SEXUAL AND REPRODUCTIVE HEALTH STRATEGY FOR THE SADC REGION

2006-2015

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PREFACE

The development of a Sexual and Reproductive Health strategy by SADC countries is a bold statement about the importance of the subject and its role in the development of its countries and the region. The SRH strategy is firmly anchored in the strategies of the African continent and the region through key documents such as the Africa Health Strategy for 2007 to 2015, the Maputo Plan of Action on Reproductive Health (both of which were endorsed by the AU Heads of States and Governments) and The SADC Protocol on Health of 2004. In the broader context, the strategy is well aligned with the global frameworks such as the 1984 International Conference on Population and Development (ICPD) and the Millennium Development goals. The two conferences explicitly identified reproductive health as a human rights issue as well as a necessary component of human development.

As underscored by the former UN Secretary General Kofi Annan, the millennium Development Goals can not be successfully achieved without recognizing the strong relationship between poverty and reproductive health outcomes. As a key component of complete and physical and mental health, good reproductive health empowers people and coupled with education, it provides women the opportunity to be a productive and contributing force for the achievement of national development objectives. Poverty and lack of education limits access to services and increases vulnerability of populations, which in turn has impact on reproductive health and on development efforts at large. Given the burden of disease and the economies of good health, Economic development has a direct relationship with reproductive health issues such as maternal morbidity and mortality which take away from the human capital essential for growth and advancement

The Sexual and Reproductive Health Strategy for the SADC provides a framework for developing reproductive health policies or for harmonization for countries who do not yet have such policies. It also guides interventions by the SADC Member States, the Secretariat, donors and other stakeholders in the region. The strategy recognizes the variable socio-economic developmental levels of the Member States and that they will be interested in different aspects of the strategy.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
DRC	Democratic Republic of Congo
GDP	Gross National Product
FP	Family Planning
FWCW	Fourth World Conference on Women
HFA	Health for All
HIV	Human Immune Deficiency Virus
ICM	Integrated Committee of Ministers
ICP	International Cooperating Partners
ICPD/PoA	International Conference on Population and Development/Plan of Action
IMR	Infant Mortality Rate
MMR	Maternal Mortality Ratio
MS	Member State
NGO	Non Governmental Organization
PAC	Post Abortion Care
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Post Natal Care
RISDP	Regional Indicative Strategic Development Plan
RH	Sexual and reproductive health
SADC	Southern African Development Community
SHDSP	Social and Human Development and Special Programmes
SRH	Sexual and Reproductive Health
SRH &R	Sexual and Reproductive Health & Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
WHA	World Health Assembly
WHO	World Health Organization
WHO/AFRO	World Health Organization/Africa Regional Office

Executive Summary

The SADC region, home to over 238.8 million people spread over 15[1] countries in Southern Africa, faces a number of developmental challenges characterized by poverty, illiteracy, unemployment and poor health and living conditions. In 1997, the SADC Heads of State approved the establishment of the SADC Health Sector which was later followed by the SADC Protocol of Health of 1999, which came into force in 2004 following ratification by at least 9 Member States. The SADC Protocol identified four important priority pillars in the health sector:; sexually transmitted infections, HIV and AIDS, reproductive health, childhood and adolescent health.

The goal of this Strategy is to provide a policy framework and guidelines to accelerate the attainment of healthy sexual and reproductive life for all SADC citizens. Consequently, the objectives of the Sexual and Reproductive Health (SRH) Regional Strategy are to strengthen the capacity of SADC Member States to deliver integrated and comprehensive SRH services, to harmonise policies, guidelines and protocols, to enhance synergy of strategies and programmes at national and regional levels and to enhance sharing of information, experiences and best practices among Member States.

The Strategy advocates harmony with other protocols, strategies and initiatives both regionally and internationally. For instance, the Strategy is consistent with the spirit and principles espoused by the 1994 International Conference on Population and Development, the Millennium Development Goals of 2000 and continental initiatives such as the Maputo Plan of Action, the Africa Health Strategy and other population and health documents.

The Strategy document proposes a holistic and integrated approach to the provision of reproductive health services. Per the decision of African Ministers of Health that met in Gaborone in September 2005, sexual and reproductive health and HIV services must be integrated. This is mainly because of the challenge that HIV/AIDS poses in the region and 93 percent of HIV transmission in Africa is through sexual interaction. Special attention is directed at men and women of reproductive ages, adolescents and youth and marginalized populations. The document identifies a number of key priority reproductive health areas for the region and these are as follows; Safe Motherhood, Family Planning, prevention of abortion and management of complications resulting from unsafe abortion, prevention and treatment of reproductive tract infections and sexually transmitted infections, HIV and AIDS, early diagnosis and treatment for reproductive health cancers, prevention and appropriate treatment of sub-fertility and infertility, adolescent and youth sexual and reproductive health, prevention and management of gender-based violence.

