE OF SANITATION** | | | | |
| Highest coverage | 100% | Mauritius<br>Seychelles (100%) | Seychelles (98%) | 2% |
| Lowest coverage | 100% | Madagascar (14%) | Madagascar (12%) | 88% |

*Source: Gender Links 2018.*

**Seychelles** has the **lowest** maternal mortality ratio in the region

Table 6.1 shows that:

- Mauritius has the highest prevalence of contraception use at 76%. South Africa held this top position in 2009 when researchers took the baseline, but coverage has declined slightly to 60%. Mozambique currently has the lowest coverage, which is an exceptionally low 12%. Angola, which held the last spot in 2009, has increased to 18%, which remains low.
- Seychelles has the lowest maternal mortality ratio in the region, with a negligible number of women dying because of pregnancy or child birth. Seychelles and Mauritius have consistently had the lowest ratios. DRC (693 per 100 000) has the highest maternal mortality. DRC has surpassed Angola, where the maternal mortality ratio over this period dropped from 1400 per 100 000 to 477 per 100 000. As countries affected by, and recovering from, conflict, DRC and Angola have consistently had the highest maternal mortality ratios.
- Skilled personnel attend all births in Mauritius and Seychelles, which represent the SADC countries leading on this indicator. The lowest level has shifted slightly from 46% in Tanzania and Angola at baseline to 44% in Madagascar now. A stricter definition of what constitutes "skilled" may result in lower coverage rates in the future.
- The Barometer has introduced a score on attitudes towards abortion for the first time. The trends table shows that Angola (52%) had the highest proportion of women and men agreeing or strongly agreeing that "a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy." Madagascar (13%) had the lowest proportion of women and men agreeing with this statement.
- Madagascar also remains in the worst spot for sanitation coverage, at just 12%, a decrease of two percentage points since 2009.

[1] Tracking of trends in health is compromised as new data is only available when researchers conduct new surveys, which is often only once every five years or so. Even then, researchers do not conduct surveys for all countries in the same year and therefore data is not always comparable. Although much routine health data is collected and reported it is not easy to compile into coverage as it does not indicate the denominator.

| Table 6.2: Health Indicators | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Angola | Botswana | DRC | eSwatini | Lesotho | Madagascar | Malawi | Mauritius | Mozambique | Namibia | Seychelles | South Africa | Tanzania | Zambia | Zimbabwe |
| % Contraceptive use among sexually active women | 18 | 53 | 20 | 65 | 60 | 40 | 59 | 76 | 12 | 56 | n/a | 60 | 34 | 49 | 67 |
| Country policy on termination of pregnancy | Illegal except to save a woman's life | Permitted in first 16 weeks in case of rape, defilement, incest | Illegal except to save a woman's life | Illegal except to save a woman's life | Illegal except to save a woman's life or if the child is in danger of abnormalities | Illegal except to save a woman's life | Illegal except when necessary to preserve a woman's life | Illegal except to save a woman's life; if woman is in danger of permanent damage of if the child is in danger of abnormalities | Legal up to 12 weeks; if incest up to 16 weeks; if foetal anomalies up to 24 weeks | Illegal except if a threat to health of mother, or if the child is in danger of abnormalities, or conception was illegal | Illegal except to save a woman's life | Legal and women can choose to terminate pregnancy | Illegal except when necessary to preserve a woman's life | Legal in limited circumstances, but lack of awareness and stigma inhibit access | Illegal except to save a woman's life; child is at risk or conception was unlawful |
| Maternal mortality ratio (out of 100, 000 live births) | 477 | 129 | 693 | 389 | 487 | 353 | 634 | 53 | 489 | 265 | (no input) | 138 | 398 | 224 | 443 |
| % Births attended by skilled personnel | 50 | 99 | 80 | 88 | 78 | 44 | 90 | 100 | 54 | 88 | 99 | 94 | 64 | 63 | 78 |
| % Total coverage of sanitation facilities | 52 | 63 | 29 | 57 | 30 | 12 | 41 | 93 | 21 | 34 | 98 | 66 | 16 | 44 | 37 |
| % Urban coverage | 89 | 79 | 37 | 63 | 37 | 18 | 47 | 94 | 42 | 54 | 97 | 70 | 31 | 56 | 49 |
| % Rural coverage | 22 | 43 | 29 | 56 | 28 | 9 | 40 | 93 | 10 | 17 | 97 | 61 | 8 | 36 | 31 |

*Source: Gender Links, 2018.*

Table 6.2 goes into further depth of the key indicators linked to sexual and reproductive health and rights in the SADC region in 2018. This includes details of each country's legislative stance on abortion. It also illustrates huge disparities throughout the region in several indicators, including sanitation coverage, which remains inadequate in most countries, especially in rural areas, yet is very good in Seychelles, with almost full coverage in both rural (97%) and urban areas (97%).

## Background

The World Health Organisation (WHO) notes that "Healthy women, children and adolescents whose rights are protected are the very heart of sustainable development." The WHO constitution enshrines their inherent right to the highest attainable standard of health, as does international human rights law. WHO notes that when countries uphold this right to health, "their access to all other human rights is also enhanced, triggering a cascade of transformative change."

Survive, thrive and transform: that is the clarion call of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). If leaders uphold rights to health and through health, delivery of the Sustainable Development Goals (SDGs) will indeed leave no one behind.[2]


"Healthy children & adolescents whose **rights** are **protected** are the very heart of sustainable development"

[2] WHO, 2017. Leading the realization of human rights to health and through health: report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents: Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents. http://apps.who.int/iris/bitstream/handle/10665/255540/9789241512459-eng.pdf;j Accessed 16 June, 2017.

Only **12%** of people in Madagascar have **access** to adequate sanitation

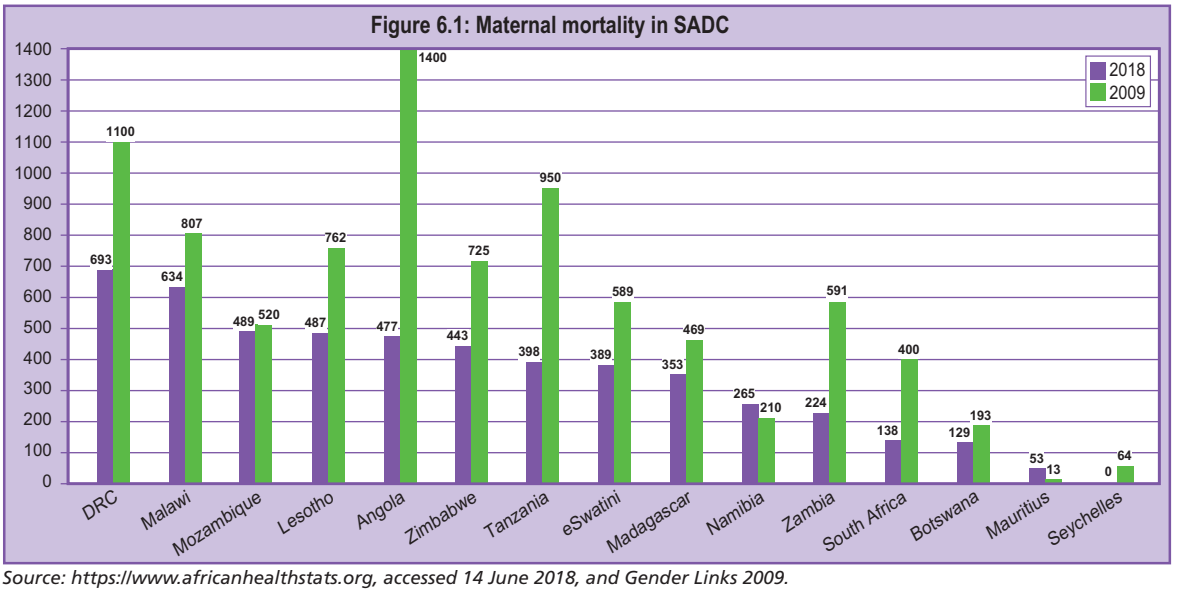
## Maternal Mortality Ratio

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

a) Eliminate maternal mortality; and

b) Develop and implement policies and programmes to address the mental, sexual and reproductive health needs of women and men in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action.

The Maternal Mortality Ratio (MMR) represents the number of women of child-bearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy; from any cause related to or aggravated by the pregnancy or its management (but not from accidental or incidental causes) per 100 000 live births.[3] The MMR represents the risk associated with each pregnancy and birth and reflects the ability of a country's healthcare system to provide safe care during pregnancy and childbirth. A live birth refers to any baby that is born and shows signs of life outside of the womb.




*Source: https://www.africanhealthstats.org, accessed 14 June 2018, and Gender Links 2009.*

Maternal mortality represents one of the sharpest indicators of inequality. Thus, while maternal mortality in the developed world stands at only 12 per 100 000 live births,[4] Figure 6.1 indicates that the rate in SADC varied from a high of 693 per 100 000 live births in DRC to a low of zero in Seychelles. It also shows progress in reducing the MMR in SADC member states from 2009 when Gender Links launched the first Barometer, to 2018. Angola had the greatest reduction (1400 to 477) followed by DRC (1100 to 693): both post-conflict countries with remarkably high levels in 2009. Both have also had lower HIV and AIDS prevalence compared to other SADC countries. High mortality related to HIV and AIDS has contributed to much slower rates of MMR reduction in much of SADC. Thus, maternal

[3] MMR definition.
[4] http://www.who.int/news-room/fact-sheets/detail/maternal-mortality accessed June 17, 2018

mortality increased slightly in Namibia (from 210 to 265), remained at almost the same level in Mozambique (520 to 489) and decreased very slowly in Botswana (193 to 129) and eSwatini (589 to 389).

