SOUTHERN AFRICA GENDER 2026

BAROMETER



Menstrual Health, Family Planning and Maternal Health

Southern Africa Gender Protocol Alliance

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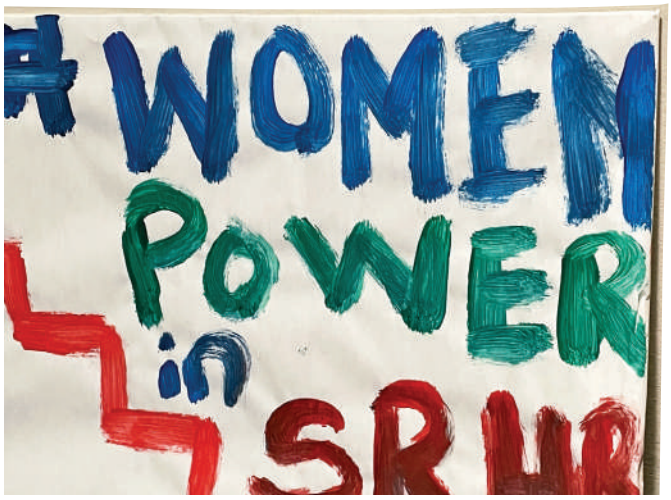


Key points

- Fifteen of sixteen SADC states have introduced HPV vaccination, with Angola, Comoros, Madagascar and Namibia launching in 2025 (WHO/UNICEF WUENIC 2025 revision). The DRC is the only remaining hold-out.
- Only Mauritius (66) and Seychelles (42) meet the SDG 3.1.1 maternal mortality target of 70 per 100,000; three states sit above 400, the DRC (547), Lesotho (478) and Madagascar (445).
- Sub-Saharan modern-contraception unmet need has fallen from 21.1% in 2012 to 18.5% in 2025 FP2030 2025 Impact Report[1]. but eight SADC states still fail to meet women's contraceptive needs (SADC Third Milestone Scorecard, February 2026).
- East and Southern Africa's adolescent birth rates remain twice the global average at 92 per 1,000 girls aged 15-19. Seven SADC states exceed 100 per 1,000, led by Mozambique at 154.
- The 20 January 2025 USAID freeze has hit SRHR delivery across SADC hard: UNFPA lost more than 40 humanitarian projects worth ~US$335 million and DREAMS shut down. The financing shock cuts across every finding in this chapter.

[1] 'Impact Report 2025' Family Planning 2030. Available at: https://www.fp2030.org/impact-report-2025/ (Accessed: 25 August 2026).

Introduction



The 2024 Barometer chapter on maternal health relied heavily on the SADC SRHR Scorecard 2023 and on national survey data that was often five or more years old.[2] That has begun to change. Four new national surveys have landed since the 2024 Barometer: the Lesotho DHS 2023-24 Final Report (November 2024), Key Indicators Reports from Malawi (2024) and Zambia (2024), and the Zimbabwe DHS 2023-24 Key Findings (June 2025). The Tanzania DHS 2022 (September 2023) and the Mozambique DHS 2022-23 (May 2024), which both pre-dated the 2024 Barometer complement this.

The WHO, UNICEF, UNFPA, the World Bank Group and the United Nations Department of Economic and Social Affairs, Population Division (UNDESA/Population Division), have published the Trends in Maternal Mortality[3] with 2000-2023 estimates. The report presents internationally comparable global, regional, and country-level estimates and trends for maternal mortality between 2000 and 2023.

It reveals that 260,000 women died from pregnancy or childbirth complications in 2023, with 70% of deaths in Sub-Saharan Africa. It calls for urgent investment in midwives, health workers, and equitable systems to close care gaps and improve sexual and reproductive health. The FP2030 2025 Impact Report has refreshed the family planning story. This chapter is therefore able to speak from a substantially updated database, even as gaps remain for Comoros, Mauritius, Namibia and Botswana on several family planning indicators.

The **SADC Third Milestone Sexual and Reproductive Health and Rights (SRHR)** Scorecard, released in February 2026 using 2025 data, is the 2026 Barometer's primary reference. Its headline is deliberately balanced: progress in reducing adolescent birth rates and maternal deaths, alongside continued gains in preventing vertical HIV transmission, contrasts with rising sexually transmitted infections, persistently high maternal mortality, and eight SADC states that are not meeting the contraceptive needs of women of reproductive age.

Overall, the Scorecard depicts a region where small-island states have achieved Sustainable Development Goal (SDG) 3 - ensuring healthy lives and promoting well-being for all at all ages by 2030 - while several larger countries continue to lag.

A recurrent theme in this chapter is **financing**. On 20 January 2025, the United States froze all foreign assistance for 90 days, subsequently cancelling most sub-awards under the President's Emergency Plan for AIDS Relief (PEPFAR), dissolving the United States Agency for International Development (USAID), and ending the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe (DREAMS) programme that had integrated HIV, sexual and reproductive health, and gender-based violence services for approximately two million adolescent girls and young women across ten SADC states.[4]

[2] Gender Links and SADC Gender Protocol Alliance (2024) SADC Gender Protocol Barometer 2024: Voice and Choice. Johannesburg: Gender Links, Chapter 2 (Health).
[3] Trends in maternal mortality 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Available at: https://www.who.int/publications/i/item/9789240108462 (Accessed: 7 September 2026).
[4] Chandra-Mouli, V et al. (2025) Modelling the impact of US foreign aid cuts on HIV incidence and mortality in low- and middle-income countries, 2025-2030. The Lancet Global Health. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00281-5/fulltext (accessed August 2026).

The Lancet Global Health predicts up to 2.93 million additional AIDS deaths across low-and middle-income countries by 2030 as a direct consequence.[5] The Gavi (Vaccine Alliance, a public-private global health partnership dedicated to increasing access to immunisation in lower-income countries) replenishment closed at just over US$9 billion, approximately US$2.9 billion short of its US$11.9 billion target.[6]

This threatens the trajectory of HPV vaccination in Africa, which had tripled from 12 to 35 countries from 2019 to 2024. HPV vaccination is a safe and effective shot that protects against human papillomavirus infections, which can cause genital warts and several types of cancer. Coverage rose from 5% in 2014 to 47% in 2024, placing the region second globally behind only the Americas.[7] HPV vaccination is estimated to have already helped avert close to one million cervical cancer deaths across 29 African countries as of 2024, with 10 further African countries planning to introduce the vaccine with Gavi support by 2030.[8]

Menstrual, maternal and family planning health in the SGDI

The Southern Africa Gender and Development Index (SGDI) is Gender Links' companion accountability tool to this Barometer. It tracks gender equality across the 16 SADC states through 70 indicators grouped into 11 thematic chapters, of which menstrual, maternal, and family planning health is one. Every SGDI indicator is standardised to a gender equality score out of 100, where 100 represents parity, the desired policy outcome, or full achievement of the underlying international target.

A country's score for each theme is the average of its indicator scores in that theme; the regional score is the average of country scores. The SGDI therefore compresses a complex evidence base into one comparable number per country per theme, while this Barometer chapter unfolds the same evidence into narrative, country context and policy detail. The two products are designed to be read together.

The SGDI MHFPMH basket comprises eight indicators. Six of them, adolescent birth rate, skilled birth attendance, maternal mortality, antenatal care, HPV vaccination and contraceptive prevalence (together with its inverse, unmet need for family planning), sit inside this chapter's Barometer dashboard and receive detailed narrative treatment in the sub-sections below.

The seventh, women's representation in sexual and reproductive health and rights news, sits inside the Barometer's Gender in Media chapter rather than this one, because it is a media-industry indicator best tracked as part of the annual media monitoring exercise; it is nevertheless reflected here in Table 2.1 and Figure 2.2 so that the SGDI-Barometer link is visible on the page. Two indicators tracked in this chapter's dashboard, basic sanitation coverage and postnatal care coverage, are Barometer additions not included by the SGDI. The Barometer retains them because sanitation is the essential infrastructure link between menstrual health, water and dignity, and because postnatal care completes the continuum of care. Table 2.1 sets out the map. The one SGDI MHFPMH indicator not otherwise covered in this chapter is covered in the Barometer Gender in Media chapter.

[5] UNAIDS (2025) The impact of US funding cuts on the HIV response, March 2025 briefing. Available at: https://www.unaids.org/en/impact-US-funding-cuts (accessed August 2026).
[6] Global Summit: Health & Prosperity through Immunisation. Available at: https://www.gavi.org/investing-gavi/resource-mobilisation-process/protecting-our-future (Accessed: 28 August 2026).
[7] Africa's routine vaccine systems deliver gains against cancer and malaria, but funding pressures loom. Available at: https://www.gavi.org/news/media-room/africas-routine-vaccine-systems-deliver-gains-against-cancer-and-malaria-funding (Accessed: 28 August 2026).
[8] Africa's routine vaccine systems deliver gains against cancer and malaria, but funding pressures loom. Available at: https://www.gavi.org/news/media-room/africas-routine-vaccine-systems-deliver-gains-against-cancer-and-malaria-funding (Accessed: 28 August 2026).

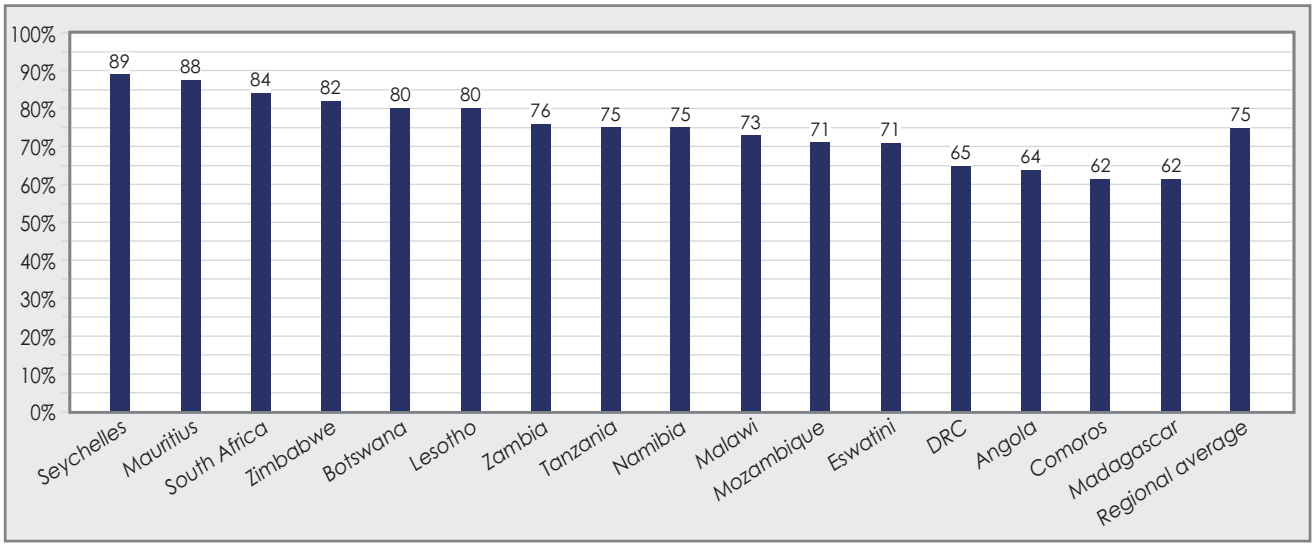
Table 2.1: SGDI MHFPMH basket and 2026 Barometer MMFP dashboard map

SGDI MHFPMH indicator	SGDI 2026 regional score (0-100)	In Barometer MMFP dashboard?	Where covered in this chapter
Women's representation in SRHR news	96	Covered elsewhere in Barometer	
Adolescent birth rate	91	Yes	Maternal health and adolescent SRHR section (see Figure 2.5)
Skilled birth attendance	84	Yes	Maternal health and adolescent SRHR section (continuum of care)
Family planning needs met	80	Yes, as unmet need for family planning (inverse)	Family planning and reproductive agency section
Maternal mortality	78	Yes	Maternal health and adolescent SRHR section (see Table 2.1)
Antenatal care (4+ visits)	64	Yes	Maternal health and adolescent SRHR section (see Figure 2.4)
HPV vaccination	62	Yes	HPV vaccination and cervical cancer elimination section (see Figure 2.6)
Contraceptive prevalence	48	Yes	Family planning and reproductive agency section
Basic sanitation coverage	Not in SGDI MHFPMH basket	Yes (Barometer addition)	Menstrual health, water, sanitation and dignity section
Postnatal care coverage	Not in SGDI MHFPMH basket	Yes (Barometer addition)	Maternal health and adolescent SRHR section (continuum of care)

Source: Gender Links (2026) SGDI

The SGDI standardises all eight indicators to a score out of 100. This gives an overall score of 75 out of 100 for menstrual, maternal and family planning health. This is the region's third-highest thematic score, after climate justice (80) and economic justice (76), and equal to the score for HIV and AIDS (75). It also exceeds the overall SGDI score of 58 across all 11 themes, indicating that SADC states have made measurable progress.

Figure 2.1: SGDI 2026 MHFPMH gender equality score, by SADC country



Source: Gender Links (2026) Southern Africa Gender and Development Index 2026, MHFPMH chapter

Figure 2.1 presents the country-level results. The regional average masks wide disparities: Seychelles (89) and Mauritius (88) lead, while Madagascar and Comoros (both 62) rank lowest.

Table 2.2: MMFP regional dashboard: Indicators across 16 SADC states

Country	Sanitation % (2024)	CPR any method %	Unmet need FP %	MMR / 100k (2023)	Skilled Birth Attendants %	HPV last dose %	ABR / 1,000 (2023)	ANC4 %	PNC 48h %	Media Parity %
Angola	50.3	13.7	38	183	50	61	140.8	61	23.3%	100
Botswana	72.1	67.4	17.3	155	100	34	53.8	n/d	n/d	58
Comoros	57.2	19.4	32	179	82	26	55.2	n/d	90.7%	n/d
DRC	16.3	20	31.6	547	85	not intro	106.9	48	49.5%	78
Eswatini	64.5	57.7	20.4	118	88	13	68.7	76	87.5%	n/d
Lesotho	47.9	67	13	478	92	30	70.6	82	84.0%	67
Madagascar	15.4	49.7	14.6	445	49	77	129.8	30	54.9%	n/d
Malawi	49.2	68	18	225	90	82	113.6	47	83.7%	33
Mauritius	97.4	63.4	n/d	66	100	87	19.8	n/d	n/d	n/d
Mozambique	38.6	26.4	26.6	82	76	74	153.5	n/d	35.8%	n/d
Namibia	38.7	55.1	12	139	88	34	66	79	69.0%	n/d
Seychelles	99.7	n/d	n/d	42	99	67	54.5	n/d	n/d	n/d
South Africa	77.4	54.6	14.9	118	97	79	51.6	76	83.6%	100
Tanzania	37.2	37.6	21	276	85	99	113.2	65	50.5%	n/d
Zambia	37.5	50	16	85	80	52	115.9	63	69.7%	56
Zimbabwe	34.6	66	7	358	78	90	98.1	76	82.1%	60

Column-header colour legend:	SGDI	Barometer - only

Source: Basic sanitation: WHO/UNICEF JMP via World Bank (SH.STA.BASS. ZS), 2024. Contraceptive prevalence and unmet need: UN Population Division / DHS / MICS national releases (varies by country; oldest data Botswana 2007-08 and Comoros 2012, newest Malawi and Zambia 2024). Maternal mortality: WHO/UNICEF/UNFPA/World Bank Trends in Maternal Mortality 2000-2023 (2025 release, 2023 estimates). Skilled birth attendance and ANC4: WHO/UNICEF/DHS (varies). HPV vaccination: WHO/UNICEF WUENIC 2025 revision. Adolescent birth rate: UN Population Division WPP 2024 via World Bank (SP.ADO.TFRT), 2023 estimates. Media parity: Gender Links Media Progress Study. 'n/d' indicates no reliable data available.