[1]Angola, Botswana, Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, Zimbbawe

To achieve its goals, the Strategy identifies key cross-cutting themes, such as health systems strengthening, attention to service quality, mainstreaming gender, creating linkages and partnerships, resource mobilization, developing monitoring, evaluation and surveillance systems.

1. Introduction and background information

SADC is committed to addressing the socio-economic and human development problems of the region. In line with this commitment, the Secretariat together with the SADC Sexual and Reproductive Health (SRH) Managers developed a 9 year Sexual and Reproductive Health Strategy to address sexual and reproductive health challenges. The Strategy is a response to the felt and unmet need as indicated by poor reproductive health outcomes in many Member States of the region. The Strategy takes into account a number of factors, including regional initiatives and those led by the African Union and international organisations. The priorities of the Strategy are informed by the challenges faced in providing Sexual and Reproductive Health services in the SADC region among which are health infrastructure and socio–economic conditions.

1.1 The SADC

The SADC was formed in 1980 then known as the Southern African Development Coordinating Conference (SADCC), a loose alliance with the main aim of coordinating development projects to lessen economic dependence on the then apartheid South Africa. The Windhoek Treaty of 1992, transformed the entity from a loose association into a development community with legal identity, mandated to promote unity, social and economic integration and development in the region.

The *vision* of SADC as declared in Windhoek in 1992 is “of a shared future: a future within a regional community” that will ensure economic well-being, improvement of the standards of living and quality of life, freedom and social justice and peace and security for the peoples of Southern Africa.

The *mission of SADC* is “To promote sustainable and equitable economic growth and socio-economic development through efficient productive systems, deeper co-operation and integration, good governance, and durable peace and security, so that the region emerges as a competitive and effective player in international relations and the world economy”.

SADC consists of 15 Member States and is a relatively large sub-region (6.2 million km²) composed of countries diverse in size. It has a total population of approximately 238.8 million with country populations ranging from 1.1 million (Swaziland) to 80 million (DRC). Socio-political conditions in the region also vary

widely underlined by a recent past of wars and conflicts and consequent instability. For instance, in 2004, the combined Gross Domestic Product (GDP) for Southern Africa was estimated at $296.4 billion. South Africa, the region's most developed economy, has a GDP of $213.1 billion, which constitutes more than two thirds of the combined GDP of the rest of the SADC members.

1.2 The Context of the SRH Strategy

The SADC SRH Strategy has been developed within the context of the global, continental and regional policy frameworks, protocols and commitments.

After a number of decades during which the international community looked at population issues from purely a demographic perspective, the **International Conference on Population and Development (ICPD),** held in Cairo in September 1994, represented a paradigm shift in dealing with the population and development issues. The ICPD/PoA shifted the attention of governments, inter-government agencies and the civil society from demographic targets to the quality of individual lives and emphasized the centrality of the individual to development. It underscored (a) the fact that women's empowerment was a development end in and of itself, (defined sexual and reproductive health and its significance to the health of particularly women, it emphasis a couple-year protection to sexual and reproductive health and rights (SRH&R), the development and empowerment encouraged making available SRH& related information to youth and adolescents.. In addition, the ICPD/PoA called upon governments and donor agencies to adopt an integrated approach for the achievement of a sustainable and people centred development.

This holistic approach was reinforced through the deliberations and recommendations of the **Fourth World Conference on Women (FWCW),** held in Beijing in September 1995, which put emphasis on gender equity and equality, reproductive rights and a rights-based approach to reproductive health. In September 2005, the World Summit also urged nations to make universal access to SRH services and of late a related target was included in the MDGs.

The **Millennium Summit,** held in September 2000, adopted the **Millennium Development Goals (MDGs)** to be achieved by 2015. Adoption of the MDGs consolidated the recommendations of the major UN conferences held in the 1990s. Universal access to reproductive health services by 2015 as stipulated in the ICPD/PoA is not explicitly articulated in the MDGs. In this regard, the then UN Secretary General Kofi Annan stated "*The Millennium Development Goals, particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed".* This message was at the Fifth Asian and Pacific Population Conference in Bangkok in December 2002. The inclusion in 2006, and in 2007 in the MDG

monitoring framework, of the new Target on Universal access to RH by 2015, cemented a more comprehensive approach, inclusive of rights and health, to addressing mortality and morbidity in both the woman and the newborn child. ICPD POA contributes not only to the health MDGs, but also to all the others, including poverty reduction and gender equality. It allows a broader base for right to health and development.