Countries also have internal inequalities between younger and older women, rural and urban, poorer and wealthier. Achieving the SADC Protocol goal of eliminating maternal mortality will require commitment from families, local authorities, national governments and development partners.

### *Countdown to 2030*

Mothers breastfeed their babies at a clinic in Mbare, a suburb of Harare, Zimbabwe's capital city. *Photo: Tapiwa Zvaraya*

The international community has established a multi-institutional body, Countdown to 2030, to track progress in implementation of Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). It tackles questions on improved achievement of reproductive, maternal, newborn, child and adolescent health. Countdown 2030 focuses on 81 countries that account for only 47% of the total global population and 64% of births but 90% of child deaths and 95% of maternal deaths:[5]

- Fifty-three countries with an under-five mortality rate or MMR higher than the SDG target fall among the countries that account for 95% of all under-five or maternal deaths. SADC members states included in this group include Angola, DRC, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe.
- The remaining 23 have an under-five mortality rate or MMR higher than the SDG but do not sit among the countries that account for 95% of all under-five or maternal deaths. These countries typically have small total populations and include SADC member states Botswana, eSwatini, Lesotho and Namibia.

Because they have comparatively low under-five mortality rates and MMR, Countdown does not include Mauritius and Seychelles.

Countdown has developed a composite coverage index, which includes a set of indicators across the continuum of maternal and child care. Researchers calculated this index for those countries with available data. SADC member states exist in both the ten countries with the lowest coverage - Nepal, Afghanistan, Niger, **DRC, Angola,** Mali, Yemen, Guinea, Nigeria and Chad - as well as the ten countries with the highest coverage levels across the continuum of care: Turkmenistan, Dominican Republic, **eSwatini, Malawi, Namibia,** Algeria, Kyrgyzstan, **Lesotho,** Indonesia and **Zimbabwe**.

WHO estimated the major causes of maternal mortality in sub-Saharan Africa in 2013:

- Indirect (other conditions such as Malaria, HIV and AIDS, etc.) 29%
- Haemorrhage or severe bleeding (usually after delivery) 25%
- Hypertension during pregnancy 16%
- Sepsis because of infections (usually after delivery) 10%
- Unsafe abortion 10%

The Countdown report draws attention not only to access to services such as antenatal care, but to the quality of care that women can access. For instance, the range of interventions that is available for antenatal care (ANC) should include: tetanus immunisation; syphilis screening and treatment; HIV testing and access to anti-retroviral treatment (ART); intermittent therapy for malaria; hypertension screening and management; and iron supplementation. Many ANC services do not include this full range.

## Access to health services

Most maternal mortality is preventable with access to good prenatal, delivery and post-natal care. This includes at least four ANC visits, with the first in the first trimester of pregnancy; deliveries in health facilities, attended by skilled health personnel; special support for younger and older mothers; adequate spacing between pregnancies; safe abortion and post-abortion services; and prevention and management of malaria and HIV and AIDS.

**Maternal mortality** is a telling indicator of inequality

[5] United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), 2017. Tracking Progress towards Universal Coverage for Reproductive, Newborn and Child Health: The 2017 Report. Washington, DC: https://data.unicef.org/wp-content/uploads/2018/01/Countdown-2030.pdf Accessed 17 June, 2018.

**Table 6.3: Antenatal care for mothers in SADC**

| Country | ANC (%) | | Place of residence (%) | | Household wealth quintile (% with ANC coverage) | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | At least one visit | At least 4 visits | Urban | Rural | 1st | 2nd | 3rd | 4th | 5th |
| | 2010-2015 | | | | | | | | |
| Angola | 82 | 61 | 74 | 39 | 34 | 45 | 64 | 82 | 88 |
| Botswana | 94 | 73 | 76 | 70 | | | | | |
| DRC | 88 | 48 | 61 | 42 | 38 | 41 | 45 | 49 | 64 |
| eSwatini | 99 | 76 | 82 | 74 | 74 | 71 | 70 | 83 | 85 |
| Lesotho | 95 | 74 | 80 | 72 | 67 | 69 | 71 | 77 | 89 |
| Madagascar | 82 | 51 | 75 | 47 | | | | | |
| Malawi | 95 | 51 | 59 | 49 | 48 | 49 | 49 | 50 | 60 |
| Mauritius | - | - | | | | | | | |
| Mozambique | 91 | 51 | 60 | 47 | 37 | 42 | 50 | 54 | 64 |
| Namibia | 97 | 63 | 64 | 61 | 60 | 54 | 59 | 65 | 78 |
| Seychelles | - | - | | | | | | | |
| South Africa | 94 | 76 | 73 | 80 | 70 | 75 | 78 | 77 | 80 |
| Tanzania | 91 | 51 | 64 | 45 | | | | | |
| Zambia | 96 | 56 | 56 | 55 | 48 | 53 | 53 | 51 | 65 |
| Zimbabwe | 98 | 76 | 77 | 75 | | | | | |

*Derived from Antenatal care coverage: at least one visit - Percentage and Antenatal care coverage: at least four visits - Percentage. https://data.unicef.org/topic/maternal-health/antenatal-care/ Last accessed 20 June 2018.*

Nurses at work at Mamohato Memorial Hospital in Maseru, Lesotho. *Photo: Lesotho Times*

**WIDE** disparities between urban and rural antenatal **care**

Access to ANC is an important contributor to reduction in maternal mortality. Table 6.3 summarises the most recent data, showing that coverage of at least one ANC visit is high across the region, with the lowest levels at 82% in Angola and Madagascar and high levels up to 99% in eSwatini and 98% in Zimbabwe. However, coverage of the recommended four visits is much lower, as low as 48% in DRC and 51% in Madagascar, Malawi, Mozambique and Tanzania. Research shows the highest levels, at 76%, in South Africa, eSwatini and Zimbabwe.

Table 6.3 also highlights wide disparities between urban and rural ANC coverage in some countries. This includes Angola (74% urban compared to 39% rural) and Madagascar (75% urban compared to 47% rural), with much narrower differentials in countries such as Namibia, where the difference is 64% urban and 61% rural, and Zimbabwe at 77% urban and 75% rural. South Africa is unusual in having higher coverage in rural areas than urban, reflecting good rural coverage and poor health services in some urban areas, especially informal settlements. Table 6.3 also illustrates differentials according to wealth quintile, which separates households into five quintiles (lowest income through to highest income) to compare the influence of wealth on various population, health and nutrition indicators. The most pronounced differential is in Angola, with narrower differences in other countries, including South Africa and eSwatini.

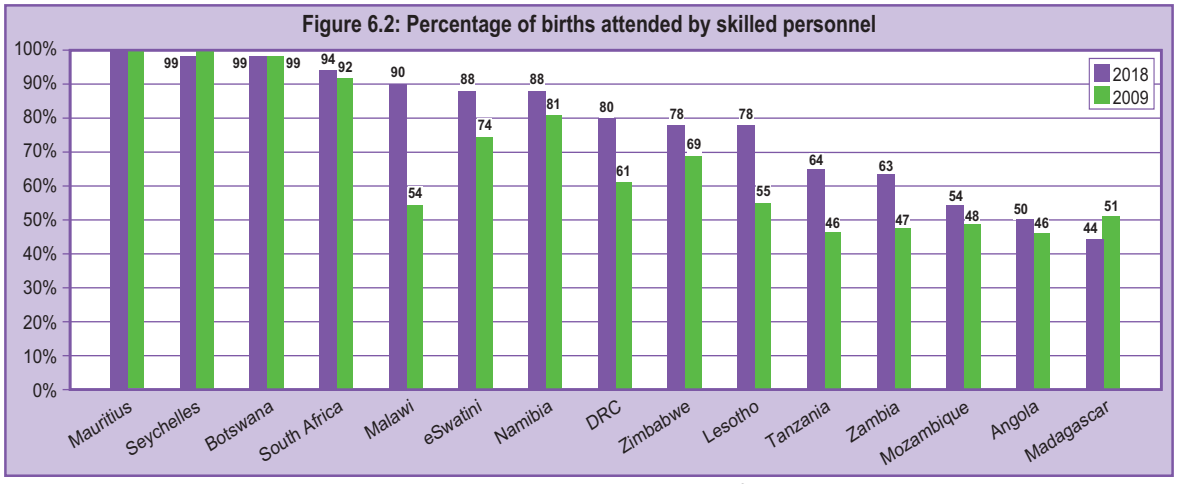
| Table 6.4: Post-natal care coverage for mothers in SADC | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Country | Year | National (%) | Residence (%) | | Household wealth quintiles (% with PNC coverage) | | | | |
| | | | Urban | Rural | 1 | 2 | 3 | 4 | 5 |
| Angola | 2016 | 23 | 31 | 12 | 9 | 13 | 27 | 36 | 41 |
| DRC | 2014 | 44 | 57 | 38 | 35 | 36 | 42 | 48 | 63 |
| eSwatini | 2014 | 88 | 94 | 85 | 82 | 86 | 85 | 95 | 92 |
| Lesotho | 2014 | 62 | 70 | 59 | 46 | 54 | 68 | 68 | 80 |
| Malawi | 2016 | 42 | 52 | 41 | 39 | 39 | 42 | 47 | 48 |
| Namibia | 2013 | 69 | 69 | 69 | 61 | 74 | 73 | 69 | 66 |
| South Africa | 2016 | 84 | 85 | 81 | 81 | 80 | 87 | 85 | 87 |
| Tanzania | 2016 | 34 | 48 | 29 | 22 | 29 | 32 | 41 | 54 |
| Zambia | 2014 | 63 | 81 | 54 | 47 | 55 | 65 | 78 | 84 |
| Zimbabwe | 2015 | 57 | 67 | 53 | 47 | 52 | 56 | 64 | 69 |

*Source: https://data.unicef.org/topic/maternal-health/ Post-natal check-up for mothers/ Last accessed 20 June, 2018.*

Table 6.4 presents the most recent available data on post-natal care (PNC) for mothers, which is also a principal factor in maternal wellbeing because several conditions, such as sepsis, can result in maternal deaths after delivery. Coverage of PNC is lower than that of ANC, with the widest differential being in Angola (61% for four ANC visits compared to 23% for PNC). However, other countries such as South Africa, eSwatini, Namibia and Zambia have higher coverage of PNC than four ANC visits. The region has general differentials of access between urban and rural areas and across wealth quintiles. Only Namibia has the same level of access for urban and rural, but this is a relatively low 69%. eSwatini has the highest coverage at 88% overall.