Table 2.2 expands each SGDI MHFPMH indicator into ten indicators across all 16 SADC member states. Each subsequent thematic section, menstrual health and WASH, family planning and reproductive agency, maternal health, HPV vaccination, and access and inclusion, benchmarks its country findings against the SGDI regional score.

Reading the dashboard by column rather than by row surfaces a strong **two-speed pattern**. The four small-island or island-adjacent economies, Mauritius, Seychelles, and to a lesser extent Botswana and Eswatini, show progress across most indicators.

The larger mainland economies, Angola, the DRC, Madagascar, Mozambique and Tanzania, are yet to cover significant ground on adolescent birth rate, maternal mortality, and sanitation. The middle tier, Zambia, Zimbabwe, Malawi, Lesotho, Namibia and South Africa, presents a mixed picture with progress on family planning and skilled birth attendance offset by weaker performance on sanitation or HPV.

Three headline **gains** stand out.

- First, Mauritius (66) and Seychelles (42) have brought **maternal mortality** below the SDG 3.1.1 target ceiling of 70 deaths per 100 000 live births.[9] Both are small-island economies with universal health coverage in place, but the achievement is real and worth naming. Mozambique (82), Zambia (85) and South Africa (118) continue to trend downward from earlier years. Together, these five states demon-

[9] World Health Organisation, UNICEF, UNFPA and World Bank Group (2025) Trends in Maternal Mortality 2000-2023. Geneva: WHO. Available at: https://data.who.int/indicators/i/C071DCB/AC597B1 (accessed August 2026).

strate that below-100 maternal mortality is achievable in the SADC operating environment. They also account for a disproportionate share of the region's overall progress since 2019.

- Second, **HPV vaccination has moved from a regional experiment to a regional programme**. The Lancet Global Health documents that African HPV vaccination programmes have almost tripled, from 12 countries in 2019 to 35 by 2024, with regional coverage rising from 5% in 2014 to 47% in 2024. Within SADC, fifteen of sixteen states have now introduced HPV vaccination into their national immunisation programmes per the WHO/UNICEF WUENIC 2025 revision. Tanzania (99% final-dose coverage), Zimbabwe (90%), Mauritius (87%), Malawi (82%) and South Africa (79%) lead the region. Angola (61%), Comoros (26%), Madagascar (77%) and Namibia (34%) newly introduced HPV during 2025 and are reflected in the regional dashboard for the first time. The Democratic Republic of the Congo remains the only SADC state yet to introduce a national HPV programme.
- Third, **family planning has posted quiet but measurable progress**.[10] The FP2030 2025 Impact Report[11] records that sub-Saharan Africa's modern-contraception unmet need dropped from 21.1% in 2012 to 18.5% in 2025. Malawi's 2024 DHS records contraceptive prevalence at 68% among women aged 15 to 49, one of the highest in SADC and above the WHO population-saturation benchmark. Zimbabwe's 2023-24 DHS records unmet need at 7%, the lowest in the region. Lesotho's 2023-24 DHS records skilled birth attendance at 92% and antenatal care coverage of at least four visits at 82%, both material improvements on the country's 2015 baseline.

Four headline **setbacks** include:

- Three SADC states have **maternal mortality** ratios above 400 per 100,000 live births, the Democratic Republic of the Congo (547), Lesotho (478) and Madagascar (445).[12] All three are more than six times the SDG 3.1.1 target, and neither the DRC nor Madagascar has shown meaningful improvement since 2015. Lesotho's high ratio sits alongside its otherwise strong performance on skilled birth attendance and antenatal care, indicating that clinical coverage is not the binding constraint; the underlying determinants are elsewhere, health-system referral, obstetric emergency response, and the intersection with high HIV prevalence.
- **Adolescent birth rates remain stubbornly high**. The UNFPA East and Southern Africa Regional Office (ESARO) reports a regional adolescent birth rate of 92 per 1,000 girls aged 15 to 19, twice the global average of 42. Seven SADC states are above 100 per 1,000: Angola (141), Madagascar (130), Malawi (114), Mozambique (154), Tanzania (113), Zambia (116) and the DRC (107). Mozambique's figure is the highest in the region and consistent with the country's Mozambique DHS 2022-23 result. Adolescent pregnancy complications and HIV remain the leading causes of death among 15-to-19-year-old girls across ESA, and the funding shocks documented later in this chapter have hit the DREAMS programme that had been the single largest integrated response to HIV.
- **HPV vaccination coverage in South Africa dipped to 20%** in 2023 following a documented supply disruption before recovering to 79% in the WUENIC 2025 revision. Even the region's strongest performing states (Tanzania 99%, Zimbabwe 90%, Mauritius 87%, Malawi 82%) remain close to but not yet above the WHO Cervical Cancer Elimination Strategy target of 90% by 2030. The Democratic Republic of the Congo has yet to introduce HPV vaccination.
- **Basic sanitation coverage** remains below 20% of the population in Madagascar (15%) and the DRC (16%) as of the 2024 WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene update. The SDG 6.2 target of achieving universal access to adequate and equitable sanitation and hygiene, and to end open defecation by 2030, is not attainable at current rates of change for either country.

10FP2030 (2025) Impact Report 2025. Washington DC: FP2030. Available at: https://www.fp2030.org/impact-report-2025/data/ (accessed August 2026).
11'Impact Report 2025'. Family Planning 2030. Available at: https://www.fp2030.org/impact-report-2025/ (Accessed: 25 August 2026).
12World Health Organisation, UNICEF, UNFPA and World Bank Group (2025) Trends in Maternal Mortality 2000-2023. Geneva: WHO. Available at: https://data.who.int/indicators/i/C071DCB/AC597B1 (accessed August 2026).

The recommendations at the end of this chapter accordingly focus on the countries and indicators where the gap between current performance and the 2030 target is largest, and where a policy or financing lever exists to close it.

Menstrual health, water, sanitation and dignity

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.



MT Foundation products to improve access to menstrual hygiene and promote menstrual health education. Site visit in Bloemfontein, Free State Province, South Africa. *Photo: Thenjiwe Ngcobo*

Menstrual health sits at the intersection of dignity, education, water, and gender equality. Period poverty, the inability to access affordable menstrual products, private sanitation, and accurate information, is not a marginal issue in the SADC region. It costs adolescent girls school days each month. It constrains women's participation in work and public life, and it is a running story of a hidden regional inequality.

The scale of period poverty across sub-Saharan Africa is documented in the 2024 systematic review published in Global Health Research and Policy.[13] The review synthesises evidence that menstrual hygiene management in the region is characterised by inadequate access to affordable and safe menstrual products, insufficient private and hygienic facilities in schools and workplaces, and pervasive stigma that keeps women and girls silent about their menstrual health. Absenteeism from school during menstruation remains a documented consequence across most SADC states without a comprehensive menstrual health policy in place. The SADC Third Milestone SRHR Scorecard records that fewer than half of SADC member states currently guarantee free menstrual products in schools, and only seven have removed value-added tax on menstrual products.

The 2024 Barometer captured the persistence of extreme practices in the region. A widely circulated 2022 Africanews report documented women and girls in rural Zimbabwe using cow dung, rags and leaves in place of sanitary products because they could not afford them or could not access them locally.[14] The story sat alongside similar reports from Malawi, Mozambique and the DRC. While the immediate humanitarian frame drew attention, the underlying story is one of a structural gap in provision. Where a national policy has closed that gap, as in Namibia through VAT removal and Zimbabwe through the Education Amendment Act, the practice has receded. Where the policy gap persists, so do unsafe practices. Young women activists in some countries are taking the lead in demanding change:

[13] Muhula, S et al. (2024) 'Menstrual hygiene management in sub-Saharan Africa: a systematic review', Global Health Research and Policy, 9. Available at: https://ghrp.biomedcentral.com/articles/10.1186/s41256-024-00358-x (accessed August 2026).
[14] Africanews (2022) 'Women and girls use cow dung as sanitary pads in rural Zimbabwe'. Available at: https://www.africanews.com (accessed August 2026).



South Africa: TOFYWD breaking barriers in Jerusalem, Johannesburg



Distribution of dignity packs after a successful young women's workshop. Jerusalem, Johannesburg South Africa. *Credit: Farai Nyamazana*

In the informal settlement of Jerusalem in northern Johannesburg, a young woman named Nondumiso is rewriting the story of dignity and empowerment for adolescent girls. Her journey began with a simple observation: too many girls in her community were missing school because of period poverty, stigma, and the lack of accurate information about their bodies. Conversations about menstruation were taboo, leaving young girls isolated and uninformed.

That started to change when The Organisation for Young Women's Dignity (TOFYWD) launched a menstrual hygiene and sexual and reproductive health education workshop in the community. The programme aimed to break the silence, provide essential products, and equip girls with knowledge about their bodies and their rights. For Nondumiso, it was life-changing. She trained as a peer educator and turned her passion into leadership, creating safe spaces for other girls to talk, learn and advocate for themselves.

"Being part of this workshop changed my life. I went from feeling helpless about the situation in my community to becoming a leader who now educates and inspires other girls. I've seen the difference it makes," say Youth Peer Educator Nondumiso.

"Before, I used to miss school during my period because I was too embarrassed and didn't have pads. Now, thanks to the sessions and the pads we receive, I feel confident, and I don't miss school anymore," adds Zamahlubi Mathangana, Grade 6 learner.

The change has been measurable. Girls attend school through their periods with confidence and dignity. Teachers report improved attendance and participation. Community leaders praise the programme for opening honest conversations that were long overdue. TOFYWD is now building partnerships with local government, businesses and health stakeholders to secure a steady supply of menstrual products and to integrate reproductive health education into school curricula. TOFYWD is extending the peer education model to neighbouring communities.

TOFYWD's work sits within the broader Flow Without Fear advocacy campaign, a community-led initiative that also engages young men and boys as partners in gender justice and gender-based violence prevention, positioning them as champions rather than bystanders. Source: The Organisation for Young Women's Dignity, Story of Change, November 2025.

Source: The Organisation for Young Women's Dignity, Story of Change, November 2025.

Legal and policy reforms: VAT removal and free products in schools

Two national policy instruments have proven most consequential for menstrual health in the region. The first is the removal of value-added tax from menstrual products, which lowers the price of a monthly essential and signals that governments treat menstrual products as a public health good rather than a taxable luxury. Namibia's Value-Added Tax Amendment Act 2022 zero-rated sanitary pads with effect from 1 January 2023, removing the previous 15% VAT. Kenya was the first country in the world to abolish VAT on sanitary pads in 2004, following lobbying from health advocates and rights groups, and at least 17 countries worldwide have since followed suit. Namibia's 2023 reform brought a SADC state into the group of pacesetters.

The 2024 Barometer records that seven SADC states have now removed VAT from menstrual products, the 2026 dashboard confirms this and adds Namibia to the group.

The second instrument is the legal guarantee of free menstrual products in schools. Zimbabwe's Education Amendment Act 2020 was the first SADC statute to make this an enforceable right, with an annual budget line since.[15] UNICEF Zimbabwe reports that public investment in menstrual health and hygiene has grown since the reform and that school-based provision has spread across provinces.[16] The 2024 Barometer records that a further four SADC states now provide menstrual ware in schools through non-statutory means, five in total when Zimbabwe is included. Kenya has since gone further with a National Menstrual Health Management Strategy 2024-2030 that other SADC states are examining as a model.



Malawi is the most visible gap country, as neither reform has been enacted. Meanwhile, at community level, initiatives such as the World Vision-supported reusable pads programme in Dowa District have stepped into the policy gap. The Malawi case shows both what community response can achieve and why it is not a substitute for national policy.

Malawi: Men as menstrual health champions in Dowa District



Community members sewing reusable sanitary pads in a school in Dowa District of Malawi. *Credit: Meclina Chirwa, Atlas Media*

In Dowa District, Malawi, an initiative supported by World Vision has changed the face of menstrual health advocacy.

The champions are men. Maxwell Mateyu and Frank Simeon joined a mother group at Nagwira Primary School to help address the menstrual poverty affecting girls and women in their community. Trained to use locally available materials to produce reusable sanitary pads, they now work alongside women leaders to make the pads, distribute them, and talk openly with parents and community members about menstrual health.

The programme runs against a long-standing regional pattern in which menstrual health advocacy has been almost entirely delivered by women. Male silence has often reinforced stigma. The Dowa initiative flips that. Men who make and hand out pads become visible interlocutors on a subject their communities have treated as taboo. Women leaders in the community report a measurable reduction in school absenteeism among girls, and community awareness of menstrual poverty has widened.

"When I first joined, some people laughed. Now the same people come and ask us for pads for their daughters. The stigma is breaking," said a Dowa community member.

The initiative is one of a small but growing set of male-champion programmes for menstrual health across the region. It is also a reminder that in the absence of a national free-in-schools policy in Malawi, community-based collaboration is doing the work the state has not yet done.

The story is significant not only for what it delivers in Dowa, but for what it demonstrates about male engagement in menstrual health, turning what has been almost exclusively a women's advocacy space into a shared responsibility.

Source: Meclina Chirwa, Atlas Media, 4 November 2025, Media Parity Capacity Building Programme.

[15] Government of Zimbabwe (2020) Education Amendment Act, 2020 - providing for free sanitary materials in schools. Harare.
[16] UNICEF (2024) Zimbabwe: Stepping up action on investment in menstrual health and hygiene. Available at: https://www.unicef.org/zimbabwe/stories/stepping-action-investment-menstrual-health-hygiene (accessed August 2026).