However, it is noted that, of the 8 MDGs, three have direct bearing on reproductive health issues. The three are related to *reduction of child mortality*, improvement of maternal health, and combating HIV and AIDS, malaria and other diseases.

The Africa Health Strategy of 2007 to 2015 represents an effort to operationalise the global commitments to deliver basic health care at continental level. The Africa Health Strategy also promotes integrated approaches and linkages to delivering health care and strengthening of health systems. The Maputo Plan of Action of September 2006, which extensively deals with universal access to comprehensive sexual and reproductive health services in Africa, identified some of the reproductive needs of the continent.

These commitments, together with the resolutions and decisions of the World Health Assembly (WHA) on sexual and reproductive health have been taken into account in developing the SADC Sexual and Reproductive Health Strategy and Plan of Action.

1.3 SADC Health

At their meeting in Mauritius in August 1997, SADC Heads of State and Government approved the establishment of the SADC Health Sector. The goal of the sector, as stated in its Health Policy Framework approved in 2000 is to "attain an acceptable standard of health for all citizens by promoting, coordinating and supporting the individual and collective efforts of Member States". Within this goal were two aims:

- to reach specific targets within the objective of "Health for All" in the 21st century by 2020 in all Member States based on the primary health care Strategy; and
- to ensure that health care is accessible to all within each Member State's economic reality.

Ministers of Health established a number of technical Committees consisting of Programme Managers and relevant Technical Experts, including one on Sexual and Reproductive Health. The committees oversee the development of plans of action, strategies and the implementation of programmes at the regional level.

1.4 SADC Protocol on Health

The Protocol on Health was developed with the aim of harmonising and rationalising resources in the implementation and the attainment of the health objectives in the region. It was ratified by more than two thirds Member States and entered into force in August 2004. The Implementation Plan of the SADC Protocol on Health has now been developed to operationalise the implementation of the SADC Protocol on Health.

The SADC Protocol on Health contains three important articles which are key to sexual and reproductive health. These are articles 10, 16 and 17. The following are extracts from these articles:

a) Article 10: HIV and AIDS and Sexually Transmitted diseases

The article outlines that for the region to deal effectively with the pandemic, the State Parties shall

- harmonise policies aiming at prevention and control;
- develop regional policies and plans that recognises intersectoral approach to the diseases;
- cooperate in the area of standardization of HIV and AIDS and STIs surveillance systems.

b) Article 16: Reproductive Health

State Parties shall formulate coherent, comparable, harmonised and standardised policies, particularly in,

- developing a surveillance system for monitoring maternal and newborn mortality;
- developing strategies to reduce maternal and newborn mortality;
- the reduction of genetic and congenital disorders leading to birth defects;
- empowering men, women and communities at large to have access to safe, effective, affordable and acceptable methods for the regulation of fertility.

c) Article 17: Childhood and Adolescent health

The article states that parties shall

- co-operate in improving the health status of children and adolescents;
- develop and formulate coherent and standardised policies;
- encourage adolescents to delay engaging in early sexual activities.

At a meeting held in Kempton Park, South Africa, in November 2005, SADC Ministers of Health endorsed the Gaborone Declaration (held a month earlier in Gaborone) by AU Ministers of Health. Relevant sections of the Declaration have

been taken into consideration in the development of this Strategy. Of the twelve areas outlined in the Declaration, the most relevant to sexual and reproductive health was the "Implementation of the ICPD Goals and objectives by adopting the Sexual and Reproductive Health Policy Framework (SRH)".

During a meeting held in Durban, South Africa in April 2006, SADC Ministers of Health noted that the AU was going to convene a Special Ministerial Conference on Sexual and Reproductive Health in September 2006. Therefore, it was important for the SADC region to prepare for the AU meeting. At the same meeting, Ministers also reiterated the necessity for the region to undertake an audit on maternal deaths. They also committed themselves to provide data to facilitate timeous completion of the audit. They further directed that the SADC Sexual and Reproductive Health Technical Committee should meet urgently to prepare a SADC Report for the Maputo AU Conference scheduled for September, 2006.