## Access to skilled health professionals

Access to skilled health professionals - such as doctors, nurses or midwives - who have access to transport for an emergency referral is a critical factor in reducing maternal mortality. Many conditions that result in maternal mortality can be managed or mitigated with timely medical assistance.




*Source: UNICEF/WHO joint database on skilled attendance at birth https://data.unicef.org/topic/maternal-health/delivery-care/ accessed 16 June 2018 and Gender Links 2009.*

***Presence of skilled health professionals varies significantly:*** Figure 6.2 shows the percentage of births attended by skilled personnel in the region, comparing 2009 and 2018. It varies from a low of 44% in 2018 in Madagascar to a high of 100% in Mauritius. Five countries have more than 90% of births attended by a skilled health professional (Mauritius, Seychelles Botswana, South Africa and Malawi) while only two still have 50% or fewer. Figure 6.2 also shows the progress countries have made in the decade since the Barometer has been tracking this indicator. This is marked for countries such as Malawi where the increase has been from 54 to 90%, Lesotho from 55 to 78% and slower for those which had high levels already in 2008 (Mauritius, Seychelles, Botswana and South Africa) or

**Access** to skilled health professionals is a **critical factor** in reducing maternal mortality

**5** countries have more than **90%** births attended by a **skilled** health professional

which were very low, such as Mozambique and Angola. Only one country, Madagascar, regressed, dropping from 51% of births attended by a skilled person to 44%. Overall, progress occurs thanks to political will and partnerships.

Throughout the MDG era, stakeholders paid attention to increasing the number of deliveries attended by a skilled health professional who could handle normal deliveries safely and recognise and refer complicated cases for emergency care. However, as increased coverage has not translated to marked reductions in maternal mortality, WHO, UNICEF and others convened a task force of experts to review the definition of skilled birth attendance. The revised definition is:

*"Skilled health personnel, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to:*

*(i) Provide and promote evidence-based, human-rights based, quality, socioculturally sensitive and dignified care to women and newborns;*

*(ii) Facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and*

*(iii) Identify and manage or refer women and/or newborns with complications.*

Rusape Town Council members during a field visit in the council in north-eastern Zimbabwe. *Photo: Tapiwa Zvaraya*

*In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimise the health and well-being of women and newborns.*

*Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns. (In different countries, these competencies are held by professionals with varying occupational titles.)"*[6]

The new definition will bring greater focus to the issue of competence and motivation of health personnel, as well as support for health personnel to perform their life saving work.

## Sexual and reproductive health and rights

**Article 26 (b):** State parties shall develop and implement policies and programmes to address the mental, sexual and reproductive health needs of women and men in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action.


*Photo: Boaki Fofana, All Africa.com*

Stakeholders first adopted the programme of action at the ground-breaking International Conference on Population and Development (ICPD) in 1994. It moved the globe from a focus on family planning to reproductive and sexual health for women and men, girls and boys. The programme asserts that everyone counts, and that development policy must improve individual lives and address inequalities. In 2014, the UN General Assembly extended the programme of action indefinitely.

[6] WHO. 2018. Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA.

**Defining SRHR**

sexual, reproductive health and rights

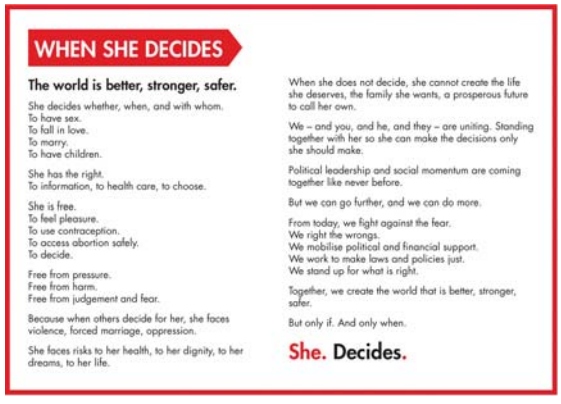
"A state of physical, emotional, mental, and social well-being related to sexuality. It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained the sexual rights of all persons must be respected, protected and fulfilled."[7]

In line with the above WHO definition, reproductive healthcare is "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 reproductive and sexually transmitted disease."

*Source: International Conference Population and Development report, para 7.2*

### *SheDecides*

Lilianne Ploumen, the Dutch minister for foreign trade and development cooperation, launched the SheDecides movement on 24 January 2017, a day after US President Donald Trump reinstated a rule blocking any US government funding to organisations that give women access to, or information about, safe abortion. Thirty-six champions lead the SheDecides movement - women and men, government ministers from developing and developed nations, activists from around the world - which urges all to "Stand up, speak out, change the rules and unlock resources" which can support education and information for girls and women about their bodies and their options, contraceptive methods and safe abortion.




Activists marked the first SheDecides day on 2 March 2018, with events in 19 countries around the world. Youth representatives from Ethiopia, Kenya, Malawi, Mozambique, Namibia, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe attended the main event in South Africa. Concrete actions taken at the event included launching the Uganda and Tanzania SheDecides movements and a call from South African Health Minister Aaron Motsoaledi to SADC health ministers to adopt the SheDecides scorecard at their ministers' meeting in November.

***Ten SADC countries have sexual and reproductive health policies:***

- eSwatini - National Policy on Sexual and Reproductive Health, 2013;
- Lesotho - National Reproductive Health policy, 2008;
- Madagascar - Reproductive Health and Family Planning Law, 2017;
- Malawi - National Reproductive Health and Rights Policy, 2009;
- Mauritius - National Sexual and Reproductive Health Policy, 2007;
- Mozambique - National Sexual and Reproductive Health Policy, 2011;
- Namibia - National Policy for Reproductive Health, 2001;
- Seychelles - Reproductive Health Policy for Seychelles, 2012;
- South Africa - Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and "National Adolescent Sexual and Reproductive Health and Rights Framework Strategy"; and
- Zambia - National Reproductive Health Policy, 2008.

Others have guidelines, such as:

- Botswana - policy guidelines and service standards for sexual and reproductive health, 2015; and
- Tanzania - SRHR guidelines and National Adolescent Reproductive Health Strategy, 2011 - 15.

**Activists** marked the **1st** #SheDecides day on **2 March 2018**

[7] World Health Organisation (2002). The world health report 2002 Reducing risks, promoting healthy life, World Health Organisation.

Protocol@Work

**Local council in eSwatini provides SRHR education to younger adolescents, sex workers and adults**

Even though eSwatini passed a National Policy on Sexual and Reproductive Health in 2013, access to SRH services in the country remains patchy. For this reason, the Pigg's Peak Council, in the north-west of the country, launched a programme to provide access to reproductive health services. It specialises in health education programmes for pregnant women and their partners, adolescents, sex workers and adults. It also provides capacity building and support for Council staff.

The Council works to meet the needs of adolescents in the community in a positive and responsible way. Initiatives include school retention and education programmes; sexuality education and life-skills training; health care training; and sensitisation on legal issues, such as age of consent and minimum age for marriage. Previously in the community, older adolescents, aged 15-19 years, traditionally received the lion's share of attention, while stakeholders have typically neglected the special needs and concerns of younger adolescents, those aged 10-14 years - some of whom are already sexually active.

Systematic data about the lives of young adolescents in developing countries remains scarce. Although researchers often collect data about school attendance and economic activities of 10-14-year-olds, they tend to only ask questions about sexual activity, condom and contraceptive use and knowledge of HIV and AIDS of respondents aged 15-19 years and older.

To serve younger adolescents, the Council partnered with Save The Children to provide sexual and reproductive information in a sensitive and age appropriate way. This includes through dialogues and discussions in communities. The programme also provides sex education to sex workers and adults to help them make healthy and informed sexual choices. It focuses on various themes, which include: combating HIV and AIDS infection in key populations such as sex workers, injecting drug users and men who have sex with men; SRHR and young people; and SRHR and young people in fragile states in Africa. This includes combating sexual violence against girls in conflict areas; female genital mutilation; teenage pregnancy; child marriage; and child prostitution.