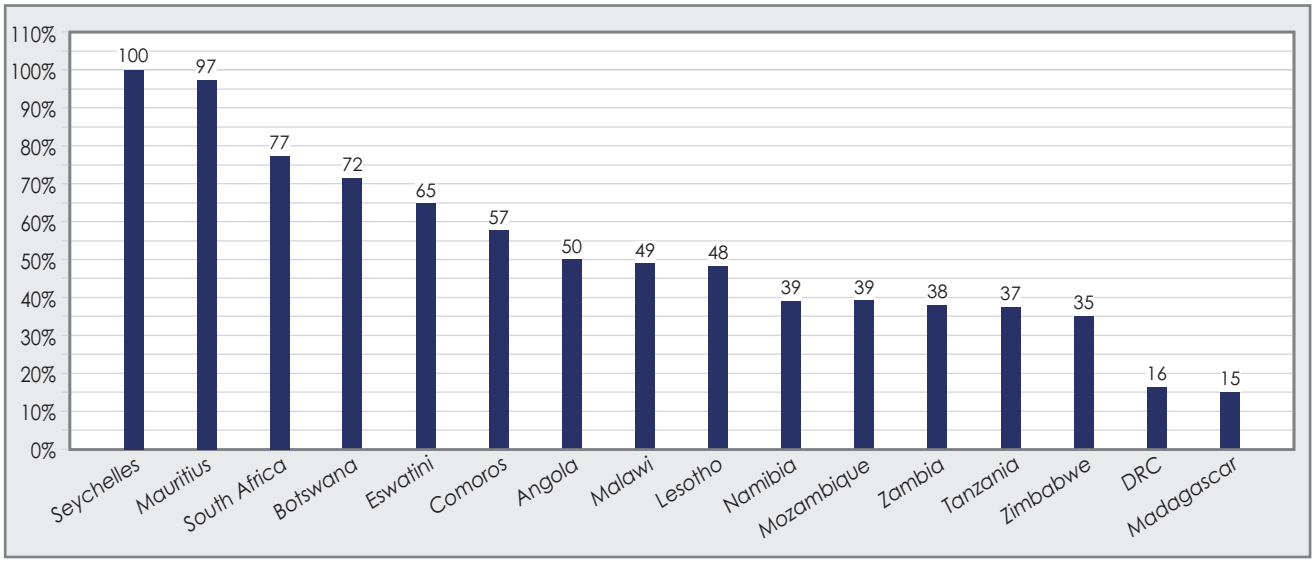
Basic sanitation and handwashing infrastructure

Article 26 (c) SADC Gender Protocol: Ensure the provision of hygiene and sanitary facilities and the 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.

Menstrual health, Water, Sanitation and Health (WASH) frame the entry point to the broader SRHR conversation. At the core of this is the recognition that women and girls have the right to information, products, private facilities, dignity and support that lets them manage a normal biological function without shame or exclusion.

Figure 2.2: % population using at least basic sanitation



Source: UNFPA World Population Dashboard 2025; national DHS/MICS releases. SGDI 2026 regional score for contraceptive prevalence: 48/100

Figure 2.2 shows that in Madagascar and the DRC, fewer than one in five people have access to at least basic sanitation. In Zimbabwe (35%), Zambia (38%), Tanzania (37%), Mozambique (39%), and Namibia (39%), coverage sits below the sub-Saharan African average. Only Mauritius (97%) and Seychelles (99%) have effectively achieved universal coverage. South Africa at 77% is the next best performer on the mainland.

Adolescent girls and women feel the gap most acutely. Menstrual hygiene management becomes structurally difficult where sanitation is limited to shared or open facilities, as privacy, disposal and hand-washing all require the same infrastructure that the coverage figures show is absent.

WHO-UNICEF Joint Monitoring Programme data on handwashing facilities at the household level, which the 2024 Barometer chapter tracked separately, mirrors the sanitation picture: universal or near-universal in Mauritius and Seychelles; low across DRC, Madagascar and Mozambique.

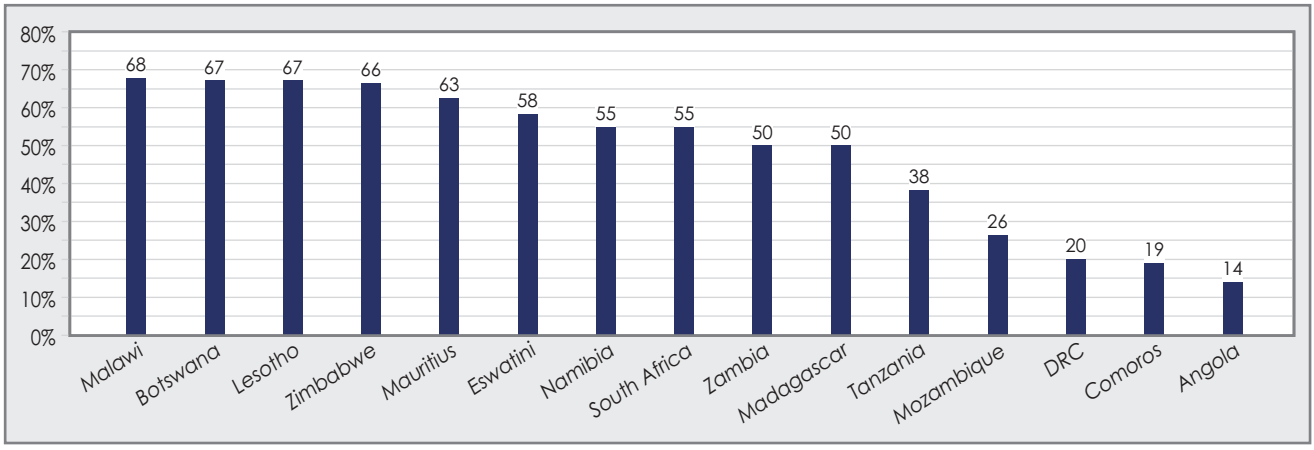
Family planning and reproductive agency

SDG 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including 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.

SADC has posted quiet gains on family planning, but the 2025 US foreign assistance collapse has hit contraceptive commodity supply hard. The Family Planning (FP) 2030 2025 Impact Report records that sub-Saharan Africa's modern-contraception unmet need dropped from 21.1% in 2012 to 18.5% in 2025, a slow but sustained regional gain.[17] Modern contraceptive users doubled in 28 of 87 FP2030 partnership countries over the same period, with the method mix shifting materially towards implants and injectables. Within East and Southern Africa, the modern contraceptive prevalence rate for married women aged 15 to 24 now ranges from 21.4% in Mozambique to 61.1% in Rwanda, indicating substantial within-region variation that the SADC dashboard also reflects.

Figure 2.3: Contraceptive prevalence rate, any method, by SADC country



Source: UNFPA World Population Dashboard 2025; national DHS/MICS releases. SGDI 2026 regional score for contraceptive prevalence: 48/100

Figure 2.3 shows that contraceptive prevalence sits at 68% in Malawi (2024 DHS), 67% in Lesotho (2023-24 DHS) 66% in Zimbabwe (2023-24 ZDHS), and 67% in Botswana, all above the WHO population-saturation benchmark of 65%.

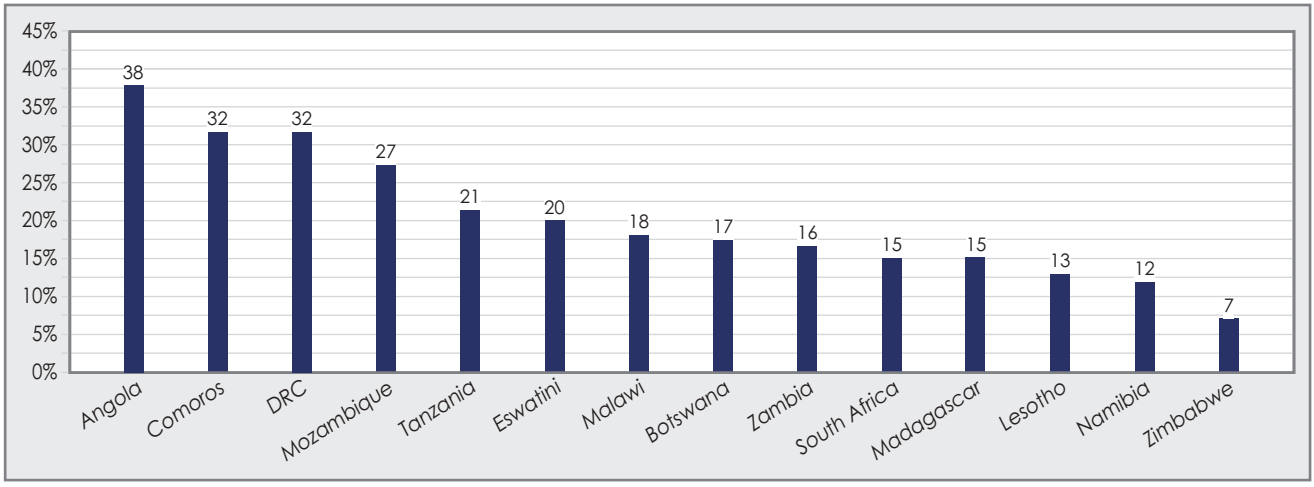
At the other end of the spectrum, Angola sits at 13.7% as of its 2015-16 IIMS, Comoros at 19.4% from the 2012 EDSC-MICS, and the DRC at 20% from the 2023-24 EDS-RDC preliminary release.

Between these two clusters sit Madagascar at 50% (2021 EDSMD-V), Namibia at 55% (2013 NDHS), South Africa at 55% (2016 SADHS), and Zambia at 50% (2024 ZDHS).

Seychelles is not shown; it has never conducted a DHS or MICS survey and is not a FP2030 partnership country, so no internationally-harmonised contraceptive prevalence estimate is published.

[17] FP2030 (2025) Impact Report 2025. Washington DC: FP2030. Available at: https://www.fp2030.org/impact-report-2025/data/ (accessed August 2026).

Figure 2.4: Unmet need for family planning



Source: SADC SRHR Third Milestone Scorecard 2025; national DHS/MICS releases. SGDI 2026 regional score for family planning needs met: 80/100

Unmet need for family planning shows the same pattern in reverse. Zimbabwe reports 7% unmet need for family planning in the 2023-24 ZDHS at national women-of-reproductive-age level, the lowest such national figure in the region and among the lowest anywhere in sub-Saharan Africa; the same survey shows adolescent unmet need at approximately 37% among unmarried 15-19-year-olds, which highlights the persistent age-based gap even in strong-performing states. Namibia (12%), Lesotho (13%), Madagascar (15%), South Africa (15%) and Zambia (16%) all sit in the light-green band. Angola at 38% (2015-16), Comoros at 32% (2012) and the DRC at 31.6% (2023-24) remain the outliers, indicating that four in ten women in Angola who want to space or limit their pregnancies cannot access contraception. The figure has not moved for a decade.

Mauritius and Seychelles are not shown. Neither has run a DHS or MICS survey in the recent reporting cycle, both sit outside the FP2030 partnership country list, and both have total fertility rates at or below replacement level; the UN Population Division's World Contraceptive Use file therefore does not publish unmet-need estimates for either. The regional analysis in this section is drawn from the 14 SADC states with data.

Reproductive agency: from access to decision-making

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.

The UNFPA State of World Population 2025 reframes the family planning debate.[18] Where previous cycles measured access to contraception, the 2025 report measures reproductive agency:[19] the freedom to decide whether to have sex, whether to have children, how many, and when. UNFPA argues that the true fertility crisis in most countries is not too many or too few births but the systematic gap between the number of children women say they want and the number they end up having. The report defines reproductive agency as a bundle of

[18] UNFPA (2025) State of World Population 2025: The real fertility crisis is the lack of reproductive agency. New York: UNFPA. Available at: https://www.unfpa.org/state-world-population-2025 (accessed August 2026).
[19] Sexual and Reproductive Agency | United Nations Population Fund. Available at: https://www.unfpa.org/SRA (Accessed: 13 September 2026).

rights that includes access to information, contraceptive choice, freedom from coercion, and support for the decisions a woman makes.

For SADC, the agency framing turns family planning from a supply to a decision-making question. Contraceptive prevalence tells us the extent to which women use a method; women's decision-making on contraception tells us the extent to which women make those decisions.[20] The 2024 Barometer chapter tracked women's involvement in decision-making on contraceptive use as a distinct indicator. The 2026 chapter adopts the same framing but sets it inside the broader UNFPA agency architecture. Where data permits, and this data is patchy across SADC, the picture is of a region where formal contraception has become more widely available but where the share of women who report making the contraceptive decision themselves has moved more slowly.

The Third Milestone SRHR Scorecard reinforces this concern.[21] The Scorecard identifies eight SADC states, that is, Angola, Comoros, the DRC, Eswatini, Lesotho, Mozambique, South Africa, and Tanzania, as not currently meeting the contraceptive needs of women of reproductive age. The eight are not all the same as the states with the lowest contraceptive prevalence. They range from Angola at 37% unmet need to South Africa at 19%, with seven of the eight showing worsening rather than improving trends against their 2019 baselines. Several countries with mid-range contraceptive prevalence rank as not meeting contraceptive prevalence because commodity supply, service access, or decision-making autonomy has weakened. The Scorecard flags this as a structural issue, not a snapshot.

The 2025 contraceptive commodity crisis

On 20 January 2025, a series of United States executive orders froze all foreign assistance for ninety days.[22] Most sub-awards under PEPFAR were subsequently cancelled, and USAID dissolved. The DREAMS programme, which integrated HIV, SRH, and gender-based violence services for approximately two million adolescent girls and young women across ten SADC states, shut down. The limited PEPFAR waiver that followed explicitly excluded abortion, family planning, diversity, equity and inclusion activities.

The cut had a profound effect on family planning commodity supply. The United States, through USAID, had been the single largest donor to contraceptive commodity procurement in the region.[23] The United Nations Population Fund lost more than forty humanitarian projects worth approximately $335 million, including contraceptive procurement and distribution work in Cabo Delgado (Mozambique), eastern DRC, and refugee-hosting areas of Tanzania. Malawi, Mozambique, Zambia and Zimbabwe reported Country-level stock-outs of implants, injectables and oral contraceptives through the first half of 2025.

The Lancet Global Health modelling published in 2025 estimated that the funding cuts could result in between 770,000 and 2.93 million additional AIDS deaths across low- and middle-income countries by 2030 if the funding is not restored.[24] The equivalent modelling for family planning outcomes, additional unintended pregnancies, additional unsafe abortions, and additional maternal deaths was still in preparation at the time of writing this chapter. What is clear now is that the sustained progress in FP2030 recorded from 2012 to 2025 is at risk of reversing across the region unless replacement financing is found.

[20] Gender Links and SADC Gender Protocol Alliance (2024) SADC Gender Protocol Barometer 2024: Voice and Choice - Chapter 2 (Health). Johannesburg: Gender Links.
[21] SADC Secretariat, UNFPA, UNICEF and WHO (2026) SADC Regional SRHR Scorecard: Third Milestone Report (2025 data). Gaborone. Available at: https://esaro.unfpa.org/en/news/newly-released-2025-scorecard-unveils-progress-and-setbacks-health-and-gender-equality (accessed August 2026).
[22] UNAIDS (2025) The impact of US funding cuts on the HIV response, March 2025 briefing. Available at: https://www.unaids.org/en/impact-US-funding-cuts (accessed August 2026).
[23] UNFPA (2025) Underfunded and overlooked: neglected crises on UNFPA's radar in 2025. Available at: https://www.unfpa.org/news/underfunded-and-overlooked-neglected-crises-unfpa%E2%80%99s-radar-2025 (accessed August 2026).
[24] Chandra-Mouli, V et al. (2025) Modelling the impact of US foreign aid cuts on HIV incidence and mortality in low- and middle-income countries, 2025-2030. The Lancet Global Health. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00281-5/fulltext (accessed August 2026).



