REPORT OF THE SADC PF STANDING COMMITTEE ON HUMAN AND SOCIAL DEVELOPMENT AND SPECIAL PROGRAMMES (HSDSP) TO THE 52ND PLENARY ASSEMBLY SESSION

THEME: "CONSOLIDATING DEMOCRACY BY BRINGING PARLIAMENT TO THE PEOPLE".

Mr President, I beg to move that this Plenary Assembly do adopt the Report of the Standing Committee on Human and Social Development and Special Programmes to the 52nd Plenary Assembly Session of the SADC Parliamentary Forum, laid on the Table on 5th December 2022.

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1.0 COMPOSITION OF THE COMMITTEE

The Committee consisted of the following members:

1. Hon. Rosie Bistoquet MP, (Seychelles) Female ***(Chairperson)***
2. Hon. Kassim Hassan Haji (Tanzania) Male ***(Vice Chairperson)***
3. Hon. Mokwaledi Moswaane (Botswana) Male
4. Hon. Deputy Speaker Balamage N'kolo Boniface MP (DRC) Male
5. Hon. Fiarovana Lovanirina Célestin (Madagascar) Male
6. Hon. Rachel Zulu (Malawi) Female
7. Hon Ashley Ittoo MP, (Mauritius) Male
8. Hon. Jerónima Agostinho MP (Mozambique) Female
9. Hon. Agnes Kafula MP (Namibia) Female
10. Hon. Desmond Lawrence Moela (South Africa) Male
11. Hon. Strydom Mpanza (Eswatini) Male
12. Hon. Julien Nyemba (Zambia) Female
13. Hon. Paurina Mpariwa (Zimbabwe) Female

2.0 TERMS OF REFERENCE

The terms of reference of the Human and Social Development and Special Programmes Standing Committee are set out in Rule 42(e) of the SADC PF Rules of Procedure.

3.0 NUMBER OF MEETINGS HELD AND THEME

The Standing Committee on Human and Social Development and Special Programmes held one meeting on Friday, 25th of November, 2022 to prepare for the virtual public hearing on Sexual Reproductive Health Rights and related matters. The Committee then subsequently convened a virtual public hearing where citizens from various Member States of SADC were able to make their submissions to the Committee. The submissions related to matters such as, *inter-alia*, child marriages, age of consent *vis-à-vis* access to contraceptives, pycho-social support and mental health, health financing and gaps in the implementation of SADC Regional Indicative Strategic Development Plan (RISDP 2020-2030) and the effects on SRHR in the SADC region.

4.0 BACKGROUND

As part of its delegated mandate, the Standing Committee on Human and Social Development and Special Programmes conducted an inaugural virtual public hearing on the 25th of November 2022. The virtual public hearing sought to gather the views of SADC citizens on matters relating to Sexual Reproductive Health Rights [SRHR]. The main purpose of the virtual public hearing was to amplify the voices of citizens in the SADC Region on matters relevant to the evolving development agenda of the region. This was consequent to the

realisation that it would be beneficial at the regional level to tap into the reservoirs of knowledge of citizens in respect to key developmental challenges confronting the region. Specifically, the objectives of the virtual public hearing by the Standing Committee on Human and Social and Social Development were:

a) To provide an opportunity to citizens to give their views around key issues which are central to redressing the current strained socio-economic climate;
b) To promote synergy between parliamentary work and citizen participation;
c) To promote participatory democracy through citizen participation in deliberative parliamentary processes;
d) To bring parliament to the people instead of the people reaching out for parliament;
e) To raise confidence that regional parliamentary processes under the aegis of regional groupings such as the Forum (and soon the SADC Parliament) can trickle down to the national level for the benefit of SADC citizens; and
f) To promote the SADC identity by making the voices of SADC citizens heard.

Citizens in SADC countries at both corporate and individual levels were invited to attend the virtual public hearing session in order to make evidence-based submissions. The presenters made submissions on specified thematic areas. The virtual public hearing was streamed live to enable wider reach of the citizens. The virtual public hearing was held against a backdrop of declining access to health services and SRHR in the SADC Region.