So far, the project has served more than 600 people in the community. Bethulsile Mncina, one of the peer educators in the Council's youth department, noted "Each one of us can make a difference, and together we make change."

The Council has involved both women and men in the programme, pairing senior-level male staff with women to help build women's skills and prepare them to rise through the Council ranks. By making a conscientious effort to remove gender disparities and equalise the work environment, the Council's men and women have increased support to each other, ensuring the entire organisation ends up better off as a result. "Many movies have strong female leads: brave, self-sufficient girls that don't think twice about fighting for what they believe with all their heart," said Sipho Shongwe, a former counsellor in the community. "They'll need a friend, or a supporter, but never a saviour. Any woman is just as capable of being a hero as any man."

*Source: Protocol@Work Summit, 2018*


Community members learn about SRHR during a 2018 training workshop in Pigg's Peak. *Photo courtesy of Linda Chissano*

In December 2017, **Madagascar** passed the Reproductive Health and Family Planning Law after many years of advocacy to revoke colonial policy that prohibited promotion of contraception. The law recognises reproductive health and family planning as basic human rights for all, irrespective of age. It defines "counselling and family planning services for sexually active teens, married or unmarried" as one of the necessary reproductive health services. The law also provides for family planning education and outreach, community-based distribution of services, improved family planning technical capacity in health facilities, and availability of commodities, including emergency contraception."[8]

Girls at Mbizo High School, in Kwekwe, Zimbabwe in 2017 carry a petition against child prostitution.
*Photo courtesy of Suzanne Hazel Madamombe*

### *Adolescent SRHR*

There is growing realisation that provision of sexual and reproductive health must begin in adolescence with a continuum of care.

**Kwekwe City Council youth centres provide information to youth about SRHR**

Gold mining areas that have attracted large numbers of informal miners surround the city of Kwekwe in central Zimbabwe. This commercial activity has led to an increasing number of children engaging in sex work. Girls from the peri urban and rural areas migrate to Kwekwe to take part in the trade. Other SRHR issues for adolescents in Kwekwe include:

- SRHR for adolescents living with HIV and AIDS: 730 adolescents live with HIV and AIDS, most of whom contracted HIV from mother to child transmission and are now in a sexually active age group.
- Risk of HIV infection for underprivileged girls who older men lure into sexual relationships.
- Boys' belief that they should be the dominant partner in a relationship with a girl, which can lead to sexual abuse.
- Use of technology for emotional abuse e.g. one girl committed suicide when a former partner posted a video of the couple engaging in sexual activity on social media.

The Kwekwe City Council has collaborated with NGOs such as Plan, Africaid and JF Kapnec Trust, as well as government ministries, to establish youth centres in clinics. At these clinics, adolescents meet with health staff to discuss SRHR and get access to SRH and HIV and AIDS services. The Zimbabwe National Family Planning Council (ZNFPC) also played a role by helping refurbish the youth centres. Additionally, the City Council contributed $5000 to support the project as well as $20 000 of in kind support.

The project aims to improve SRH decision-making skills for adolescent girls and boys and provide a space for them to discuss difficult issues such as rights to legal abortion and HIV testing; child sex work; sexual abuse; and gender-based violence (GBV). The project works with both girls and boys and has a focus on molding responsible men who will not abuse wome, who stand up against GBV and who will always practice safe sex. The youth centres also offer positive recreation for youth.

At the centres, NGOs and government ministries give workshops for the youth. The Ministry of Women's Affairs, for instance, has trained youth on entrepreneurial skills. NGOs have also conducted workshops for policymakers and the community on the SRH needs and rights of adolescents. The leadership of the centres created an adolescent SRH committee to oversee, implement and monitor the activities under the programme. So far, 1640 adolescents have benefitted directly and indirectly from the programme.

Before the programme, local adolescents living with HIV used to miss school to queue monthly for their medication. After some advocacy around the issue, the adolescents now receive enough medicine for a whole term. Stakeholders at the centres continue to advocate on other issues such as legalisation of termination of unwanted pregnancy and testing of children in schools.

One adolescent male in the programme instigated the Stop Child Prostitution campaign, noting that "Men are taking advantage of our sisters. The young girls in poverty end up doing sugar daddies and they get pregnant and die of HIV. It's now time to say 'No' to these sugar daddies."

[8] https://medium.com/@FP2020Global_20685/madagascar-enacts-historic-family-planning-law-8ac7ab62e0ad. Accessed 20 June 2018.

One of the young women beneficiaries said: "I am a young girl whose parents have not been formally employed. I suffered sexual abuse at a young age and I was looked after by my grandmother. I got into child prostitution at 12 years after realisation that I had no hope in this life. My turning point happened when I contracted an STI and I got treatment at Al Davies Clinic and I got introduced to the adolescent SRHR programme. Since I started participating in the programme, I managed to get information that has given me hope. I am now out of prostitution."

In many places, communities cast out children involved in prostitution because they believe they are evil or did not listen to their parents. No one cares for these children. However, the community engagement provided by this project has helped shift attitudes. One woman assisted a girl after she noticed that the girl was walking strangely. The woman befriended the girl, who confided in her that she had contracted an STI but worried about seeking medical assistance. The woman took the girl to the clinic, where health professionals treated her.

In the past, the community had also held a negative attitude towards those who attended the youth centres, with many worrying the programme encouraged children to have sex. After a programme review, stakeholders decided that the programme could also train policymakers and community members. This sensitisation helped increase attendance to the centres.

*Source: Protocol@Work Summit, 2018*

Teenage marriage & child marriage are **linked**

## Teenage pregnancy

There is a close relationship between teenage pregnancy and child marriage. In some instances, unintended pregnancy results in child marriage. In others, child marriage results in teenage pregnancy. Unintended pregnancy is often a result of poor or inaccurate knowledge about SRHR, with poor access to SRH services, especially contraception. Levels of access to contraceptives are much lower for adolescents than for older women.

**Table 6.5: Rates of births by age 18**

| Country | Births by Age 18 (%) |
|---|---|
| Mozambique | 40 |
| Madagascar | 36 |
| Malawi | 31 |
| Zambia | 31 |
| Lesotho | 29 |
| Tanzania | 28 |
| DRC | 27 |
| Zimbabwe | 22 |
| eSwatini | 17 |
| South Africa | 15 |
| Namibia | 15 |

*Source: UNICEF Global Database: Child Marriage. https://data.unicef.org/topic/child-protection/child-marriage/ and Births by 18. https://data.unicef.org/topic/maternal-health/adolescent-health/ Last accessed 29 June 2018.*

Table 6.5 illustrates that high numbers of young girls in SADC continue to bear children before they turn 18 and become adults. This includes more than one-third of girls in Mozambique and Madagascar and more than a quarter of all young girls in Malawi, Zambia, Lesotho, Tanzania and DRC.

In June 2018, **Zimbabwe** launched a school health policy that the ministries of health and child care and primary and secondary education jointly developed and will implement. The United Nations Population Fund (UNFPA) notes that some of the challenges facing adolescents in Zimbabwe include teenage pregnancy, sexually transmitted infections including HIV and AIDS, unsafe abortions, child marriage and lack of access to SRH information services.[9]

## Menstrual health

There has been growing interest in the region around the subject of menstrual health or hygiene, particularly for adolescents. Menstruation begins with menarche, its first occurrence, usually by the age of 14. Some evidence suggests that improved health and nutritional status result in lower ages of menarche. Menstruation ends with menopause, usually around the age of 50. Menstruation signifies a woman's fertile age during which she can biologically become pregnant. Lack of preparation for menstruation, poor availability of menstrual hygiene products and pain result in menstruation often being associated with shame, fear and reduced participation by girls and women in social, cultural and educational endeavours. There has been recent interest in supporting girls to ensure participation in education, with several projects providing disposable or re-usable sanitary napkins and collaborating with schools to ensure they have adequate sanitation facilities.

[9] https://zimbabwe.unfpa.org/en/news/zimbabwe-school-health-policy-promote-sexual-and-reproductive-health-schools. Accessed June 30, 2018.

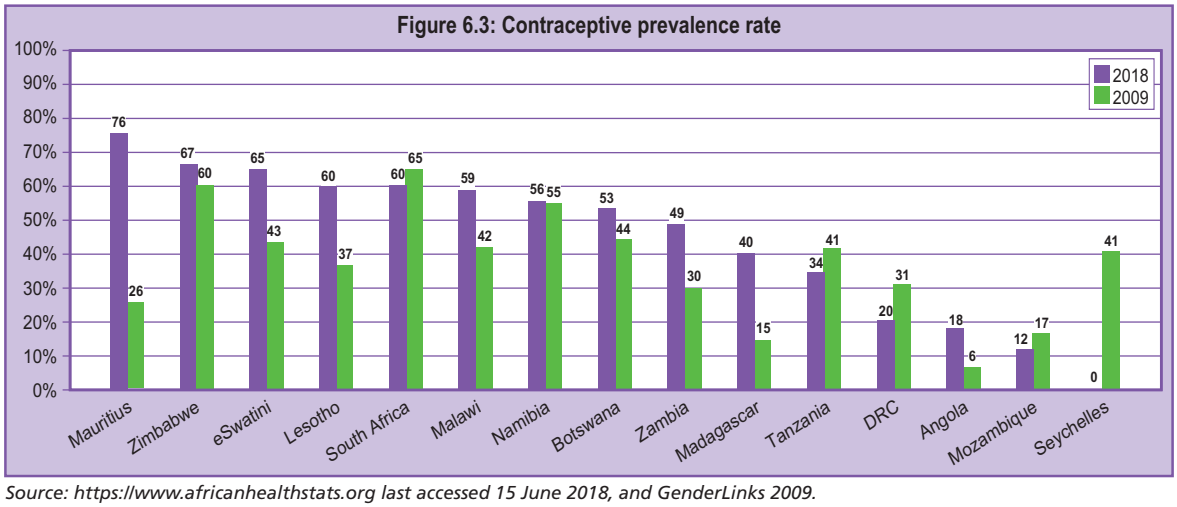
Women inspect sanitary napkins in Kadoma, Zimbabwe.
*Photo: Tapiwa Zvaraya*