Namibia: Dream Decide Lead, youth peers and a digital referral app in Ohangwena

The Ohangwena Region in northern Namibia records the highest rates of teenage pregnancy in the country. Between 2020 and 2024, thousands of girls under 19 became pregnant. Contributing factors include limited contraceptive access, poor sexual and reproductive health and rights knowledge, stigma, and the systematic exclusion of young people from decisions that affect them.



Veronika Haimbili receiving her well deserved awards.
Photo: Colleen Lowe Morna

The *Empowering Youth for Improved Contraceptive Access in Namibia* initiative, led by WOSSO fellow Veronika Haimbili, put young people in the driving seat. The project trained Junior Mayors and Junior Councillors in SRHR, leadership, communication, and peer education. Peer-to-peer sessions, youth dialogues, school engagements, and community conversations challenged the silence and stigma around teenage pregnancy and contraceptive use. The shift from adult-led instruction to youth-led advocacy created safer spaces for honest discussion, and young leaders engaged parents, community leaders, and health workers to influence cultural barriers and strengthen links to health facilities.

A digital referral app marked the turning point. Before the project, many young people did not know where to seek help, lacked reliable information, or feared judgement at health facilities. With the app, adolescents gained direct access to youth-friendly SRHR information and referral pathways, and service providers gained a coordination and referral tool that improved youth uptake.

The initiative laid a foundation for scaling. The youth-centred model can be replicated in other high-burden regions in Namibia and beyond. Junior Councillors and youth leaders will mentor incoming cohorts, and partnerships with local authorities and the Ministry of Health will sustain and expand service access. Digital platforms will extend reach at low marginal cost, an important consideration in a region facing a broader financing squeeze.

Source: Veronika Hambili - WOSSO Fellowship Story of Change, Ohangwena Region, Namibia.

Adolescent SRH

In the 30 years since policymakers adopted a Programme of Action at the 1994 International Conference on Population and Development (ICPD), the Southern African Development Community (SADC) region has made significant progress on sexual and reproductive health and rights (SRHR). The ICPD centred reproductive health and the empowerment of women and introduced the concepts of SRHR.

Yet millions of people - especially young people, who comprise more than 1.2 billion of the world population and up to 60% of SADC's population - still do not have access to SRH information and services.

To address widening ASRHR gaps, the World Health Organisation (WHO) has increased its research portfolio, set norms and standards, encouraged country support and advocacy - all of which it sets out in the first report in a new series on adolescent health, titled *Working for a Brighter, Healthier Future*. Alongside the challenges, the report highlights how people

around the world have been coming together to improve the health and well-being of adolescents. WHO has also broadened the scope of its work at regional and country level.[25] In terms of data, the WHO collects and analyses data by age and sex; supports the creation of national strategies and plans that take into account the needs of adolescents; and helps shape high-level policies to address the environmental, economic, and other factors that affect adolescents' health.[26]

Regionally, the SADC SRHR Policy advocates for early access to adolescent SRHR (ASRHR) as a means of postponing sexual debut. At the national level, SADC countries have ASRHR programmes and policies that, while often outdated, promote adolescent sexual health.

Comprehensive sexual education (CSE)



Menstrual Hygiene Education, Thobeka Primary School, Zone 6 Meadowlands. *Credit: Siphelele Kunene*

All sixteen SADC states are signatories to the 2013 Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people, renewed and refreshed as the 2021 Regional Commitment, which runs to 2030.[27] Coverage of school-based CSE has expanded but quality remains uneven, with religious and political pushback narrowing the syllabus in South Africa, Zambia and Zimbabwe over the past three years. Out-of-school CSE, reaching the estimated 30% of SADC adolescents not in secondary school, is far weaker, and often left to civil society.

On youth-friendly services, the DREAMS partnership (PEPFAR's flagship adolescent-girls-and-young-women programme) was the largest single delivery vehicle in the region until January 2025, when the US aid freeze halted new procurement and paused service delivery in most of the eleven SADC DREAMS countries.

DREAMS reached approximately 2.3 million adolescent girls and young women globally in FY2024, the majority in East and Southern Africa with combinations of HIV testing, PrEP, contraceptive counselling and economic empowerment.[28] The 2025 disruption threatens to reverse a decade of gains on adolescent HIV incidence and unintended pregnancy prevention simultaneously. Filling that gap will require sustained SADC-state domestic financing, which is not yet in place.

[25] First WHO report highlights efforts to improving health and well-being of adolescents worldwide, https://www.who.int/news/item/18-01-2022-first-who-report-highlights-efforts-to-improving-health-and-well-being-of-adolescents-worldwide, accessed: 30 September 2022.
[26] ibid
[27] UNESCO and UNFPA (2021) The 2021 Regional Commitment for a Sustained Response to Adolescent and Youth Health and Well-being in Eastern and Southern Africa, Nairobi: UNESCO ROSA.
[28] PEPFAR (2024) DREAMS: Working together for an AIDS-free future for girls and women, Washington DC: US Department of State.



South Africa: Youth Action Health, from knowledge to choice

In Polokwane's Capricorn District in Limpopo Province, ten teenagers at M.E. Makgato High School have quietly rewritten how sexual and reproductive health is discussed on their campus. In late 2024, Youth Action Health, a youth-led organisation working in under-resourced Limpopo schools, trained the ten as SRHR advocates: knowledge on the biology of reproduction, on gender-based violence prevention, on rights under the South African Choice on Termination of Pregnancy Act and the Sexual Offences Act, plus practical skills in facilitation, peer counselling and referral to nearby clinics.



ME Makgato SRHR Advocates, Polokwane, Limpopo, South Africa.
Credit: Siphelile Kunene

The choice to build a school-based advocacy structure rather than run a series of one-off assemblies was deliberate. Youth Action Health had watched successive external campaigns arrive, distribute pamphlets, take photographs, and leave, with no lasting change to what learners knew or where they went for help. "Young people are not just recipients of information," the organisation's design brief argued. "They are active drivers of change within their own communities."

The results at M.E. Makgato are consistent with that thesis. The trained advocates now facilitate peer-led sessions on menstruation, consent, contraception and referral pathways during breaks and after school. Learner support agents have integrated the advocacy group into the school's broader wellbeing programme. "I can now guide my peers to the right support and reduce stigma around SRHR in our school," said Natasha Manyekere, one of the ten. A second advocate spoke of learning how to create safe spaces where other learners can talk about their sexual and reproductive health without fear. A third emphasised the practical skills, how to listen, how to refer, how to support.

The wider Youth Action Health project reflects on lessons that have implications for the whole region: sustainability rests on strong internal structures within the school itself, not on repeat external visits; young people need long-term financial sustainability behind them, not stop-start grant cycles; and SRHR programming has to remain adaptive to interconnected pressures on adolescents, including climate and economic stress. In a province where the adolescent birth rate is one of South Africa's highest, ten trained advocates in one school is a small number. Replicated across the Capricorn District and beyond, it is a model.

Source: Youth Action Health story of change, presented by Molepa Leah Sebola, April 2026, Renewed Women's Voice and Leadership Fund reporting series, Gender Links.

Adolescent SRH and the adolescent birth rate

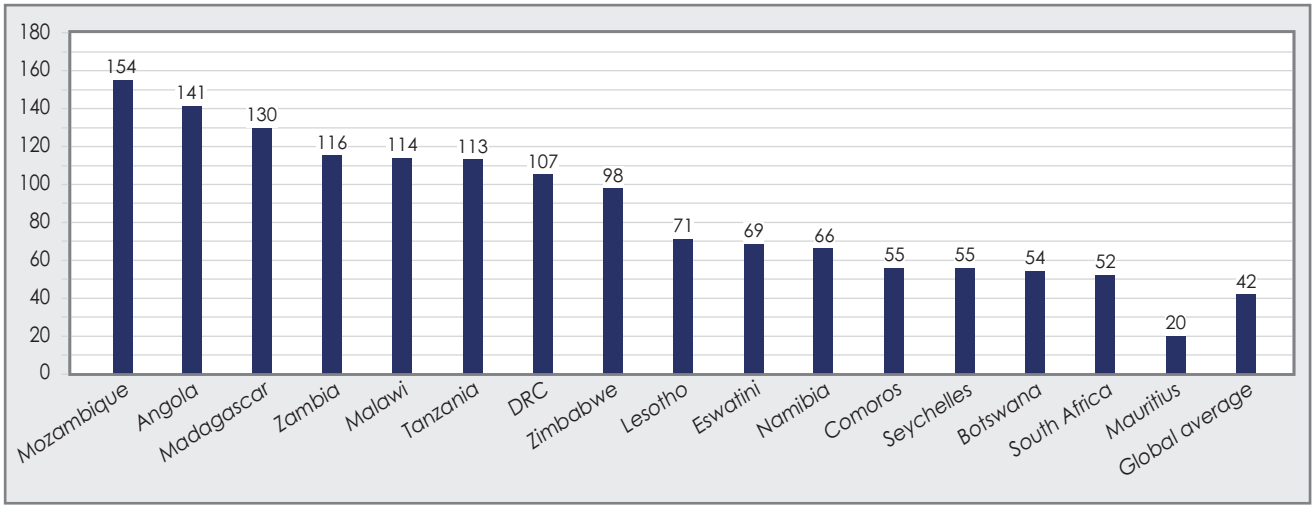
Nothing shortens the arc of a young woman's life more decisively than an unplanned adolescent pregnancy

Nothing shortens the arc of a young woman's life more decisively than an unplanned adolescent pregnancy. Adolescent mothers face materially higher risk of eclampsia, obstructed labour, obstetric fistula, and maternal death than mothers aged 20 to 24. Their infants are more likely to be born preterm, small-for-gestational-age and to die in the first month of life.

Behind every one of these clinical risks sits a school abandoned, a career deferred, an income foregone, and, often, an intimate partner relationship that the young woman entered without full consent or full information.

The SADC region's adolescent birth rate (ABR) is one of the highest in the world. The UNFPA ESARO regional aggregate for 2023 was 92 births per 1,000 women aged 15 to 19, more than twice the global average of around 42.[29]

Figure 2.5: Adolescent birth rate by SADC country



Source: UNFPA ESARO regional adolescent pregnancy data (2023); UN Population Division WPP 2024

Figure 2.5 shows that seven SADC states record ABRs above 100 per 1,000: Mozambique (154), Angola (141), Madagascar (130), Zambia (116), Malawi (114), Tanzania (113) and the DRC (107). These are country-wide averages and mask further inequalities. In the poorest wealth quintile in Mozambique, more than one in three girls aged 15 to 19 has already begun childbearing. Mauritius (20 per 1,000) sits well below the global average of 42, and Seychelles (55) just above it. Botswana (54), South Africa (52), Namibia (66) and Lesotho (71) fall in a middle band that is still well above what a country at those income levels would be expected to achieve.

Three drivers pull the SADC ABR up: Child marriage, gaps in comprehensive sexuality education (CSE) and gaps in youth-friendly SRH services. On child marriage, the region has made real if incomplete progress. Twelve SADC states now set the minimum legal age of marriage at 18 without exception. Comoros, DRC and Tanzania retain parental-consent loopholes that still permit child marriage in practice.[30] But legal change has run ahead of enforcement. UNICEF's 2024 update estimated that 34% of women aged 20 to 24 in sub-Saharan Africa married before 18, a figure that has barely moved in five years.

In November 2025, gender, health and education ministries from 15 SADC states convened in Cape Town for a regional consultative forum on engaging men and boys in addressing gender-based violence, HIV and SRHR, hosted under the SADC Ministers Responsible for Gender and Women's Affairs process. The forum's outcomes, reported to the SADC Senior Officials' meeting of June 2026, identified national and regional priorities for treating men and boys as transformative partners in adolescent SRH, a framing that had for two decades been advanced primarily by community organisations rather than by health ministry's themselves.

[30] Girls Not Brides (2024) Global country profiles: Southern Africa, available at https://www.girlsnotbrides.org/atlas/regions/southern-africa/.

Maternal mortality

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 to:

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

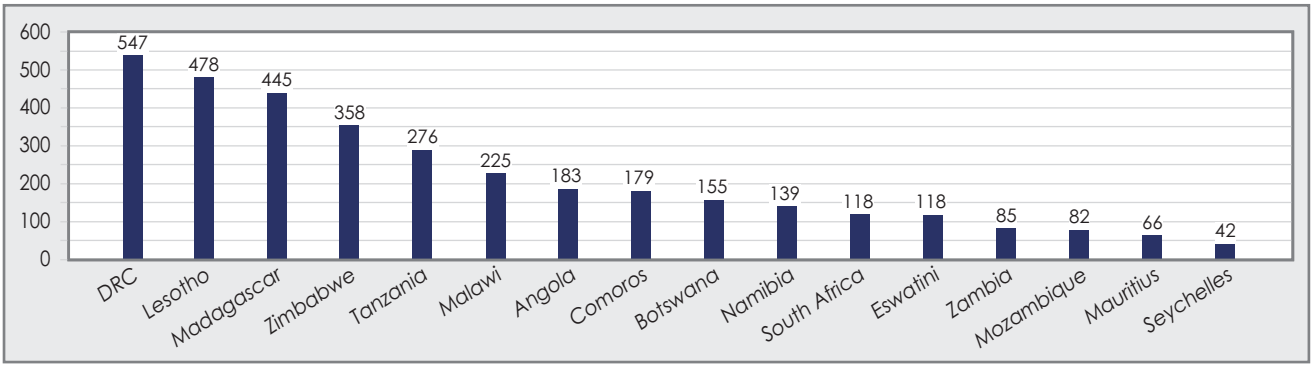
Maputo Protocol Article 14.1: Ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. This includes:
a) The right to control their fertility;
b) The right to decide whether to have children, the number of children and the spacing of children; and
c) The right to choose any method of contraception.

Every day in 2023, an estimated 712 women died from preventable causes related to pregnancy and childbirth worldwide, and sub-Saharan Africa carried 70% of that burden.[31] Behind that statistic sits an even harder truth: most of these deaths are not medical mysteries. They are the predictable result of a young woman reaching a clinic that has run out of oxytocin, of a labouring mother waiting for a midwife who is covering three wards, of an adolescent giving birth before her body has finished growing, of a household deciding it cannot afford the taxi to the district hospital.

Maternal deaths track the strength of health systems and the depth of gender inequality more precisely than almost any other indicator. This section examines the SADC region's progress and setbacks on maternal survival, on the continuum of antenatal, delivery and postnatal care, and on adolescent sexual and reproductive health, before turning to the way climate shocks are pulling maternal outcomes backwards across the region.The picture that emerges from 2026 SADC data is one of slow, unevenly distributed gains threatened by three converging pressures. These include the collapse of external HIV and family planning financing, the acceleration of climate shocks on already fragile health systems, and the persistent, systemic shortage of midwives to staff the very services that women need.

Globally, the maternal mortality ratio (MMR) fell 40% between 2000 and 2023, from 328 to 197 deaths per 100,000 live births, but the pace of decline stalled between 2016 and 2023 to just 1.5% a year, well below the 15% annual reduction needed to reach SDG target 3.1 of fewer than 70 maternal deaths per 100,000 live births by 2030.