1.5 Process of developing the Strategy

Recognizing the call by SADC Ministers of Health to address problems of SRH, an audit of reproductive health related mortality and morbidity was conducted in Member States by country Managers and Technical Experts with financial assistance from UNFPA. The technical experts supported data collection and report writing in Member States where there was limited capacity.

As part of the process, a questionnaire was developed and sent to all SADC Member States to guide data collection for the audit. Subsequently, a meeting of the SADC SRH Managers was convened and Managers were requested to bring relevant information to the meeting. The meeting was held in Johannesburg, South Africa, on 21st to 23rd August 2006. The presentations by Member States were used to develop an Audit Report which formed the basis of the development of the Sexual and Reproductive Health Strategy for the region.

The Strategy was developed in the course of 2006 and a draft report was approved by Member States later in the year. At the same time, it was important to harmonize the Strategy with documents, developments and protocols at the international and regional levels as well as new technologies that have become available for use since then, for example, male circumcision.

1.6 SRH Challenge in SADC

Reproductive health issues in the SADC region are consistent with those identified by the Maputo Plan of action for Africa. The SADC Audit Report of November 2007 on mortality and morbidity indicates that sexual and reproductive health status of people in the SADC region is relatively low.

Maternal mortality in SADC countries is high; ranging from 124 in South Africa to 1,300 in Angola per 100,000 live births. Maternal mortality trends are not showing substantial progress during the last two decades in the majority of countries and are even increasing in countries like Namibia. Only one member state, Mauritius is an outlier with maternal mortality of 45 per 100 000 live births. Direct causes of maternal morbidity and mortality are well known; hemorrhage, sepsis, pre-eclampsia/eclampsia, complications of unsafe abortion, and obstructed labour. Indirect causes are identified as HIV and AIDS, Malaria, TB and anaemia. Perinatal mortality and morbidity is also very high, many of these deaths are related to the poor health of the woman, the inadequate and the poor quality of care during pregnancy, labour and the post partum period. Interventions aimed to prevent and address these complications are well known and are cost-effective. These interventions should be accessible at first level (basic Emergency obstetric and neonatal care – EmONC) and referral level (comprehensive – EmONC). The weakness of health systems and the lack of access to skilled birth attendance[2], in particular to a midwife or other with midwifery skills (MOMs) working in an enabling environment, during pregnancy, childbirth and the post-partum period, particularly when complication occurs, are the major determinants to maternal mortality.

Antenatal care has become an integral part of MCH care of most health care systems in SADC for decades but services are still not always focused[3] and integrated and the mothers are not fully utilizing this service. Most countries report high rates of ANC for the first visit (over 90%), but less than 50% of women visit facilities for the recommended four antenatal visits. Coverage for prevention of mother to child transmission of HIV (PMTCT) is also low despite the high ANC attendance rate.

Secondly, a large proportion of pregnant women deliver outside health facilities. Birth deliveries attended by skilled service providers range from 42% in Angola to 99% in Mauritius. Paradoxically, in some countries reporting high rates of health facility delivery, there is also high maternal mortality ratios. This is the case with Botswana, South Africa and Zimbabwe and this suggests poor service quality at health facilities.

Safe Termination of Pregnancy (where it is legal) and effective post-abortion care could reduce maternal mortality in many of the SADC countries. Only two countries have legalized abortion, namely South Africa and Zambia. Even when allowed, there is the implication that procedures must be carried out by or under the supervision of doctors, a scarce resource in all of SADC countries. Post Abortion Care (PAC) is however more widely available and in some countries, incomplete abortion is managed successfully by nurse midwives using the manual vacuum aspiration.

[2] Skilled birth attendant definition
[3] Focused ANC services: WHO definition

Family Planning (FP) services have been in operation for about half a century in most SADC countries. The Total Fertility Rate has declined even though it still remains high in most countries and ranges from 2.7 in South Africa to 6.9 children per woman in Angola. In the same vein, the Contraceptive Prevalence Rate (CPR) has also increased but is still too low in most countries. It ranges from 6% in Angola to 75 % in Mauritius. Only three countries in SADC have CPR above 50%. and these are Mauritius (75%), South Africa (65%) and Zimbabwe (54%). Under these circumstances, it is unlikely that unmet need for FP would be realized in most countries. Family Planning is one of the three pillars of maternal mortality reduction strategies (with EmONC and Skilled birth attendance) as it is evaluated that FP services could reduce MMR by 30% and have also an impact on newborn and child mortality.