There has been much less interest in menstrual health for older women, including the impact of menstruation on tertiary education or work, and little interest in issues of menstrual disorders such as dysmenorrhea (cramping) and menstrual irregularities. For women to embrace menstruation as a symbol of their power rather than something to be embarrassed about requires more research and investment in factors that promote menstrual health such as education and awareness about menstruation for girls and boys; availability and accessibility of menstrual products; and availability of adequate water and sanitation.[10]

## Access to contraception

Access to contraception knowledge and commodities represents a critical step in promoting control over when and how often to have a child: being able to decide. Improved access, including availability of commodities when needed, for all women and men would result in much lower levels of unintended pregnancy, unsafe abortions and transmission of HIV from mothers to babies.

Contraceptive prevalence is the percentage of women currently using, or whose sexual partner currently uses, at least one method of contraception, regardless of the method. It is usually reported for married or in-union women aged 15 to 49. Contraceptive methods include clinic and supply (modern) methods and non-supply (traditional) methods. Clinic and supply methods include female and male sterilisation, intrauterine devices (IUDs), hormonal methods (oral pills, injectables, and hormone-releasing implants, skin patches and vaginal rings), condoms and vaginal barrier methods (diaphragm, cervical cap and spermicidal foams, jellies, creams and sponges). Traditional methods include rhythm, withdrawal, abstinence and lactational amenorrhoea.[11] As many women and their partners wish to become pregnant the target on this indicator is not 100%, but higher levels of prevalence represent more control over fertility.




*Source: https://www.africanhealthstats.org last accessed 15 June 2018, and GenderLinks 2009.*

***Contraceptive usage is improving:*** Figure 6.3 shows the contraceptive prevalence rate (CPR) in SADC, reflecting slow improvement in access to contraception in the decade that the Barometer has tracked this indicator. Mauritius has both the highest coverage at 76% and one of the greatest increases over the decade (from 26% to 76%). Other countries with significant increases in coverage over the decade include eSwatini, Lesotho, Malawi and Zambia. Mozambique still has very low coverage at 12%.

Many **young girls** continue to **bear children** before they turn **18**

[10] UNFPA ESA. 2017. Menstrual Health Management in East and Southern Africa: a Review Paper. Johannesburg, South Africa.
[11] http://www.who.int/whosis/whostat2006ContraceptivePrevalenceRate.pdf

Mozambique has the region's **lowest** contra-ceptive prevalence

In July 2017, Family Planning 2020 (FP2020), a global partnership that "supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have," convened a high-level meeting in London to reinvigorate efforts to expand access to contraceptives, especially for adolescents and women in humanitarian settings.[12] The meeting also considered how to finance this goal, including mobilisation of private sector contributions. FP2020 is focusing attention on 69 countries, including several SADC member states: DRC, Lesotho, Madagascar, Malawi, Mozambique, Tanzania, Zambia and Zimbabwe.

In 2017, the **DRC** renewed its previous FP2020 commitments and committed to accelerate the achievement of 19% CPR and access to family planning services for 2.1 million additional women of reproductive age (15-49) by 2020. The DRC will: 1) support the implementation of the National Strategic Family Planning, 2014-2020; 2) from 2017, allocate domestic resources of at least 2.5 million dollars annually to "purchase of contraceptives;" 3) vote on the law on reproductive health and family planning, for all women of reproductive age, by December 2020; and 4) reform laws that protect adolescent girls from early marriage through education, awareness raising, social reintegration, and women's empowerment programs. Additionally, it will foster the support of the private sector for family planning and scale up community-based distribution of contraceptives.[13]

## The right to choose

In 2006, the African Policy Framework on Sexual and Reproductive Health and Rights recommended in 2006 that policymakers needed to consider the issue of unsafe abortion in a dispassionate way. They called on them to view it as a public health issue because it results in elevated levels of morbidity and mortality in women, and particularly young women. However, in most SADC countries, the legislative environment remains unsupportive of safe abortion

**Table 6.6: Legal status of abortion in SADC**

| Country | Law | Main points |
|---|---|---|
| **Angola** | Penal Code 2014[14] | Termination only permissible to save the life of a woman. |
| **Botswana** | 2. Penal Code (Amendment) Act, 1991 - Section 160 | Abortion is only legal if: pregnancy is a result of rape; if the mother's life is at risk or may cause harm to her mentally (because of rape or incest) and physically; or the unborn child will suffer or later develop physical or mental abnormality. Termination has to be performed before 16 weeks.[15] |
| **DRC** | The constitution | Abortion is illegal except in cases where a woman's life is in danger.[16] |
| **Lesotho** | The Penal Code (2010)[17] | Abortion is not legal except to save the life of a pregnant woman (by a registered medical professional, with the written opinion of another registered medical professional); or to prevent the birth of a child who will be seriously physically or mentally handicapped, with the professional who performs the termination having obtained a certificate stating the handicap of the unborn child; termination can also be undertaken if the female is pregnant due to incest or rape. |
| **Madagascar** | Reproductive Health and Family Planning Law 2017 | Abortion under any circumstance remains illegal. In Criminal Procedure law, an abortion can be performed to save the life of a woman. |
| **Malawi** | Penal Code | Currently, Malawi only allows abortion to save a woman's life. The Law Commission of Malawi has drafted the Termination of Pregnancy Bill to legalise safe abortion for women in the event of incest, rape or severe foetal abnormalities.[18] |
| **Mauritius** | Criminal Code Amendment Act 2012[19] | Abortion is legal to save the life of a pregnant woman; to save the pregnant woman from any permanent physical damage because of the pregnancy; the pregnancy is within 14 weeks and the girl is younger than the age of 16; and if the foetus may suffer severe malformation or abnormalities. |

[12] http://www.familyplanning2020.org/
[13] http://www.familyplanning2020.org/entities/112 accessed June 23, 2018
[14] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
[15] http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions/ https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm http://www.wipo.int/wipolex/en/text.jsp?file_id=238601
[16] https://www.google.co.za/#safe=off&q=abortion+bill+1991+democratic+republic+of+Congo (UN Publication)
[17] https://lesotholii.org/ls/legislation/num-act/6
[18] http://www.satregional.org/wp-content/uploads/2018/05/Age-of-consent-Malawi.pdf
[19] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[20] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique

| Country | Law | Main points |
|---|---|---|
| **Mozambique** | Penal Code | Abortion is legal to save the life of the pregnant woman and to safeguard her physical and mental wellness. Termination of pregnancy upon request is legal up to 12 weeks; in the case of incest, termination is legal up to 16 weeks; in the case of foetal anomalies, termination is legal up to 24 weeks. A certified practitioner must perform the termination at designated facilities.[20] |
| **Namibia** | Abortion and Sterilization Act 2 of 1975 | Abortion is legal: (1) in the event that the pregnancy poses a threat to the physical and mental health of the pregnant woman - two medical practitioners must approve in writing that the pregnancy is a risk; (2) where the unborn child is at risk of a serious mental or physical deformity and handicap; (3) where two other medical practitioners confirm that the woman has been raped or is a victim of incest and (4) where a woman has been deemed to be an idiot or an imbecile as per the Immorality Act of 1957, which makes sex with her illegal.[21] |
| **Seychelles** | Termination of pregnancy Act, 2012 | If three medical practitioners agree in good faith, termination can be undertaken at Victoria Hospital, Mahe, when a woman's life is deemed to be in danger or if the cost of carrying the foetus is greater than the pregnant woman's physical and mental health. Termination can be carried out if the child is at risk of serious mental and physical deformities.[22] |
| **South Africa** | Choice on Termination of Pregnancy Amendment Act No. 1 of 2008[23] | Specifies the kind of facility allowed to terminate, periods where women can terminate and the services available to any woman who wants to terminate out of choice, including counselling. It also specifies the right to terminate without consent of other parties apart from medical practitioners. |
| **eSwatini** | The Constitution | Only possible where the life of the pregnant woman is in danger.[24] |
| **Tanzania** | Penal Code[25] | Termination of pregnancy is only possible where the pregnant woman is at risk of death, or where the pregnancy threatens the mental and physical wellbeing of the pregnant woman. |
| **Zambia** | Termination of Pregnancy Act, 13 October 1972 | Abortion is legal under certain conditions for social and economic reasons. Once three medical practitioners have agreed, a termination can be performed on a pregnant woman if the pregnancy will cause her death, or if the pregnancy will cause mental or physical damage to the woman, also in the event that the child is at risk of mental and physical deformities.[26] |
| **Zimbabwe** | Termination of Pregnancy Act of 1977, Chapter 15: 10[27] | Only under circumstances where the life of the mother is in danger, where the child will suffer from complications after birth or if conception is deemed unlawful (instances of rape). A magistrate must grant permission. In 2012, policy approved for women who undergo illegal abortions to receive medical post-abortion care without being referred to the police. |

*Source: Gender Links, 2018.*

As illustrated in Table 6.6, abortion is only available on request in South Africa and Mozambique, while it is legal in Zambia under certain conditions. All other countries continue to criminalise most abortions with some exceptions, such as in circumstances where a woman's life is in danger or the pregnancy is a result of rape or incest.