Figure 2.6: Maternal mortality ratio, by SADC country (deaths per 100,000 live births)



Source: WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (2025) Trends in Maternal Mortality 2000-2023. SGDI 2026 regional score for maternal mortality: 78/100

[31] WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (2025) Trends in maternal mortality 2000 to 2023, Geneva: World Health Organization.

As reflected in Figure 2.6, only two SADC states, Mauritius (66 per 100,000) and Seychelles (42 per 100,000), currently meet the SDG target of below 70 deaths per 100,000. At the other end of the spectrum, three SADC states record MMRs above 400 per 100,000 live births: DRC (547), Lesotho (478) and Madagascar (445). Angola and Zambia sit above the SADC regional aggregate of roughly 260. The mainland median has barely moved since 2020. The SGDI 2026 assigns SADC a regional gender equality score of 78 out of 100 on maternal mortality, with country-level scores ranging from 100 in Mauritius and Botswana to 49 in Madagascar and 50 in Angola.

The causes are old and preventable. Post-partum haemorrhage is the leading direct cause across the region, followed by hypertensive disorders (pre-eclampsia and eclampsia), sepsis and unsafe abortion complications.[32] Indirect causes account for approximately 28.6% of maternal deaths in sub-Saharan Africa, roughly the same share as in southern Asia and materially higher than in any other WHO region, with HIV, malaria and tuberculosis contributing the largest share of that burden.[33] HIV alone was estimated to account for roughly one in four[34] pregnancy-related deaths in sub-Saharan Africa in the pre-universal-ART period, with the burden concentrated in the four highest-prevalence SADC states, Botswana, Eswatini, Lesotho and South Africa. Antiretroviral coverage among pregnant women in these four states exceeded 90% by 2023[35], materially narrowing that gap.

UNAIDS Global AIDS Update 2025 modelling projected significant additional HIV-related deaths and additional deaths of children under five in sub-Saharan Africa by 2030 if PEPFAR funding losses are not replaced, with several peer-reviewed studies converging on projections in the range of millions of additional adult HIV deaths and hundreds of thousands of additional child deaths across low- and middle-income countries.[36] Every one of those maternal and child deaths is a policy choice, not an act of nature.

There are, however, concrete examples of what focused investment can deliver. UNFPA's Maternal and Newborn Health Fund reports a 37% decline in maternal deaths across its 44 partner countries between 2010 and 2023, nearly 1.7 times the global rate of decline over the same period, driven in part by the scale-up of WHO-recommended commodities such as tranexamic acid and heat-stable carbetocin for post-partum haemorrhage, now introduced or expanded in 77% of Fund countries[37]. Since 2008, the Fund has supported the training of 864,030 midwives, including 88,030 in 2025 alone, and 60% of the 2,282 midwifery schools operating across Fund countries are now nationally accredited and aligned to WHO and International Confederation of Midwives standards.

At national level, the accountability infrastructure that surrounds maternal deaths is also gradually strengthening. South Africa's National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) released the 2020-2022 Saving Mothers Report during 2024/25, continuing a triennial series that has run since 1998 and remains one of the most sophisticated maternal-death review processes in the region. Following requests from the Zambia and Eswatini Ministries of Health, the NCCEMD provided training in the confidential enquiry process to both countries in the same reporting period, a rare and welcome example of intra-SADC methodology transfer on maternal accountability[38].

[32] WHO (2024) A roadmap to combat postpartum haemorrhage between 2023 and 2030, Geneva: World Health Organization.
[33] Cresswell JA, Alkema L, Wilmoth JR, Say L, and colleagues (2025) 'Global and regional causes of maternal deaths 2009-20: a WHO systematic analysis', The Lancet Global Health, 13(4): e626-e634. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(24)00560-6/fulltext (accessed September 2026).
[34] Zaba B, Calvert C, Marston M, Isingo R, Nakiyingi-Miiro J, Lutalo T, Crampin A, Robertson L, Herbst K, Newell M-L, and Todd J (2013) 'Effect of HIV infection on pregnancy-related mortality in sub-Saharan Africa: secondary analyses of pooled community-based data from the network for Analysing Longitudinal Population-based HIV/AIDS data on Africa (ALPHA)', The Lancet, 381(9879): 1763-1771. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60803-X/fulltext (accessed September 2026).
[35] UNAIDS (2024) Global AIDS Update 2024: The Urgency of Now - AIDS at a Crossroads, Geneva: Joint United Nations Programme on HIV/AIDS. Available at: https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024 (accessed September 2026).
[36] KFF (2025) The impact of a temporary foreign aid pause on global health, Washington DC: Kaiser Family Foundation.
[37] UNFPA (2026) Maternal and Newborn Health Fund 2025 Impact Report, New York: United Nations Population Fund, August. Available at: https://www.unfpa.org/publications/unfpa-maternal-and-newborn-health-fund-2025-impact-report (accessed September 2026).
[38] South Africa, National Department of Health (2025) Annual Report 2024/2025 (RP350/2025), Pretoria: National Department of Health. Available at: https://www.health.gov.za/annual-reports/ (accessed September 2026).

The continuum of care: antenatal, delivery and postnatal

Maternal survival depends on a continuum that begins before conception and continues six weeks past delivery. The midwifery workforce sits at the centre of the maternal survival equation. Here the SADC region remains structurally short. The UNFPA's 2024 State of the World's Midwifery East and Southern Africa regional report puts the current regional workforce at approximately 209,000 midwives and nurse-midwives, the highest recorded to date, against an estimated shortfall of more than 300,000 practitioners measured against WHO benchmarks. Globally, the same report identifies a shortage of 900,000 midwives within a wider 1.1 million Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH)-worker gap, with the largest shortfalls concentrated in East and Southern Africa.[39]

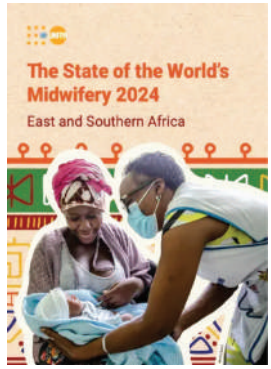
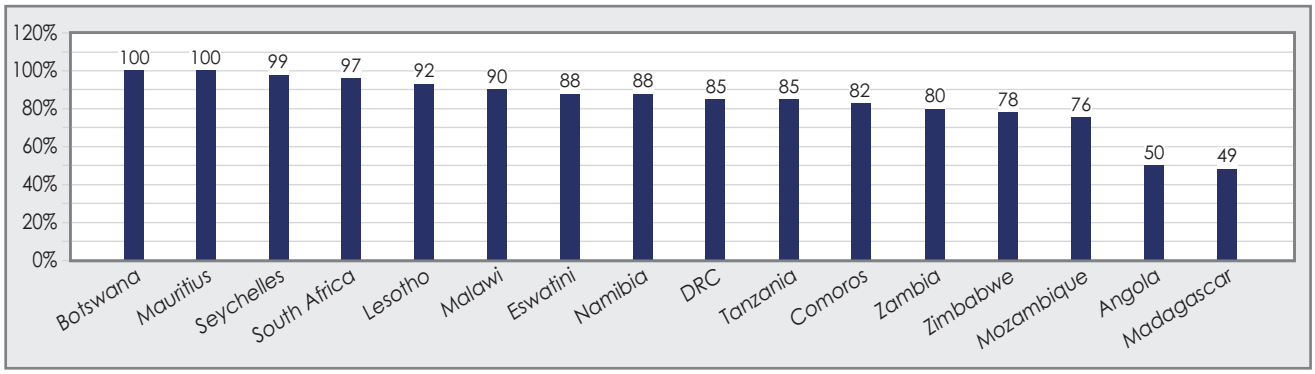


Figure 2.7: Skilled birth attendance (SBA) by SADC country



Source: UNICEF Global Database on Delivery Care (2024)

Four SADC states, Botswana (100%), Mauritius (100%), Seychelles (99%) and South Africa (97%), report SBA at or above 95%. A second cluster (Lesotho 92%, Malawi 90%, Eswatini 88% and Namibia 88%) sits between 88% and 92%. DRC and Tanzania (both 85%), Comoros (82%), Zambia (80%), Zimbabwe (78%) and Mozambique (76%) form a mid-range band. Even the two lowest performers, Angola (50%) and Madagascar (49%), have shown decade-long gains against their early-2010s baselines. The regional unweighted aggregate sits at approximately 84%, a decade-long improvement of roughly 10-15 percentage points[40] on the 2015 UNICEF baseline.

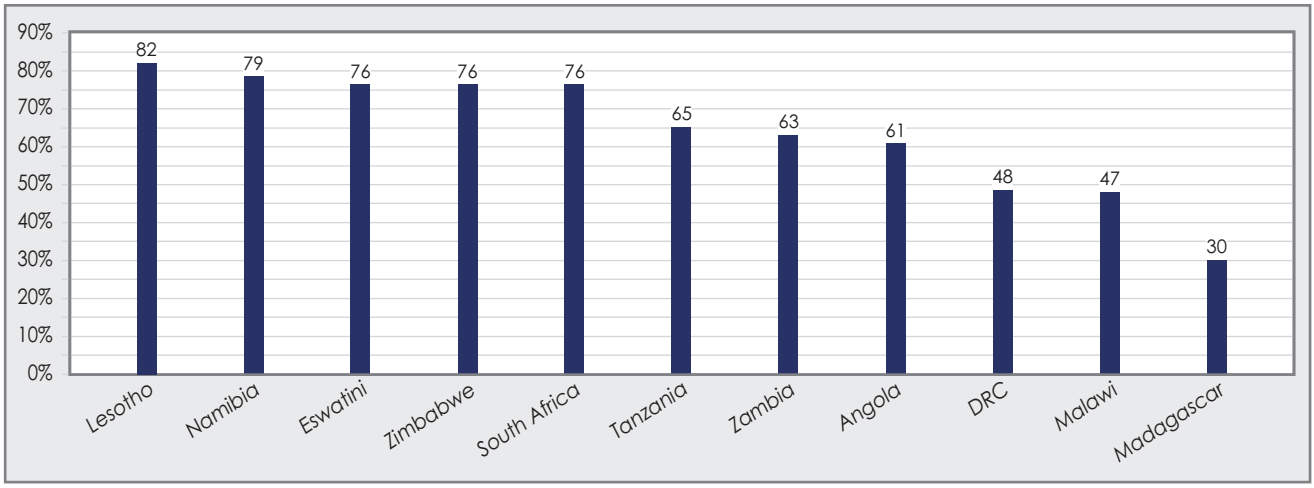
What SBA does not tell us is whether the birth attendant had the drugs, equipment, blood supply and referral options needed when a complication occurred. The quality-of-care gap between a birth attended in a Seychellois hospital and one attended in a Malagasy rural health centre remains vast, and the SDG indicator hides that.

Antenatal care coverage with at least four visits is a weaker signal. Regional ANC4 coverage sits around 68%, below both the sub-Saharan Africa aggregate and the WHO 2016 recommendation of eight antenatal contacts (ANC8), which few SADC states even measure. Where data exists, the ANC8 picture is starkly worse, under 30% in most low-income SADC states. Late booking (after 20 weeks) remains the norm rather than the exception in Angola, Comoros, DRC, Madagascar, Malawi, Mozambique and

[39] UNFPA ESARO (2024) The State of the World's Midwifery 2024 - East and Southern Africa Region, Johannesburg: United Nations Population Fund East and Southern Africa Regional Office. Available at: https://esaro.unfpa.org/sites/default/files/pub-pdf/2025-06/Final%20Approved%20TheStateoftheWorldsMidwifery%20ESA%202024_1.pdf (accessed September 2026).
[40] UNICEF (2024) Delivery care: Skilled attendant at birth, global database, available at https://data.unicef.org/topic/maternal-health/delivery-care/.

Tanzania. Late booking matters because most pregnancy-related risk assessment, HIV testing and treatment initiation, syphilis screening and iron or folic acid supplementation should begin in the first trimester.

Figure 2.8: Antenatal care coverage (4+ visits, %) by SADC country

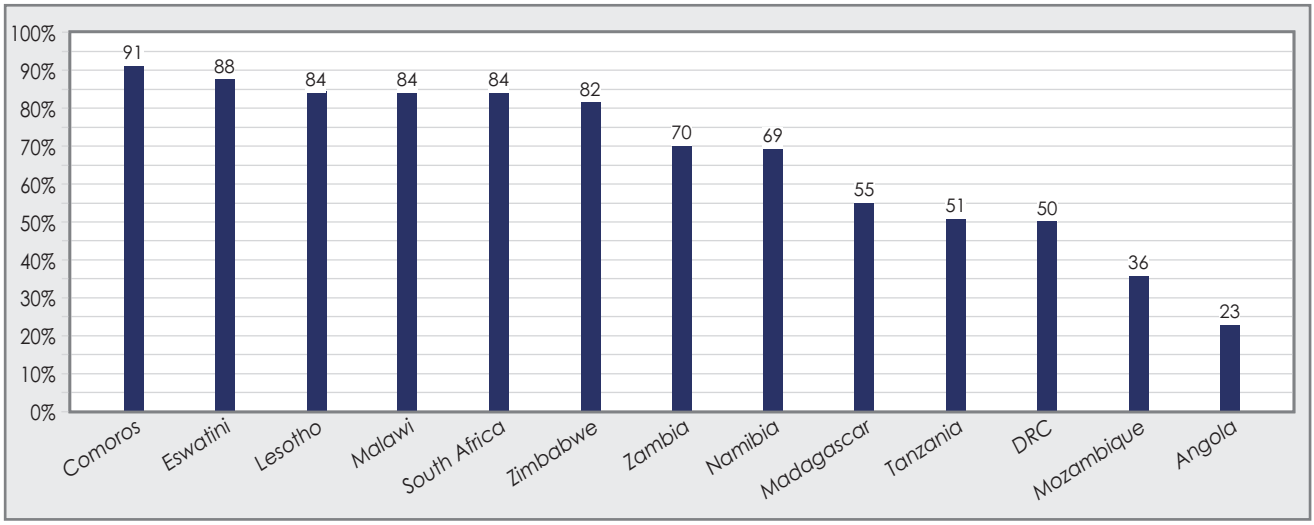


Source: SGDI 2026, MHFPMH chapter (drawn from national DHS/MICS latest available surveys). SGDI 2026 regional score for this indicator: 64/100

Beyond coverage, the accountability infrastructure that surrounds maternal deaths is also gradually strengthening. The UNFPA Maternal and Newborn Health Fund reports that 82% of its 44 partner countries have implemented or scaled Maternal and Perinatal Death Surveillance and Response (MPDSR) systems. No SADC state currently mandates MPDSR nationally without exception.

Postnatal care is the weakest link in the SADC continuum. Thirteen SADC states have PNC-within-48-hours-for-mothers coverage in the UNICEF Maternal and Newborn Health Coverage Database (November 2024 release); Botswana, Mauritius and Seychelles have no eligible survey in the database.