5.0 PRESENTATIONS

5.1 Key Issues from the submissions during a virtual public hearing on SRHR

Having received oral submissions on various SRHR issues, the Committee noted the following issues for consideration:

a) The centrality of the SADC Regional Indicative Strategic Development Plan (RISDP 2020-2030) in guiding and directing regional integration and cooperation in the SADC Regional Economic Community (REC). RISDP is anchored on a firm foundation of Peace, Security and Democratic Governance, and premised on three interrelated pillars, namely: Industrial Development and Market Integration; Infrastructure Development in support of Regional Integration; and more importantly, Social and Human Capital Development;

b) The main challenge, however, was that RISDP and the accompanying Implementation Matrix were silent on implementation of SRHR. Such an

omission compromises the delivery of the SRHR agenda. Key indicators such as, *inter-alia*, reduction of new-born mortality rate, teen pregnancies and a reduction of maternal mortality ratio are not expressly captured by RISDP;

c) There was lack of funding to public health care in the SADC Region. Over reliance on donor support towards health services coupled with low capital health expenditure had contributed to low and unsustainable health financing in the SADC region;

d) Child marriages were rampant in the SADC Region. The prevailing statutory framework did not offer much scope in protecting persons forced into early marriages. This was compounded by alleged corrupt practices that worked in favour of perpetrators of child marriages;

e) Communities did not fully understand and have access to the laws that relate to SRHR. This often led to ignorance of the law and underreporting of cases of abuse;

f) There was a general conception that society did not care much about the girl child. This made it challenging to achieve universal health coverage as envisaged under SDG 3 relating to ensuring healthy lives and SDG 5 centred on gender equality;

g) There was a general lack of information on SRHR which contributed to a low uptake of contraceptives. This increased the propensity for unwanted teen pregnancies. Contraceptive commodities such as contraceptive implants were not readily available in certain countries in Southern Africa. There was also a marked decline in male condom usage and apathy on the use of the female condom. Stock-outs of major contraceptives were common;

h) Drop-outs of young girls from schools were increasing. This was compounded by the fact that the existing legal frameworks were ineffective in protecting the girl child;

i) The age of consent was a key factor which militated against access to contraceptives. This was worsened by a non-permissive legal environment and certain religious practices;

j) There was subdued ownership of contraceptives programmes, with the bulk of the funding provided by non-state actors. This was not the best practice for ensuring sustainability in the provision of health services to citizens in the SADC Region;

k) Centralised procurement often led to inefficient use of scarce resources, creating a heightened risk of corruption;

l) In some countries in the region, functionally defective condoms were procured, putting the lives of users at risk;

m) There were eight (8) million unsafe abortions in Africa each year. The cases had been on a spiraling trajectory over the last three (3) decades. This was mainly attributable to restrictive legal policies and statutes;

n) Only five (5) countries in the SADC Region had abortion specific laws. In this context, laws must be reformed to allow for safe abortions. A case in point was Rwanda where it was not materially challenging to acquire a pregnancy termination order;

o) Some Member States were yet to sign the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. The Protocol, commonly known the Maputo Protocol, was an international human rights instrument established by the African Union. The Protocol, *inter-alia*, obligated state Parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures. State parties must promote the principle of equality between women and men and ensure effective application of the Protocol;

p) Mental health as a human rights issue was critical in managing issues relating to SRHR. Cases of teen pregnancies and child marriages were rampant. Early marriages and teen pregnancies tended to have an eternal psychological toll on the mental integrity and fabric of young persons that are forced in to early marriages;

q) Empirical research confirmed that early marriages left an indelible footprint on young people, often culminating in feelings of resentment, anger and rejection. Abused youth were often isolated socially and emotionally. Others struggled with suicidal tendencies. They ended up engulfed in a vicious cycle which further traumatized them. Children born out of abusive relationships and marriages often showed signs of psychological strain;

r) There was limited access to SRHR services, particularly by adolescents as well as others in marginalised societies. There was also lack of access to medical commodities on account of the age of consent restrictions. Research data showed that the median age of sexual intercourse was sixteen (16) years. Cases of sexual intercourse for those under sixteen (16) were commonplace. This had a concomitant effect of increased cases of unintended pregnancies. Another challenge related to lack of screening services, particularly for such diseases like cervical cancer. Lack of investment in SRHR put many lives at risk. In this regard, a recommendation was made for increased investment in SRHR by both the state and non-state actors;

s) Most counties had weak institutional capacity in health financing. Private health insurance was expensive and out of the reach of many. This was further compounded by underfunding of public health insurance schemes. This led to catastrophic health expenditure by citizens. Catastrophic

health expenditure (CHE) means that medical spending of a household exceeded a certain level of capacity to pay; and

t) The adverse effects of climate change and the COVID-pandemic had eroded the gains that had been made in SRHR because during these crises, social protections systems were destabilized, leading to diminished access to healthcare. This had left many people vulnerable.