On 24 February 2018, **Angola**'s parliament approved an amendment to the abortion law, making all abortions, without exception, illegal and punish-able by between four to ten years' imprisonment. This is part of the process of replacing Angola's 1886 penal code. Parliament passed the first reading of the bill without public consultation, and activists accused parliamentarians of ignoring their views. Legislators later withdrew the bill pending further debate after women marched in the streets to support the right to abortion.[28]

## SADC Protocol@Work case studies

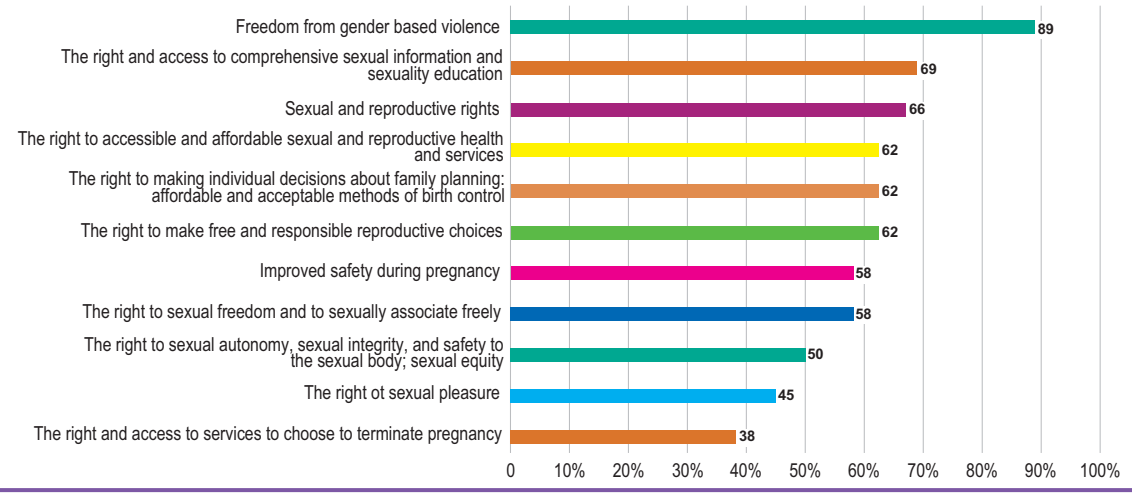
A total of 75 good practices on Sexual and Reproductive Health and Rights (SRHR) were presented at Summits between 2017 and 2018. Of these 31 were on gender-based violence (GBV), 30 on health, and 14 on HIV and AIDS.

Abortion is **only** available on request in **SA** and **Mozambique**

[21] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[22] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[23] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[24] http://srhr.org/abortion-policies/country/swaziland/
[25] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
[26] https://www.hsph.harvard.edu/population/abortion/ZAMBIA.abo.htm
[27] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[28] https://www.hrw.org/world-report/2018/country-chapters/angola accessed 15 June 2018.

**89%** of the **Summit entries** on **freedom** from **GBV**

**Figure 6.4: Topics**

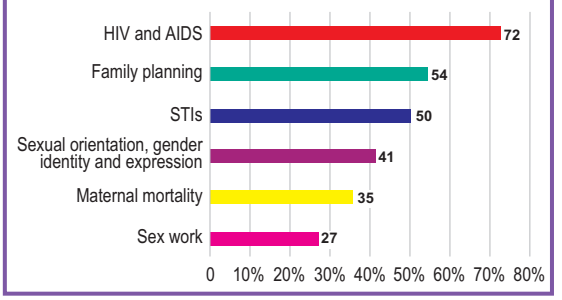



*Source: Gender Links, 2018.*

Figure 6.4 shows that:

- A total of 89% of the Summit entries in the Sexual and Reproductive Health and Rights category included a focus on the freedom from GBV. This a positive sign given the scale of the GBV pandemic in the region.
- Of the 75 case studies 69% covered sexual information and sexuality education and 62% on sexual and reproductive rights.
- Of the total, 62% of the entries focus on the right to accessible and affordable sexual and reproductive health service. Similar proportions of case studies focused on decisions on family planning and reproductive choices. While more than 50% of the case studies focus on these topics it is not sufficient. Women need access to effective and high quality sexual and reproductive health services and contraception. There must an increased focus in these areas.
- Between 45 and 58% of the case studies conducted activities to promote safety in pregnancy, sexual freedom, sexual autonomy and sexual pleasure.
- In all SADC countries the right to termination of pregnancy is legal in a particular and limited set of circumstances except in South Africa where it is a fundamental human right for women. The right to abortion must become an inalienable right for all women across SADC. In the absence of the legal right to abortion women seek illegal abortions that have detrimental effects on their health and sometimes results in death.

**Figure 6.5: Sub topis**




*Source: Gender Links, 2018.*

Figure 6.5 shows that:

- HIV and AIDS received extensive coverage in the case studies, 72% of the entries made reference to HIV and AIDS. The highest number of case studies covered the topic GBV. The intersection between GBV and HIV and AIDS may account for the large proportion of entries in that cover both areas. One of the 14 HIV and AIDS case studies focused on prevention and three on HIV and AIDS and sex work. The majority of the case studies focuses on care and treatment.
- Around half of the Summit entries focused on family planning and Sexually Transmitted Infections (STI's). This number is low given that many women are unable to negotiate safe sex and contract STIs and HIV and AIDS through unprotected sex.

- At 41%, the number of studies making reference to sexual orientation, gender identity and expression is on the rise. Homosexuality is still illegal in many SADC countries.
- Only 35% of the case studies referenced maternal mortality. Levels of maternal mortality in the SADC are high in several.
- Nine of the 16 SADC countries (DRC, Malawi, Mozambique, Lesotho, Angola, Zimbabwe, Tanzania, Swaziland and Madagascar) feature amongst the 35 countries with the highest maternal mortality rates worldwide. Health systems must provide improved safety and services for women during pregnancy.
- Only 27% of the case studies made reference to sex work. Sex workers are often experience marginalisation, stigmatisation and criminalisation making preventing them from accessing healthcare, legal and social services. On average, sex workers are 10 times more likely to become infected with HIV than adults in the general population.[29]

**Making care accessible to sex workers in Zimbabwe**

Women accessing health care services in Kadoma.
*Photo: Thomas Ferenando*

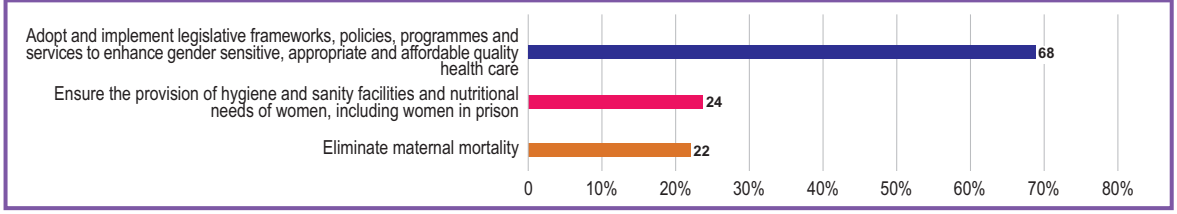
Kadoma has many commercial sex workers who need access to health, treatment and care services. The Ministry set up a clinic at the Kadoma hospital to assist sex workers. The services include HIV therapy, treatment for STIs and counselling.

The clinic offers HIV prevention programs for sex workers, especially female sex workers. Given their marginalisation, concerted efforts must be made to ensure sex workers have equitable access to HIV prevention, care, and treatment services, as well as wider health services, particularly for STIs, mental health, and addictions.

Women in commercial sex work now have equal access to health, treatment and care services.

*Source: SADC Protocol@Work summit, Zimbabwe 2018*

**Figure 6.6: Addressing the Protocol targets on SRHR**




*Source: Gender Links, 2018.*

Figure 6.6 show that:

- 68% of the case studies focused on the provision of gender sensitive, appropriate and affordable health care. While substantial there is a need for more interventions as the current health systems are providing inadequate treatment and care.
- About a quarter of all case studies focus on women's mental, sexual and reproductive health. Only 24% of the submissions focused on the provision of the hygiene and sanitary facilities, and nutritional needs of women.
- The lowest proportion of case studies were on maternal mortality. As mentioned previously high levels of maternal mortality persist in SADC. The issue needs urgent attention.

[29] UNAIDS (2016) 'Prevention Gap Report'.

Protocol@Work

**AMICAALL Swaziland promotes access to SRHR**

The Alliance of Mayors and Municipal Leaders on HIV and AIDS in Africa (AMICAALL) creates access sexual and reproductive health services in Piggs Peak in the Hhohho district. UN agencies claim, sexual and reproductive health includes physical, as well as psycho-logical well-being vis-a-vis sexuality.