Figure 2.9: Postnatal care for mothers within 48 hours, by SADC country



Source: UNICEF (2024) Maternal and Newborn Health Coverage Database, November 2024 release, indicator MNCH_PNCMOM

Figure 2.9 shows that among the thirteen reporting states, coverage ranges from 23% (Angola, DHS 2015-16) at the low end to 91% (Comoros, MICS 2022) at the high end, with a top cluster above 80% (Comoros, Eswatini, Lesotho, Malawi, South Africa and Zimbabwe), a middle band in the 50-70% range (Namibia, Zambia, Madagascar, Tanzania and the DRC), and a floor set by Mozambique (36%, IDS 2022-23) and Angola.

Most maternal deaths cluster in the first 24 hours after delivery, so a woman discharged the same day without a follow-up plan is at high risk. WHO issued updated postnatal care guidance in late 2022 recommending at least four postnatal contacts in the first six weeks (day 1, day 3, weeks 1 to 2, week 6), but implementation across the SADC region remains at the level of policy adoption rather than service delivery. The Malawi exception (84% in the 2019-20 MICS), driven by a systematic community-health-worker follow-up model, is a case worth studying in the next reporting cycle.



Zimbabwe: Engaging men as champions for SRHR in Bindura

Rita Tiriboyi, a WOSSO fellow and founder of Re Inspiration for Girlchild Empowerment (RIGE), leads an initiative in a rural community in Bindura to engage men as champions for sexual and reproductive health and rights. RIGE maintains that while efforts to empower women have grown, men have been largely excluded from the conversations that might let them support their own families' reproductive health.



Rita Tiriboyi disseminating SRHR messages with male champions during a soccer tournament break in Bindura, rural Zimbabwe. *Credit: Kaptchad dreams*

RIGE addresses this through men's forum dialogues, speak-out sessions with traditional and local leaders, and SRHR-themed men's soccer tournaments. The soccer tournament is not incidental but an entry point that gets men into a space where SRHR conversation becomes possible. By December 2025, more than 510 men had been directly reached, up from 290 the year before. Collaboration with local leaders has strengthened the initiative. Traditional leaders, councillors, district health officials and religious leaders have begun integrating SRHR discussions into their community structures.

A community advocacy banner mounted at a local business centre now marks the collective commitment. A WhatsApp group for identified male champions sustains ongoing discussion and peer education. Tiriboyi is invited to major community gatherings, including the chief's court, where the chief handled a recent rape case with newfound understanding after a male champion acknowledged wrongdoing, a small but concrete indicator of the behavioural transformation the initiative is building towards.

The FP2030 and UNFPA literature identifies male engagement as one of the most under-leveraged determinants of family planning uptake, particularly for injectables and long-acting methods where male opposition is a documented barrier. The RIGE model is low-cost, community-led, and directly replicable in other SADC settings where patriarchal norms are the binding constraint on family planning.

Source: RIGE Zimbabwe, WOSSO Fellowship Story of Change, Bindura.

Climate and maternal health: an accelerating crisis

Climate change is now one of the largest emerging threats to maternal and newborn health in the SADC region. Evidence has moved from anticipation to observed harm in just the last three years. Extreme heat is associated with preterm birth, stillbirth, hypertensive disorders in pregnancy, and dehydration. Floods and cyclones disable health facilities, displace pregnant women from their normal care providers, contaminate water supplies, and interrupt cold chains for oxytocin and vaccines. Droughts drive food insecurity and maternal undernutrition. Every one of these mechanisms is playing out at scale in Southern Africa in the current reporting period.

The direct human impact was set out in UNFPA's Cyclone Chido flash updates through January 2025. The Cabo Delgado and Nampula provinces together carried an estimated 98% of Mozambique's affected population (approximately 453,970 people, 120 recorded deaths and 868 injuries). The Multi-Sectoral Initial Rapid Assessment found that roughly 44% of health facilities in the affected zone were damaged, with over 50 partially or completely inoperable. UNFPA's initial rapid assessment identified 3,122 pregnant women requiring urgent obstetric support, a figure revised upwards within weeks to approximately 12,000, alongside more than 44,000 women of reproductive age in the affected zone. The response deployed dignity kits, temporary health facilities and reproductive health kits into a system whose pre-existing capacity was already thin, a pattern the region should expect to repeat as cyclone frequency rises.

Chido is not an isolated event. Cyclone Idai (2019), Cyclone Kenneth (2019), Cyclone Freddy (2023), the longest-lasting tropical cyclone on record), and Cyclone Chido (2024) form a four-storm sequence over six years that has repeatedly hit some of the SADC region's most maternal-health-vulnerable districts. The Intergovernmental Panel on Climate Change's Sixth Assessment Report (AR6)[41] attributes rising cyclone intensity in the South-West Indian Ocean to warmer sea surface temperatures with high confidence. What was once a once-a-decade storm is now a once-every-eighteen-months storm.[42]

Extreme heat is the slower-burning half of the climate-maternal health story, and it is under-recognised in most SADC national maternal health strategies. A 2020 systematic review and meta-analysis found that each 1°C rise in ambient temperature during pregnancy was associated with approximately a 5% increase in preterm birth risk, alongside elevated risks of low birth weight and stillbirth.[43] The same review found preterm births to be 16% more common on heatwave days than on non-heatwave days. Risk therefore climbs sharply as episodic extreme heat becomes more frequent, the pattern Southern Africa is already seeing. The region is warming at twice the global mean rate. SADC health information systems do not yet capture heat-attributable maternal complications separately, so what we can measure lags what is happening on the wards.

The policy response is beginning to catch up. WHO's 2023 Alliance for Transformative Action on Climate and Health (ATACH) has SADC members Malawi, Mozambique, Zambia and Zimbabwe committed to building climate-resilient and low-carbon health systems. The SADC Secretariat's Climate Change Strategy and Action Plan (2020 to 2030) references maternal and reproductive health as a priority area, but resourcing behind that reference remains thin. National adaptation plans for health should include emergency obstetric care contingency arrangements, cold-chain redundancy for oxytocics, heat-adjusted antenatal care protocols and community-level early warning systems that reach pregnant women. Few SADC states have all four in place.

[41] IPCC (2023) Climate Change 2023: Synthesis Report, Geneva: Intergovernmental Panel on Climate Change, https://www.ipcc.ch/report/ar6/syr/ (Accessed: 17 September 2026).
[42] IPCC (2023) Climate Change 2023: Synthesis Report, Geneva: Intergovernmental Panel on Climate Change, https://www.ipcc.ch/report/ar6/syr/ (Accessed: 17 September 2026).
[43] Chersich MF, Pham MD, Areal A, Rylander C, Hardin K, Beltempo M, Clay R, Kupfer L, Faal G, Sarumi A, Cordingley S, Katsande L, Roos N, Solarin I, Otugo O, Sifuentes-Alvarez A, Dumbaya S, Umutoni A, Tsanhani S, Duan Y, Roos T, Ku JH, Yang R, Kunneke M, Farr K, Oyibo M, Schlick E and Hajat S (2020) 'Associations between high temperatures in pregnancy and risk of preterm birth, low birth weight, and stillbirths: systematic review and meta-analysis', The BMJ, 371:m3811. Available at: https://www.bmj.com/content/371/bmj.m3811 (accessed September 2026).



Lesotho: Behind the smile, a woman's battle with anxiety

Maternal mental health is the silent half of the maternal health story. WHO estimates that around one in five women in low- and middle-income countries experience a mental health condition during pregnancy or in the year after birth, and that suicide is now among the leading causes of maternal death in the first postnatal year in several countries. Depression and anxiety in the perinatal period predict poor breastfeeding, poor child nutrition, poor parental attachment and higher risk of subsequent pregnancy complications. Yet fewer than one in ten affected women in the SADC region receive treatment.

Matlalane Morata, a working mother in Lesotho, is one of them. Her story, published by the Informative Newspaper in Maseru in February 2026 as part of the Gender Links Media Parity Capacity Building Programme, opens on the small betrayals of a body that will not calm: a heart that races on a familiar road, a panic attack that grips her behind the wheel of her car, an anxious night that runs into an anxious morning. She hid the symptoms first from colleagues, then from her partner, and finally, for a while, from herself.

Morata's turning point came when she sought professional help. The diagnostic label, generalised anxiety disorder, arrived alongside a hospital admission, a course of therapy and a prescription. Slowly she reconstructed her routine. "I would tell any woman who is struggling," she said in the interview, "the shame is not yours to carry. Ask for help." The article situates her experience within a broader Lesotho picture in which stigma, cultural expectation and severe shortages of mental health professionals mean most women in her position will never reach a diagnosis, let alone treatment.

The clinical evidence is on Morata's side. Screening for perinatal depression and anxiety using the Edinburgh Postnatal Depression Scale in antenatal and postnatal clinics is cheap, feasible and effective, and its integration into the WHO-recommended package of maternal care is now standard guidance. In practice, none of the sixteen SADC national maternal health strategies currently mandate routine perinatal mental health screening at every ANC or PNC contact. The absence is a policy gap that costs lives and, more commonly, costs mothers' years of avoidable suffering.

Source: Sakachane P (2026) 'Behind the smile: a woman's battle with anxiety', Informative Newspaper, Maseru, 6 February, republished under the Gender Links Media Parity Capacity Building Programme.

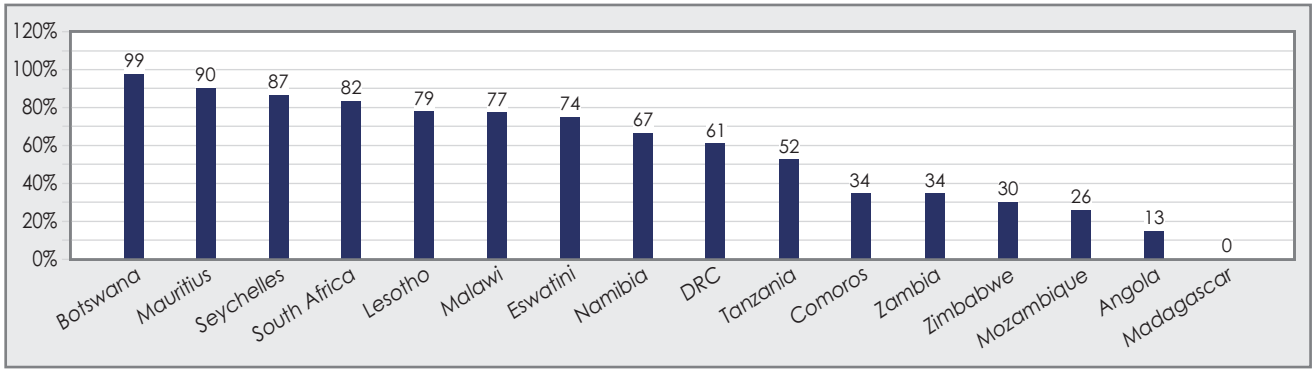
HPV vaccination and cervical cancer elimination

Cervical cancer is the fourth-most-common cancer among women worldwide, but among women in Southern and Eastern Africa it is the leading cause of cancer death.[44] Seven of the ten countries in the world with the highest age-standardised cervical cancer mortality are in the SADC region: Eswatini, Lesotho, Malawi, Mozambique, Zambia and Zimbabwe all record mortality rates above 40 per 100,000 women, roughly six times the global average.

High-risk human papillomavirus (HPV) accounts for most of these deaths, preventable with a combination of adolescent vaccination, adult screening, and timely treatment of pre-cancerous lesions. This gap between science and delivery is one of the widest in the region.

[44] WHO (2024) Cervical cancer fact sheet, available at https://www.who.int/news-room/fact-sheets/detail/cervical-cancer.

Figure 2.10: HPV vaccination coverage (final dose) by SADC country



Source: WHO/UNICEF WUENIC 2025 revision (Botswana: 2024 data as 2025 not yet reported)

Figure 2.10 reports final-dose HPV coverage per the WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC) 2025 revision. Fifteen of the sixteen SADC states have now introduced HPV vaccination into their national immunisation programmes; only the Democratic Republic of the Congo has yet to do so. Four states, Angola, Comoros, Madagascar and Namibia, introduced HPV vaccination during 2025, reflected in the WUENIC 2025 revision for the first time. Regionally, unweighted final-dose coverage sits at approximately 60% across the fifteen introducing states, above the 47% African regional average and second globally behind only the Region of the Americas. The SGDI 2026 assigns SADC a regional gender equality score of 62 out of 100 on HPV vaccination, up from 53 in the SGDI 2024 baseline once the WUENIC 2025 revision is folded in, reflecting the four new SADC introductions in 2025 and gains in continued top-tier performers.

Five states now report final-dose coverage at or above 79%: Tanzania (99%), Zimbabwe (90%), Mauritius (87%), Malawi (82%) and South Africa (79%). A middle band of four states, Madagascar (77%), Mozambique (74%), Seychelles (67%) and Angola (61%), sits between 60% and 78%. Zambia (52%), Botswana (34%), Namibia (34%), Lesotho (30%), Comoros (26%) and Eswatini (13%) sit below the WHO 60% interim benchmark. Botswana's final-dose figure sits alongside a first-dose coverage of 93%, meaning that most girls in Botswana receive the first dose but only about a third complete the second dose of the country's two-dose schedule, a delivery-completion gap that the WHO 90-70-90 elimination framework sub-section returns to.

The World Health Organisation's shift to a single-dose HPV schedule in 2022, backed by a Strategic Advisory Group of Experts recommen-dation and Gavi financing, has removed one of the main historical bottlenecks, that is, the need to reach the same adolescent girl twice.[45] Zambia, Zimbabwe and South Africa moved to single-dose schedules in 2023 and 2024, and reported first-year coverage improvements of between five and twelve percentage points as a result. Single-dose delivery, combined with school-based platforms and expanded age eligibility (nine to 14 in most programmes, with catch-up to 18 in some), is the pathway to closing the coverage gap. What the DRC now needs most is not new science but the political and financial commitment to introduce the schedule, and Botswana in particular needs a completion-focused push to close the gap between first and final dose.

The financing gap is worrying. The Gavi 2025 replenishment closed at just over US$9 billion, approximately US$2.9 billion short of its US$11.9 billion target, threatening the trajectory of HPV vaccination in Africa. HPV vaccination is estimated to have already helped avert close to 1 million cervical cancer deaths across 29 African countries as of 2024, with 10 further African countries planning to introduce the vaccine with Gavi support by 2030.[46]

[45] WHO Strategic Advisory Group of Experts on Immunization (2022) Meeting of the Strategic Advisory Group of Experts on Immunization, April 2022: conclusions and recommendations, Weekly Epidemiological Record No. 24, 2022, 97: 261 to 276.

[46] Gavi, the Vaccine Alliance and World Health Organization Regional Office for Africa (2026) 'Africa's routine vaccine systems deliver gains against cancer and malaria, but funding pressures loom', joint news release, Brazzaville/Geneva, 24 April, available at: https://www.gavi.org/news/media-room/africas-routine-vaccine-systems-deliver-gains-against-cancer-and-malaria-funding (accessed August 2026).