6.0 RECOMMENDATIONS

Having deliberated on the matters concerning SRHR and having considered the issues that impede access to information on SRHR, health care, contraceptives, smooth implementation of health financing systems, the HSDSP Committee recommends that the Plenary Assembly should:

a) **Urge** SADC countries to update the SADC Regional Indicative Strategic Development Plan (RISDP 2020-2030) so that it encapsulates specific issues relating to SRHR issues. RISDP must be realigned to include the SADC SRHR Strategy in order to advance SRHR in driving the regional agenda;

b) **Implore** countries to invest in psycho-social support using both traditional funding mechanisms such as the national budget and non-traditional sources of funding such as development partner support;

c) **Recommend** the need to facilitate revision and effective execution of resource allocation frameworks including public finance management systems across the healthcare and education delivery systems. At least 20% of national budgets should be channelled to education in order to keep more girls in school;

d) **Encourage** countries in the region to review and reform their laws in order to remove barriers to accessing contraceptives as well promote access to safe abortions;

e) **Further Implore** countries to prioritise the rolling out of publicly funded insurance programmes that target the vulnerable, pursuant to the need to address catastrophic expenditure which is rampant in the region;

f) **Further encourage** Parliaments in the SADC region to enhance budget and financial oversight so that there is prudential use of budgetary resources in all public sectors. Oversight techniques, specifically targeting procurement systems must be further enhanced to curb corruption in the public sector;

g) **Request** member countries to strategically employ the use of digital technologies in raising awareness of SRHR issues, particularly in view of

the fact that most of the teenagers are very proficient in the use of ICT Technologies;

h) **Implore** countries to raise awareness on public laws relating to child marriages so that publicity must go beyond the statutory gazetting of statutes;
i) **Appeal** to countries in the region to take steps to strengthen access to information by communities with the intention of influencing behavioural change relevant for the implementation of viable SRHR programmes; and
j) **Direct** the Secretariat to develop a Plan of Action that will give momentum to the implementation of these recommendations.

7.0 CONCLUSION

Addressing issues of SRHR requires a coordinated approach at both the SADC regional level and also at the level of Member States. As such, there is need to urgently review the SADC Regional Indicative Strategic Development Plan (RISDP 2020-2030) so that it responds positively to SRHR issues. The Standing Committee on Human and Social Development and Special Programmes undertakes to mobilise political action for the reform of laws, practices and policies that limit access to SRHR.

The Committee places on record its gratitude to the Secretariat and all SADC citizens who participated whether as presenters or as observers, for the support rendered during its meeting and inaugural virtual public hearing.

Appendix I – List of Officials

1.	Ms Boemo Sekgoma	SADC PF secretariat
2.	Ms Clare Musonda	SADC PF Secretariat
3.	Ms. Paulina Kanguatjivi	SADC PF Secretariat
4.	Mr Ronald Windwaai	SADC PF Secretariat
5.	Mr Andrew Maramwidze	SADC PF Secretariat
6.	Ms Veronica Ribeiro	Angola
7.	Mr Johane Gandiwa	Rapporteur (Zimbabwe)

Appendix II – List of Presenters

1. Mr Adolf Mavheneke-PSA Alliance
2. Ms Loyce Njenge, Zimbabwe-Rozaria Memorial Trust
3. Ms Millicent Sithaile,Botswana-SAT
4. Mr. Perrykent Nkole, Zambia- SAT
5. Ms Charmain Ricardo-SAfAIDS
6. Ms Loveness Madzuru, Zimbabwe-Rozaria Memorial Trust
7. Kenneth Juma, Southern African Litigation Centre
8. Anthony Kamande, Oxfam