AMICAALL Swaziland conducting a workshop on safe sex and contraception.
*Photo courtesy of Linda Chissano*

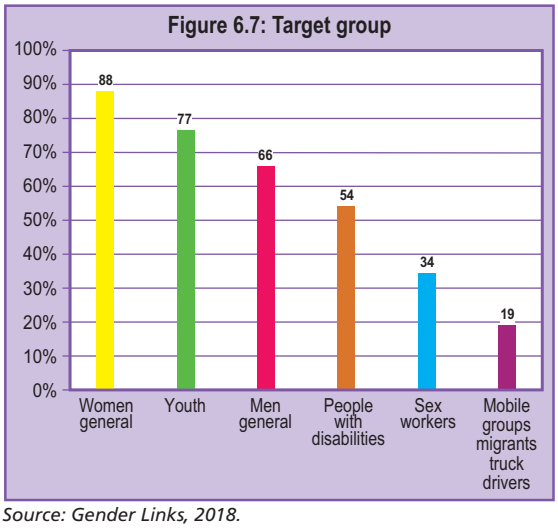
Reproductive health implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Individuals face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment.

It is possible for example, that low income individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health. Women bear and usually nurture children, so their reproductive health is inseparable from gender equality. Denial of such rights also worsens poverty.

The organisation informs women and men about and have access to safe, effective, affordable and acceptable methods of birth control. Women are often unable to access maternal health services due to lack of knowledge about the existence of such services or lack of freedom of movement. The project provides access to health services particularly in areas with high levels of poverty.

AMICAALL Swaziland promotes positive sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

*Source: SADC Protocol@Work summit, eSwatini 2018*




*Source: Gender Links, 2018.*

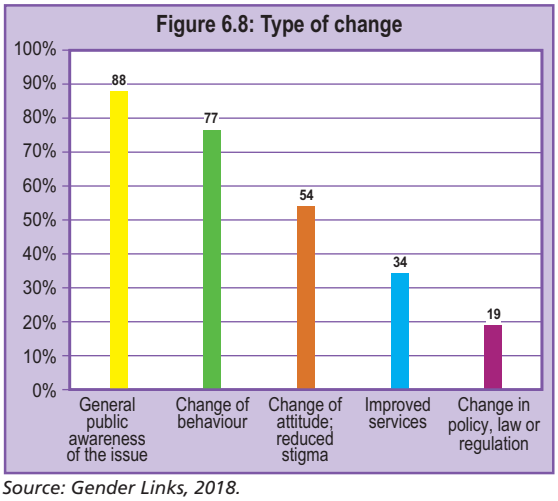
Figure 6.7 shows that:

- Women constitute 88% of the target group in the category sexual and reproductive health and rights. Lower proportions of youth (77%) and men (66%) are targeted.
- More than half (54%) the case studies targeted people with disabilities. This is an important development. Initiatives are targeting the unique needs of people with disabilities while at the same moving them from beng a "special population" to being an integral part of communities.
- Sex workers are afriad to access sexual and reproductive health services because of stigma and discrimination. They are particularly vulnerable to contracting HIV and to experiencing GBV. It is encouraging to note that 34% of the case studies specifically targeted sex workers.

- Less than a fifth of all case studies targeted mobile populations, drug users, LGBTIQ persons and prisoners: HIV and AIDS is one of SADC's most urgent challenges. Moblie populations, drug users and prisoners are vulnerable to contracting HIV. LGBTIQ persons sometimes need specialised sexual and reproductive health services and face discrimination when accessing such services. More targeted interventions are need to address the sexual and reproductive health and rights of these target groups.

Figure 6.8 shows that:

- Of the 75 case studies 86% created greater public awareness about sexual and reproductive health and rights, 81% and 80% resulted in changes in behaviour and attitudes respectively.
- Large proportion of the case studies contribute to better service delivery. The crisis in the provision of public health in most SADC countries has severely impacted sexual and reproductive health services. It is encouraging to note that 77% of the case studies focus on improved services.
- A recurring theme across all categories is the limited focus on policy and legislative change. This is true in the SRHR category with only 54% of the case studies recording changes in legislation and policy.




*Source: Gender Links, 2018.*

## Sanitation

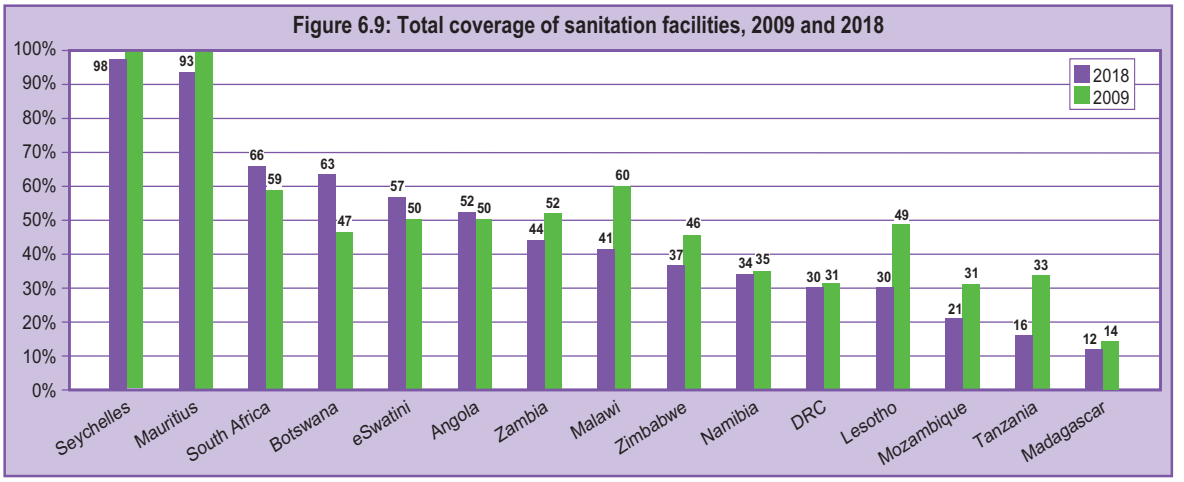
**Article 26 (c):** Ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

Availability of decent sanitation in easy reach of the home is fundamental for the health, safety and dignity of all, but particularly women and girls. Although providing hygiene and sanitation facilities are provisions of the Protocol, developments in the region in this area have been slow.

Focus on women's hygiene and nutritional needs is low. *Photo: Gender Links*

HIV & AIDS is **1** of SADC's most **urgent** challenges

Many people still **lack access** to sanitation, particularly in **rural areas**




*Source: UNICEF 2017.*

Fig 6.9 compares coverage in 2018 with coverage in 2009, when researchers compiled the first Barometer. Few countries have made significant improvements over this period, while coverage in most (Seychelles, Mauritius, Zambia, Malawi, Zimbabwe, Namibia, DRC, Lesotho, Mozambique, Tanzania and Madagascar) has declined. Rising populations require expanded investment just to maintain levels of coverage.

A recent WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) report, *Progress on drinking water, sanitation and hygiene: 2017 update and Sustainable Development Goal baselines*, presents the first global assessment of "safely managed" drinking water and sanitation services. The overriding conclusion is that too many people still lack access, particularly in rural areas.[29]

**Table 6.7: SADC sanitation in rural and urban areas**

| Country | NATIONAL | | | | RURAL | | | | URBAN | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | At least basic | Limited (shared) | Unimproved | Open defaecation | At least basic | Limited (shared) | Unimproved | Open defaecation | At least basic | Limited (shared) | Unimproved | Open defaecation |
| Seychelles | 100 | 0 | 0 | 0 | - | - | - | - | - | - | - | - |
| Mauritius | 93 | 6 | 0 | 0 | 93 | 7 | 1 | 0 | 94 | 6 | 0 | 0 |
| South Africa | 73 | 17 | 8 | 2 | 69 | 10 | 17 | 5 | 76 | 20 | 4 | 1 |
| Botswana | 60 | 8 | 15 | 17 | 40 | 10 | 14 | 37 | 75 | 6 | 16 | 2 |
| eSwatini | 58 | 24 | 7 | 11 | 58 | 21 | 8 | 14 | 58 | 35 | 6 | 1 |
| Malawi | 44 | 23 | 27 | 7 | 43 | 20 | 30 | 7 | 49 | 38 | 12 | 2 |
| Lesotho | 44 | 17 | 9 | 30 | 43 | 7 | 10 | 40 | 46 | 44 | 7 | 4 |
| Zimbabwe | 39 | 24 | 11 | 27 | 31 | 15 | 15 | 39 | 54 | 42 | 4 | 0 |
| Angola | 39 | 15 | 13 | 33 | 21 | 6 | 17 | 56 | 62 | 27 | 8 | 3 |
| Namibia | 34 | 11 | 5 | 50 | 15 | 3 | 5 | 76 | 55 | 21 | 4 | 20 |
| Zambia | 31 | 12 | 42 | 15 | 19 | 7 | 50 | 25 | 49 | 20 | 30 | 1 |
| Tanzania | 24 | 13 | 52 | 11 | 17 | 4 | 63 | 16 | 37 | 34 | 27 | 2 |
| Mozambique | 24 | 5 | 36 | 36 | 12 | 3 | 38 | 47 | 47 | 9 | 32 | 13 |
| DRC | 20 | 21 | 47 | 12 | 18 | 13 | 51 | 18 | 23 | 32 | 42 | 4 |
| Madagascar | 10 | 15 | 32 | 44 | 6 | 9 | 29 | 55 | 16 | 24 | 37 | 23 |

*Derived from UNICEF Global Databases: Sanitation. https://data.unicef.org/topic/water-and-sanitation/drinking-water/ Accessed 20 June 2018.*

[29] http://www.unwater.org/publication_categories/whounicef-joint-monitoring-programme-for-water-supply-sanitation-hygiene-jmp/

Table 6.7 shows the status of SADC countries regarding sanitation. Seychelles and Mauritius are clearly far ahead of the rest of SADC. Meanwhile, ten SADC countries do not have even 50% coverage of basic services nationally and, though urban coverage is much better, seven countries do not have 50% coverage of basic sanitation in urban areas. The extent of open defecation, especially in rural areas, is disturbing. Namibia (76%), Angola (56%) and Madagascar (55%) have more than 50% open defecation in rural areas. However, other countries, such as Malawi (7%) and South Africa (5%), have been able to make noteworthy progress in this regard and also have lower than 10% open defecation, even in rural areas.