The WHO 90-70-90 elimination framework

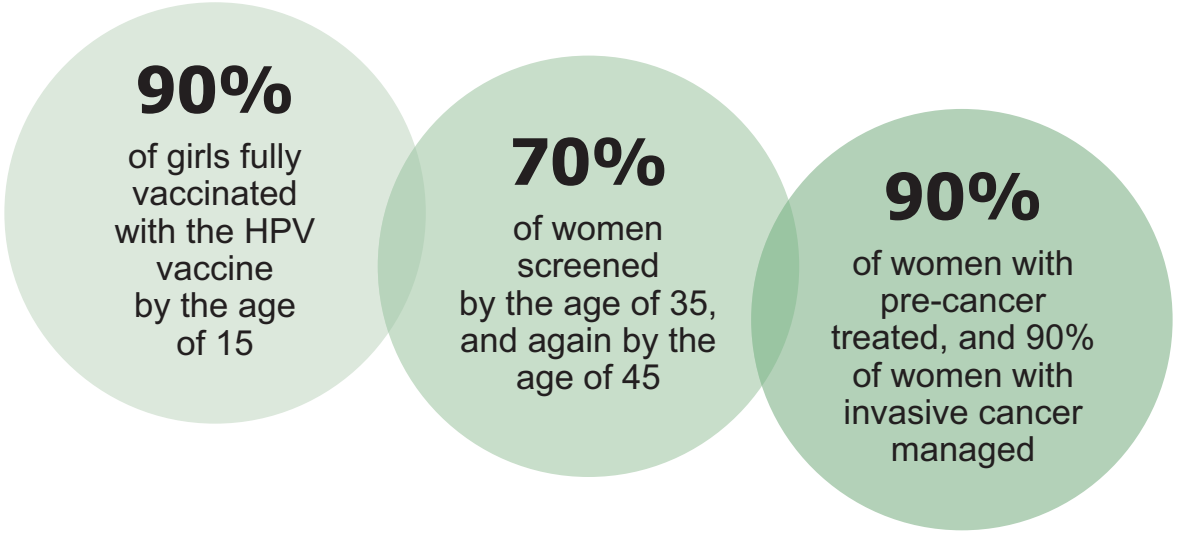
The WHO Global Strategy to Accelerate the Elimination of Cervical Cancer as a Public Health Problem, adopted by the World Health Assembly in November 2020, sets three targets that every country should reach by 2030: 90% of girls fully vaccinated against HPV by age 15; 70% of women screened with a high-performance test by age 35 and again by 45; and 90% of women identified with cervical disease treated (90% of women with pre-cancer, 90% of women with invasive cancer managed).[47] No SADC state currently meets all three targets. Mauritius and Seychelles are within reach on the vaccination pillar.

The regional weakness is in screening. Outside South Africa, Botswana and Mauritius, routine HPV DNA screening at scale is rare, and where screening exists, it is typically visual inspection with acetic acid (VIA), which has lower sensitivity and specificity than HPV testing.

The SADC region also has serious treatment capacity gaps. Radiotherapy is available in only nine of sixteen SADC states. Even in those countries, machines are often concentrated in one or two urban centres with waiting lists that can run to months. UNITAID's recent investments in point-of-care HPV DNA testing and thermal ablation for cervical pre-cancer treatment have begun to widen access. Malawi, with Unitaid and CHAI support, is scaling up community-based HPV self-sampling, but the technology-scale gap remains considerable.

Women living with HIV are approximately six times more likely to develop cervical cancer than HIV-negative women, and progress from pre-cancer to invasive disease more rapidly.[48] In a region where nearly 20 million adults are living with HIV and where women make up 60% of that population, the HIV-cervical-cancer intersection is not a footnote. It is the central clinical reality. WHO guidelines now recommend annual HPV screening from age 25 for women living with HIV, but integration of this recommendation into national HIV treatment programmes remains partial.

Fewer than half of women living with HIV in the SADC region receive routine cervical screening at their ART visits. The infrastructure to do this exists in every ART clinic, trained nurses, a private examination room, and a case management system that already brings women back twice a year. What is missing is the political and clinical decision to add cervical screening to the standard package of HIV care. Making that decision would be one of the highest-impact reforms available to any SADC health minister in the current planning cycle.



[47] WHO (2020) Global strategy to accelerate the elimination of cervical cancer as a public health problem, Geneva: World Health Organization.
[48] Stelzle D, Tanaka LF, Lee KK et al. (2021) 'Estimates of the global burden of cervical cancer associated with HIV', The Lancet Global Health, 9: e161 to e169.



Lesotho: Protecting children and fighting cancer

In February 2026, the Informative Newspaper in Maseru profiled Lesotho's expanded childhood vaccination campaign, a Ministry of Health-led initiative built around HPV vaccination for girls aged nine to fourteen alongside routine immunisations for boys and girls aged six against tetanus, diphtheria and polio. The reporting frames the campaign as part of the country's response to a growing cancer burden, with cervical cancer among women identified as a specific gender-linked health risk that vaccination can prevent.

Lesotho introduced HPV vaccination into its national immunisation programme in 2014 as one of the earliest African adopters, in partnership with Gavi. The 2026 campaign profiled by the newspaper reflects the second-generation shift, from a stand-alone HPV campaign to an integrated childhood vaccination platform that also covers tetanus, diphtheria and polio for boys and girls aged six. The Ministry of Health delivers the platform through schools, churches and community structures, a design that reflects lessons learned about reaching hard-to-reach communities in Lesotho's mountainous districts. Coverage of the final HPV dose reached 56% in the most recent WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC 2024).

Civil society organisations are central to the campaign's community reach. Paballo-ea-Bophelo, a Lesotho-based health-communications NGO, supports the Ministry through storytelling, testimony from cervical cancer survivors and their families, and short-form video in local languages. The organisation's approach is deliberately narrative rather than didactic. "Facts alone do not change behaviour," its director told the newspaper. "Stories do." Vaccine hesitancy in Lesotho, as elsewhere in the region, has been fuelled by online misinformation, and the campaign's counter strategy has centred on locally trusted voices, teachers, church leaders, traditional healers, cancer survivors, rather than on centralised public health messaging alone.

Lesotho's 30% HPV coverage (WUENIC 2025 revision) still falls short of the WHO 90% target, but the direction of travel is right, and the delivery model has features that the DRC could adapt as they design their own first-generation introductions: government-led integration with existing childhood vaccination platforms, civil society partnership for community trust-building, and school-based delivery as the coverage backbone. A cervical cancer death is one of the slowest, most painful and most inequitable deaths in modern medicine. Preventing it starts with a nine-year-old, a health worker and a single dose.

Source: Sakachane P (2026) 'Protecting children and fighting cancer in Lesotho', Informative Newspaper, Maseru, 11 February, republished under the Gender Links Media Parity Capacity Building Programme.



Mother feeds baby medicine at PMTCT Clinic in Maputo. *Photo: Trevor Davies*

HPV vaccination is one of the clearest examples in this chapter of a science-policy-service alignment that works when governments choose to act. The next section turns to the parts of the SRHR agenda where policy has yet to catch up with need or with rights: safe abortion access, disability-inclusive SRH, LGBTIQ+ health and the digital dimension of sexual and reproductive rights.

Access, rights and inclusion

The indicators tracked in the regional dashboard measure what health systems deliver in aggregate. This section examines what they deliver, or fail to deliver, to the groups who have historically been furthest from care: women seeking to end a pregnancy, women and girls with disabilities, LGBTIQ+ people, and adolescents navigating an increasingly digital sexual and reproductive rights landscape. The SADC Protocol on Gender and Development requires that services be accessible without discrimination. The 2026 evidence suggests the region is a considerable distance from that standard.

Disability-inclusive SRHR

Women and girls with disabilities make up an estimated 16% of women in the SADC region[49] yet hardly feature in national SRHR data collection[50]. Barriers include physical inaccessibility of clinics, absence of sign language and Braille health information, provider assumptions that women with disabilities are asexual or should not be sexually active, breaches of confidentiality by staff not trained on disability rights, and, for women with intellectual disabilities, a persistent pattern of forced contraception and forced sterilisation that remains legal in several SADC states through guardianship provisions.[51] The SADC Regional Strategy on Disability Mainstreaming (2023 to 2030) commits member states to disaggregate all health data by disability status. Progress on that commitment has been minimal at the time of writing.

The SADC Regional Indicative Strategic Development Plan (RISDP) 2020-2030 commits member states to mainstream disability inclusion across all sectors and programmes, including through disability-disaggregated data collection. Progress on that commitment has been minimal at the time of writing.

LGBTIQ+ health and gender-diverse SRHR

The legal environment for LGBTIQ+ people in the SADC region has shifted in the last decade. Angola, Botswana, Mozambique and Seychelles have decriminalised same-sex sexual conduct in this period. South Africa remains the only SADC member state that allows with full marriage equality and constitutional protection against discrimination on grounds of sexual orientation. Namibia's Supreme Court ruled in May 2023 that immigration recognise same-sex marriages contracted abroad.

But criminalisation persists in Comoros, DRC (in practice through public morality provisions), Eswatini, Lesotho (though rarely enforced), Malawi, Mauritius (though the 2023 Supreme



Engaging with healthcare information at a Youth HIV and AIDS corner at Livingstone City Council, Zambia. *Photo: Albert Ngosa*

[49] World Health Organization (2022) Global report on health equity for persons with disabilities, Geneva: World Health Organization. Available at: https://www.who.int/publications/i/item/9789240063600 (accessed September 2026);
[50] UN Women - Africa (2026) Sex, Age and Disability Disaggregated Data (SADDD) Data Collection Training Manual, Nairobi: UN Women East and Southern Africa Regional Office. Available at: https://africa.unwomen.org/en/digital-library/publications/2026/02/sex-age-and-disability-disaggregated-data-saddd-data-collection-training-manual (accessed September 2026).
[51] UN Human Rights Council (2022) 'Report of the Special Rapporteur on the rights of persons with disabilities: sexual and reproductive health and rights of girls and young women with disabilities', A/HRC/49/52.
[52] Human Dignity Trust (2024) Country Profiles: Southern and Eastern Africa, available at https://www.humandignitytrust.org/country-profiles/.



Botswana Trans Initiative: Inclusive healthcare through community leadership

The Botswana Trans Initiative (BTI) works to advance the health and rights of transgender and gender-diverse persons in Botswana, a country that has taken meaningful legal steps on gender recognition in recent years, but where trans persons still face routine barriers in healthcare settings: providers unfamiliar with gender-affirming care, insufficient inclusion of gender diversity in national SRHR and HIV programming, and the everyday injuries of being misnamed and misgendered by the people meant to be caring for them.

BTI's approach centres provider sensitisation, community-led evidence, and lived-experience storytelling. Its sensitisation sessions bring healthcare providers, policymakers and national HIV programme staff into direct dialogue with trans community members. Providers who have completed the sessions report increased understanding and improved respectful engagement, using affirmed names and pronouns, taking sexual histories that do not assume cisgender partners, and offering PrEP and PEP without discomfort. Trans clients report greater confidence in seeking healthcare and stronger peer support networks.

The initiative's advocacy work engages policymakers on human rights violations documented through community-led monitoring. Its policy asks are practical: integrate gender diversity into national health training curricula, integrate trans-competent care into national HIV programme protocols, and adopt SRHR policies that recognise gender-diverse people. "Storytelling and lived experiences," the organisation's leadership emphasise, "are what turn abstract commitments into changed practice."

The Botswana Trans Initiative model, provider training as the near-term lever, policy reform as the medium-term goal, and community leadership as the sustaining infrastructure, offers a template for other SADC states as their own legal environments evolve. Sustained change will depend on continued collaboration with healthcare institutions, government partners and community leaders. In every country in the region, the group with the least visibility in the health system is the group whose visibility matters most. *Source: Botswana Trans Initiative story of change, Marang Fund Gender Links.*

Court decision struck down the Sodomy provision), Tanzania (with a hostile enforcement climate), Zambia and Zimbabwe.[52] The health consequences of criminalisation are well documented. These include reduced HIV testing, delayed treatment initiation, worse mental health outcomes and elevated exposure to violence.

For transgender and gender-diverse people specifically, the SADC region has almost no formal gender-affirming healthcare provision. Hormone therapy is available only in South Africa's public system (and even there patchily) and in a handful of private clinics elsewhere. Gender-affirming surgery is available only in South Africa. Trans people report frequent misgendering by health providers, refusal of care, and either denial of, or lack of access to, HIV prevention services designed with their bodies and lives in mind. Community-led organisations, the Botswana Trans Initiative, Iranti in South Africa, and TransBantu in Zambia, are filling the gap that health systems have not.

The political environment shaping LGBTIQ+ SRH access has hardened over the reporting period, with health implications that indicators of decriminalisation alone do not capture. The proposed African Charter on Family Sovereignty and Values, and organised anti-rights campaigning documented across Tanzania, Zimbabwe, Madagascar and elsewhere, are backed by transnational conservative networks whose downstream effects on the health system are provider stigma, service refusal and legislative pressure to roll back existing LGBTIQ+ SRHR protections.

Speaking at the Southern African Civil Society Forum[53] in Durban in August 2026, an African Methodist Episcopal Church pastor, framed faith institutions as contested sites, carrying both liberation-theology and reactionary currents, and argued for direct engagement with progressive religious voices rather than retreat from them. Speaking at the same panel, Linda Baumann of the Namibia Diverse Women's Associations emphasised alliance-building across feminist, LGBTIQ+, faith-based and traditional-leadership actors as the response most likely to protect the sexual and reproductive health gains catalogued in this chapter.

The 2024 South African General Household Survey finding that only around 39,4% of households now fit the narrow nuclear-family model of parents and children[54] is a data point worth carrying into the SRHR policy debate. The health system already serves diverse families, whether the political discourse acknowledges it.

Digital SRHR: opportunity and risk

Mobile penetration in SADC hit 84% of adults in 2024, with smartphone use above 60% and women's ownership catching up (approximately 7-point gender gap). Digital platforms now deliver SRHR at scale, South Africa's MomConnect (approximately 5m pregnant women and new mothers since 2014) and B-Wise youth portal, Malawi's Chipatala Cha Pa Foni hotline (since 2011), Namibia's WOSSO Dream Decide Lead contraceptive referral app, region-wide menstrual-tracking apps and telemedicine for medication abortion where this is legal. They lower privacy barriers for adolescents, cut provider-encounter shame and reach populations formal services miss.

They also carry risk. Misinformation on contraception, HPV vaccination and abortion has grown sharply since 2023, amplified by algorithms and organised anti-rights campaigns. Tech-facilitated gender-based violence and online harassment of women speaking on SRHR are documented and rising.[55] Most SADC data-protection frameworks have not caught up with the specific risks facing sensitive health-app users, subpoenas where abortion is criminalised, breaches, and surveillance-driven service avoidance. Regulation and digital-rights advocacy both have a way to travel.

2026 research on digital public infrastructure in South Africa found that the authoritarian tendency of surveillance affects service outreach on health, GBV support and information related to sexuality and reproductive health, as trust erosion drives users to withdraw from platforms altogether.[56] Regulation and digital-rights advocacy for SRHR data users therefore need to move together.

Access, rights, and inclusion gaps are visible in every corner of the SADC region's MMFP picture. Closing them requires policy reform, provider training and community leadership, but also, always, money.

The funding landscape for MMFP in 2026

The matrix below summarises the state of MMFP financing in the SADC region in 2026; the paragraphs that follow unpack the domestic and external pictures in turn.

[53] Other Foundation panel, 25 August 2026
[54] StatsSA releases General Household Survey 2024 | South African Government. Available at: https://www.gov.za/news/media-statements/statssa-releases-general-household-survey-2024-27-may-2025 (Accessed: 14 September 2026).
[55] Web Foundation and World Wide Web Foundation (2023) Tech-facilitated gender-based violence in Africa: a research brief, Washington DC.
[56] African Internet Rights Alliance (AIRA) and Pollicy (2026) Systemic Barriers, Gendered Consequences: An Afro-feminist Analysis of Digital Public Infrastructure in Uganda, South Africa and Kenya, launched 31 March 2026. Available at: https://aira.africa/wp-content/uploads/2026/03/Systemic-Barriers-Gendered-Consequence-AIRA-x-Pollicy-Report-.pdf (accessed September 2026).

Table 2.3: Summary of the MMPF landscape in SADC 2026

	DOMESTIC	FOREIGN
POSITIVES +	South Africa (~13.9%) and Botswana (~13%) approach the Abuja 15% commitment. Malawi's health share edged up from 8.7% to 9.0% in 2024/25. Three untapped domestic levers exist: progressive health taxes on tobacco, alcohol and sugar (US$1-2 billion regional potential); ring-fenced SRHR budget lines; SPPS pooled procurement (up to 40% savings).[57 58 59]	Bill & Melinda Gates Foundation May 2025 accelerated draw-down (US$200bn over 20 years) with women's and children's health among four priority areas. EU, Norway and Global Fund partial step-up on adolescent HIV/SRHR. Gavi continues to underwrite HPV roll-out in the region.[60 61 62]
NEGATIVES -	Regional median health-budget share is ~8% (vs Abuja 15%). DRC, Madagascar, Malawi, Mozambique and Tanzania sit below 6%. Per-capita government health spend is under US$25 in the four lowest states. Out-of-pocket share averages 26% regionally (Angola 37%, DRC 43%, Madagascar 33%). Most SADC health budgets have no distinct SRHR line - SRHR competes with all other primary-care priorities and is cut first when budgets tighten.[63 64]	20 January 2025: US executive orders froze all foreign assistance, cancelled most PEPFAR sub-awards, dissolved USAID, and ended DREAMS. UNFPA lost >40 humanitarian projects (~US$335m). Gavi 2025 replenishment closed at ~US$9bn, US$2.9bn short of the US$11.9bn target. [65 66 67] Lancet Global Health modelling projects up to 2.93m additional AIDS deaths by 2030 if funding is not restored.[68]
ON BALANCE	Structurally under-invested for a generation. Even the best-performing states remain below the Abuja commitment. The 2025 tightening deepens the gap rather than closes it.	Most negative external-financing environment in a decade. The 2025 shock is not fully offset by the new commitments in the positives cell; SADC MMFP now depends more on domestic financing than at any point since Abuja.

The matrix summarises the complex domestic and foreign funding landscape for MMFP. On a positive note some countries are approaching the 15% GDP in health spending, and the Gates Foundation announced a significant increase in funding in the wake of the USAID funding cuts.

On the other hand many countries are still behind on health spending, and the USAID cuts run deep. Never before has there been a greater need for SADC countries to re-prioritise their spending, as the sections that follow show:

[57] WHO Regional Office for Africa (2023) WHO African Region Health Expenditure Atlas 2023, Brazzaville: WHO Regional Office for Africa, drawing on WHO Global Health Expenditure Database. Available at: https://www.afro.who.int/publications/who-african-region-health-expenditure-atlas-2023 (accessed September 2026).
[58] UNICEF Malawi (2024) Health Budget Brief 2024/25, Lilongwe: UNICEF Malawi. Available at: https://www.unicef.org/malawi/media/11766/file/UNICEF_MLW_Health_Budget_Brief_2024-25.pdf (accessed September 2026).
[59] SADC Secretariat (2024) SADC Pooled Procurement Services (SPPS) framework - regional cost-savings analysis. Gaborone: SADC Secretariat, Directorate of Social and Human Development.
[60] Bill & Melinda Gates Foundation (2025) 'Statement on future giving', May 2025. Available at: https://www.gatesfoundation.org/ideas/statement-future-giving (accessed September 2026).
[61] European Commission (2025) Team Europe SRHR initiative: 2025 progress update. Brussels: DG INTPA. Available at: https://international-partnerships.ec.europa.eu (accessed September 2026).
[62] Gavi, the Vaccine Alliance and World Health Organisation Regional Office for Africa (2026) 'Africa's routine vaccine systems deliver gains against cancer and malaria, but funding pressures loom', joint news release, Brazzaville/Geneva, 24 April. Available at: https://www.gavi.org/news/media-room/africa-routine-vaccine-systems-cancer-malaria (accessed September 2026).
[63] WHO Regional Office for Africa (2023) WHO African Region Health Expenditure Atlas 2023.
[64] WHO Regional Office for Africa (2023) WHO African Region Health Expenditure Atlas 2023.
[65] KFF (2025) The impact of a temporary foreign aid pause on global health, Washington DC: Kaiser Family Foundation.
[66] UNFPA (2025) Underfunded and overlooked: neglected crises on UNFPA's radar in 2025. Available at: https://www.unfpa.org/news/underfunded-and-overlooked-neglected-crises-unfpas-radar-2025 (accessed August 2026).
[67] Gavi, the Vaccine Alliance (2025) Global Summit: Health & Prosperity through Immunisation - replenishment tracker. Available at: https://www.gavi.org/investing-gavi/resource-mobilisation-process/protecting-our-future (accessed September 2026).
[68] Chandra-Mouli, V et al. (2025) 'Modelling the impact of US foreign aid cuts on HIV incidence and mortality in low- and middle-income countries, 2025-2030', The Lancet Global Health. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(25)00170-6/fulltext (accessed September 2026).

Domestic financing: the Abuja gap

The Abuja Declaration of 2001 committed African Union states to allocate at least 15% of their annual budgets to health.

For MMFP services specifically, out-of-pocket costs frequently include transport to the clinic, the mama-kit brought to delivery, the cost of a caesarean when complications arise, and the informal payments that grease under-resourced systems. Catastrophic health expenditure, spending that pushes a household into or deeper into poverty, falls disproportionately on households with pregnant women and new mothers.

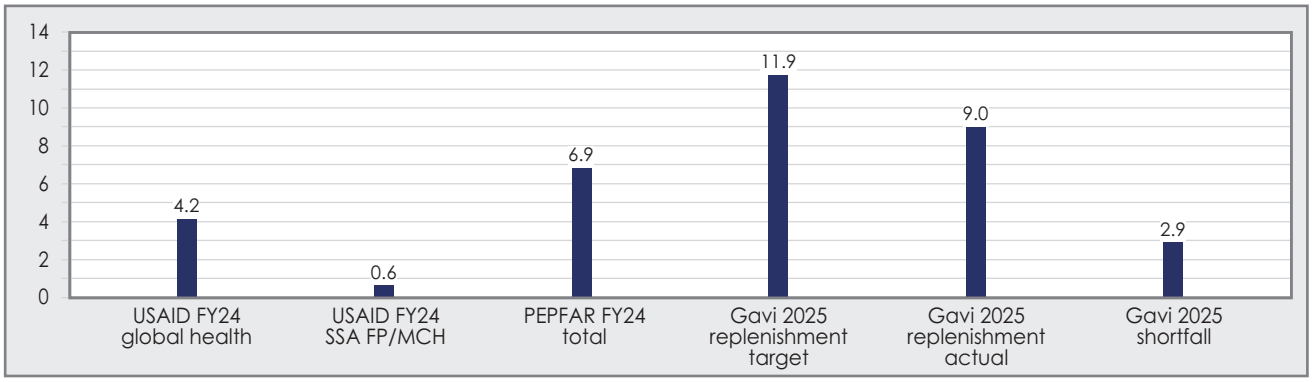


Oxfam's analysis at the August 2026 Southern African Civil Society Forum in Durban put **Malawi**'s health share at approximately 9% for 2024/25, alongside austerity-driven cuts to social protection. Malawi is representative of the mainland median rather than exceptional; it is cited here because the specific budget analysis is publicly available.

The 2025 external-financing shock

The external-financing environment is the worst it has been in a decade. The scale of the shock is set out in Figure 2.11 and the FOREIGN column of the matrix above. What the numbers do not capture is that the cuts landed simultaneously on the delivery platforms that carried adolescent SRH (DREAMS), commodity procurement (USAID Global Health Supply Chain) and vaccine roll-out (Gavi replenishment), a compounding effect no single indicator here shows.

Figure 2.11: 2025 external financing shock for SADC MMFP (US$ billion)



Source: USAID FY2024 budget request; PEPFAR FY2024 obligations; Gavi 5.0 replenishment tracker (2025)

The partial-offset story listed in the matrix (Table 2.3) above (EU, Norway, Global Fund, Gates Foundation) is not sufficient to close the US-shaped hole. The Lancet Global Health modelling cited in the maternal health section makes clear that domestic African government financing will have to carry more of the load, a shift consistent with the African Union's declared trajectory but which, at current rates, will take more than a decade to deliver fully.

Gender-responsive budgeting and the SRHR line

A structural weakness across most SADC health budgets is the absence of a distinct budget line for sexual and reproductive health and rights. Contraceptive commodities, maternal health outreach, HPV vaccination and menstrual health programming are typically funded from a general medicines-and-supplies vote that competes with all other primary healthcare priorities, and from external grants that are earmarked but time-limited. When either source is squeezed, as both

are in 2025, SRHR is disproportionately cut because it lacks a legally protected budget floor.

The SADC Guidelines on Gender Responsive Budgeting (2014), read alongside Article 15 of the SADC Protocol on Gender and Development, call on member states to establish gender-marked budget lines for SRHR, adopt gender-responsive procurement of health commodities, and publish gender-disaggregated health expenditure data annually.[69] Implementation has been slow.

Only Botswana, Namibia, South Africa and Zimbabwe currently publish anything approaching gender-disaggregated health expenditure. A concerted push to make gender-responsive budgeting the default across the region would raise the visibility of MMFP spending, protect it during fiscal contractions, and give civil society the numbers needed to hold governments accountable.

Filling the gap

Three levers are within SADC-state control and would improve MMFP without waiting for donors. First, health taxes on tobacco, alcohol and sugary drinks, already working in Botswana, South Africa and Zambia, could raise US$1-2 billion a year if extended region-wide with a share earmarked for MMFP. Second, pooled buying through SADC Pooled Procurement Services could cut commodity costs by up to 40%. Third, task-shifting routine SRHR from doctors to trained midwives, nurses and community health workers stretches existing budgets by 30-40% (Ethiopia's Health Extension Programme; Malawi's health surveillance assistants (HSAs)[70].

Conclusions

The Sustainable Development Goals adopted in 2015 set out five commitments directly relevant to this chapter:

- Reducing maternal mortality below 70 per 100,000 live births (SDG 3.1),
- Ending preventable newborn and under-five deaths (SDG 3.2),
- Universal access to sexual and reproductive healthcare including family planning (SDG 3.7),
- Universal health coverage (SDG 3.8), and
- Universal access to adequate sanitation and hygiene (SDG 6.2).

Based on the evidence in the chapter, SADC cannot meet its 2030 commitments without a substantive change of pace.Only two states meet the SDG maternal mortality target; three sit above 400. The regional adolescent birth rate (92 per 1,000) is more than twice the global average and falling too slowly. Four states have not begun HPV vaccination. Six report basic sanitation access below 50%. Only three in ten mothers receive a postnatal check-up within 48 hours. The midwifery workforce is structurally short of its own benchmarks in every mainland state.

This is not for want of scientific knowledge or good policy. The SADC Protocol on Gender and Development, the Maputo Protocol (ratified by 14 of 16 states), the 2021 Regional Commitment on adolescent SRHR and the WHO 90-70-90 cervical cancer strategy set the correct standards, rights framework, programmatic direction and clinical pathway. What is missing at scale is delivery, and behind the delivery gap sits a financing gap that widened sharply in 2025 with the collapse of US external assistance, the shortfall in Gavi's replenishment, and the US$335 million UNFPA loss.

[69] SADC Secretariat (2014) SADC Guidelines on Gender Responsive Budgeting, Gaborone: SADC Secretariat, Gender Unit; and Southern African Development Community (2016) SADC Protocol on Gender and Development (Revised), Article 15, Gaborone: SADC Secretariat. Available at: https://www.sadc.int/sites/default/files/2023-02/EN-REVISED_SADC_PROTOCOL_ON_GENDER_AND_DEVELOPMENT_2016-final.pdf (accessed September 2026).

[70] Smith JM, Nkhoma D and Kachale F (2020) 'Enabling and hindering factors of health surveillance assistants' roles in the provision of contraceptive services in Mangochi, Malawi', Reproductive Health, 17(1): 51. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7171808/ (accessed September 2026)

Recommendations

The Southern Africa Gender Protocol Alliance is calling on SADC to review the Gender Protocol by 2030. Article 26 covers sexual and reproductive health and reproductive rights.

This article is quite brief. It refers to the SADC Protocol on Health and to other regional and international commitments by Member States on health-related issues. It only refers to eliminating maternal mortality; mental and SRH needs of men and women; hygiene, sanitation and nutrition.

At a minimum, it should specifically reference the SADC SRHR Strategy, which SADC adopted after the last Protocol revision, the Maputo Protocol, and the Abuja Declaration on health-budget commitments. Since the last revision, the world has lived through COVID, and other pandemics such as Ebola now threaten SADC. Many gaps remain, even when compared with the Maputo Protocol.

Main gaps in the SADC Gender Protocol include:

- The right to control their fertility, decide whether to have children, number of children and spacing; to contraception.
- The protocol does not refer to age, and specifically makes no mention of the need for attention to adolescent SRHR or Teenage pregnancy.
- Menstrual Health.
- Maternal morbidity including Obstetric Fistula, Cancers of the reproductive system, especially cervical cancer.
- Provision of comprehensive sexuality education.
- Commitment to budget for health.
- Access to safe abortion and post abortion care.

Recommended amendments/additions:

SADC should overhaul this article to provide at least as much protection as the Maputo Protocol.

- Include rights to determine fertility, number and spacing of children, and to contraception.
- Include specific sub-sections on stigma-free access to SRHR for adolescents, with a subsection on preventing teenage pregnancy and on supporting teen mothers, including provisions for them to return to school (this is included in the SADC CSW resolution).
- Include a subsection on menstrual health - including removal of VAT on menstrual products, education for girls and boys on menstrual health, involvement of parents.
- Provision for prevention and management of Maternal morbidity, with specific reference to obstetric fistula, cancers of the reproductive system, particularly cervical cancer and HPV vaccination.
- Separate provisions for access to safe water and sanitation and access to adequate nutrition, noting that nutrition is access to enough food and nutritious food (there are problems of obesity as a result of consuming the wrong type of food).
- Provision for Comprehensive sexuality education (as noted in section on Constitutional and legal rights).
- Strengthen capacity to recognise potential pandemics and to respond timeously.
- Commitment to domestic budget for health at least at the commitments of the Abuja declaration.

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