Fadzanayi Gamira collects water at a borehole in Ruwa, Zimbabwe. While men sometimes take responsibility for water collection, women primarily do this work in most SADC countries. *Photo: Tapiwa Zvaraya*

Water provision is a critical issue for women's health and wellbeing. The JMP also monitors water-related SDG targets under the recently established Global Expanded Monitoring Initiative (GEMI). Improved drinking water sources are those which by nature of their design and construction have the potential to deliver safe water. The JMP classification of water sources for purposes of monitoring progress in meeting the SDG targets is:

- **Safely managed drinking water service:** improved source meeting three criteria:
  - Accessible on premises;
  - Water available when needed; and
  - Water should be free from contamination.
- **Basic drinking water service:** if the improved source does not meet any one of these criteria, but a round trip to collect water takes 30 minutes or less, including queuing.
- **A limited service:** if a round trip to collect water from an improved source exceeds 30 minutes, including queuing.

The JMP classifies unimproved sources of water, which represent unsafe water which users must boil to be potable, as:

- **Unimproved:** Drinking water from an unprotected dug well or unprotected spring.
- **Surface water:** Drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal.

Previous JMP analysis has shown that collecting water that is either from unimproved sources or surface water is more likely to take more than 30 minutes. This represents a double burden.

Though globally 71% of the world's population is accessing water from a safely managed drinking water source, sub-Saharan Africa has the lowest coverage at 24%, with a further 34% accessing basic water services. This means that 42% of people in sub-Saharan Africa still only access limited or unimproved sources of water.[30]

The **burden** of collecting water falls disproportionately on

and **girls**

[30] World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), 2017. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: Switzerland.

Mauritius & Seychelles have **achieved** almost universal **coverage** of basic **safe water** provision

**Table 6.8: SADC baseline drinking water status**

| Country | NATIONAL | | | | RURAL | | | | URBAN | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | At least basic | Limited | Unimproved | Surface water | At least basic | Limited | Unimproved | Surface water | At least basic | Limited | Unimproved | Surface water |
| Mauritius | 100 | 0 | 0 | 0 | 100 | 0 | 0 | 0 | 100 | 0 | 0 | 0 |
| Seychelles | 96 | - | 0 | 4 | - | - | - | - | - | - | - | - |
| South Africa | 85 | 10 | 2 | 3 | 63 | 24 | 5 | 9 | 97 | 3 | 0 | 0 |
| Botswana | 79 | 18 | 1 | 2 | 58 | 35 | 2 | 5 | 95 | 5 | 0 | 0 |
| Namibia | 79 | 6 | 5 | 10 | 63 | 11 | 7 | 19 | 97 | 1 | 2 | 0 |
| Lesotho | 72 | 12 | 16 | 1 | 66 | 13 | 21 | 1 | 87 | 8 | 4 | 0 |
| ESwatini | 68 | 8 | 10 | 15 | 60 | 9 | 12 | 19 | 95 | 2 | 2 | 2 |
| Malawi | 67 | 20 | 10 | 3 | 63 | 22 | 12 | 3 | 87 | 9 | 4 | 0 |
| Zimbabwe | 67 | 10 | 17 | 7 | 54 | 12 | 23 | 11 | 94 | 4 | 3 | 0 |
| Zambia | 61 | 6 | 21 | 12 | 44 | 7 | 29 | 19 | 86 | 4 | 9 | 1 |
| Madagascar | 51 | 3 | 31 | 16 | 34 | 2 | 41 | 23 | 82 | 4 | 12 | 2 |
| Tanzania | 50 | 13 | 24 | 13 | 37 | 15 | 31 | 18 | 79 | 9 | 9 | 3 |
| Mozambique | 47 | 14 | 24 | 14 | 32 | 17 | 32 | 19 | 79 | 9 | 8 | 3 |
| DRC | 42 | 12 | 36 | 10 | 21 | 11 | 53 | 16 | 70 | 14 | 14 | 2 |
| Angola | 41 | 16 | 19 | 24 | 23 | 13 | 22 | 42 | 63 | 19 | 15 | 3 |

*Derived from UNICEF Global Databases: Drinking Water. https://data.unicef.org/topic/water-and-sanitation/drinking-water/ Accessed June 20, 2018.*

Women collecting water in DRC. *Photo: Gender Links*

Table 6.9 shows that Mauritius and Seychelles have already achieved almost universal coverage of at least basic safe water provision. Ten other countries have 50% or more basic coverage. Angola has the lowest coverage, at 41%, followed by DRC at 42%. There is wide disparity between rural and urban populations in the region, underscoring the fact that achieving SDG-6, to ensure "access to safe water and sanitation," will require a huge investment over the next 15 years.

## Women in refugee camps and prisons

The DRC presents an ongoing and deepening refugee crisis in SADC. In early 2018 an estimated 740 000 refugees from DRC had fled to neighbouring countries, including Angola, Burundi, the Central African Republic, Rwanda, the Republic of Congo, South Sudan, Tanzania, Uganda, and Zambia, as well as Southern Africa and beyond.[31] Angola, Zambia and Uganda have received the greatest inflow of new refugees in 2018. The majority of refugees in Angola and Zambia are women and children under the age of 18. Immediate needs include: health (including maternal and child health, adolescent sexual and reproductive health); nutrition, food production, water and sanitation.

[31] UNHCR, 2018. The Democratic Republic of the Congo: Regional Refugee Response Plan, January - December 2018.

**Improved sanitation, hygiene and food preparation help address malnutrition in Zambia**

The Tithandizane community-based programme in Zambia has set out to improve the health of infants and children through nutritional awareness and support. It provides knowledge and skills on food processing, utilisation and storage. The innovative project began out of a need to reduce malnutrition in the Katele District. Malnutrition impacts child development, especially for children younger than five years. The causes of malnutrition include poor feeding practices; inadequate food intake both in terms of quality and quantity; poor sanitation; and inadequate knowledge by mothers on food preparation.

The project, which began in 2009 in one area of Katete District in the Eastern Province, improves child health, growth and development through an increased focus on nutrition awareness to reduce child mortality and morbidity rates caused by elevated levels of malnutrition. This has been an issue in the area, especially due to poor feeding practices, culture and traditions, HIV and AIDS, poor maternal health, inadequate child care, low crop production causing food insecurity and poor food storage.

The programme has seen success by engaging the community in awareness and education programmes. In addition, the programme employs food processing demonstrations and health education to train community members. This has led to the establishment of nutrition clubs. The clubs align with local cooperatives that preserve vegetables and provide nutrition training. Stakeholders evaluate the programme at quarterly review meetings and through monitoring forms, questionnaires and in-field follow-ups.

The project has partnered with rural health centres, cooperatives, and the Ministry of Social Welfare. The project, which has been funded solely through community contributions, has so far reached 500 direct beneficiaries and indirectly benefitted approximately 5000 community members.

The community has been slow to adopt new cooking methods, which sometimes presents a challenge. Additionally, community members have inadequate knowledge of food processing, utilisation and storage, and poor sanitation and hygiene is common in the community.

Women have benefitted from the project through capacity building, dietary preparation, entrepreneurship skills, provision of inputs for conservation farming and through linkages to cooperatives. In addition to that, community members have seen changes in improved health, better food preparation and improved food security.

Community ownership is key in achieving good health, and volunteerism is important for planning, implementation and evaluation. The community feels confident that the programme will be sustainable in the long run.

*Source: Zelipa Mwale, Katete District, Zambia SADC Protocol@Work 2018*

Access to potable water is essential for the provision of women's sexual and reproductive health needs.
*Photo: Tapiwa Zvaraya*

High levels of **unsafe** abortion **NEED** attention!

## Next steps

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

- Governments in SADC need to pay attention to the high levels of unsafe abortion, particularly amongst younger women, including through:
  - Increasing accessibility and availability of contraception to all to reduce the need for termination of pregnancy.
  - Reviewing legislation and provision of services to make safe abortions more readily available.
- Reduce inequities in the provision of SRHR services, maternal health services, water and sanitation between rural and urban areas and across wealth quintiles. This will require action at the local level in underserved areas.
- Provide and promote evidence-based, human-rights based, quality, socio-culturally sensitive and dignified care, especially to women and newborns.
- Improve the quality of services for all, including training and motivation of health care providers.
- Improve provision of SRHR services for adolescents, including information, menstrual health and access to contraceptives.
- Take action to end child marriage, including legislation and mobilisation of families and local leaders.
- Invest in programmes to bring safe drinking water and sanitation services to all, including rural and urban communities in all parts of the region.


Immune boosting vaccine injections administered at a clinic in Lesotho. *Photo: Gender Links*