SADC countries recognize that **adolescent reproductive health** merits special consideration for a number of reasons. The population of the SADC countries, like the rest of Africa, is young and faces vulnerability resulting from a wide range of causes; among others, major transitional problems, lack of parental guidance, eroded community norms and lack of access to health services. Maternal morbidity is higher among youth because of risks of early pregnancy associated with medical, social and service related factors. Abortion, in the context of its illegal status in most African countries, poses a great risk for youth in the continent. The youth face other diseases that afflict them, namely, TB, sexually transmitted infections, including HIV and AIDS. Yet youth friendly services have yet to be adequately developed.

Indicators on adolescent health in general and reproductive health specifically, identify great risks associated with this age. Risk of maternal mortality is higher for girls during adolescence; abortion is higher and sexually active youth are likely to be exposed to multiple sexual partners. More than 50% of all new HIV infections occur among young people aged of 15-24 years. Invariably, HIV prevalence levels are higher for girls than boys throughout Africa. All these situations indicate the gap in services for adolescents and young people.

HIV infection, AIDS and STIs in the SADC countries continue to pose a serious challenge to the SADC countries since the 1980s. Southern Africa is the sub-region in the world most devastated by the HIV and AIDS pandemic. Almost all countries are in the very high or higher categories for HIV prevalence. The SADC region has an HIV and AIDS programme to implement the Maseru Declaration on Combating HIV and AIDS, which was adopted by Heads of State and Government in July 2003. The programme aims at complementing Member States' efforts in their fight against the pandemic.

HIV and AIDS issues in the region are being addressed through the SADC Strategic Framework and Programme of Action on HIV and AIDS. HIV and AIDS problems span from prevention, care, treatment and support for all affected and infected groups. The large number of infected people and those affected (for

example, orphans), raises new challenges of the reproductive health needs of these groups,

There are **other RH problems** that were identified by the audit report of 2007 but there was no data available to indicate the prevalence levels in the region. However, the report recognizes increased morbidity and mortality from cancers of the reproductive organs (for example, prostate, breast and cervical cancer). Infertility, which affects both women and men can lead to great suffering, stigmatization and divorces. Gender-based violence contributes to negative health outcomes in the region and yet the magnitude of the problem is not yet quantified. Cases reported to law enforcements agents probably reflect only a small fraction of the extent of the problem as many cases remain unreported. In general, there is dearth of information on these reproductive health issues and the public sector in most Member States lacks the facilities for basic investigations and treatment.

2. Scope and Coverage of SRH

A wide range of sexual and reproductive health services derived from international initiatives described in earlier sections above is indicated, being mindful that priorities may differ for each Member State and may change with respect to time. Secondly, the Strategy was developed in 2006 and since then some technologies have come to the forefront and SADC Member States may like to consider them. For instance, Male Circumcision is gaining increasing recognition as a new additional technology for preventing HIV infection and some Member States may consider adoption of the technology.

At national level, priorities may differ between Member States depending on context and local realities. Both regional and national priorities may change over time. Based on international initiatives, the Africa Sexual and Reproductive Health Policy Framework and the Maputo Plan of Action (PoA) on SRHR , the following key areas are identified as priority areas that require attention from SADC member states;

- Safe Motherhood
    - Focused Antenatal care, skilled attendance at delivery, and postpartum and postnatal care
    - Management of obstetric and neonatal complications and emergencies
- Family planning/birth spacing services
- Prevention of abortion and management of complications resulting from unsafe abortion
- Prevention and treatment of reproductive tract infections and sexually transmitted infections
- HIV and AIDS and its integration with SRH services

- Early diagnosis and treatment for RH cancers (breast, cervical, male related)
- Promotion of education and support for exclusive breast feeding
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting
- Adolescent and youth sexual and reproductive health
- Prevention and management of gender-based violence

3. Guiding Principles

To effectively implement this Strategy, the following are key guiding principles for Member States

- Align policies, strategies and interventions to internationally and regionally agreed policy and strategic instruments and existing national initiatives on SRH
- Take a human rights approach to providing SRH services, including the right of all persons to the highest attainable standard of health.
- Policies, strategies and programmes must promote integrated and comprehensive service delivery and inter-sectoral collaboration at international, regional and national levels
- Member States and communities must actively participate and lead the design, implementation, monitoring and evaluation of service delivery efforts for ownership and sustainability
- Policies, strategies and programmes must be gender sensitive, particularly considering gender driven differences that cause vulnerability to SRH challenges.
- Priority for service delivery should be given to vulnerable population groups such as orphans and other vulnerable children and youth, poor women and men, people living with disabilities, old people and people living with HIV and AIDS.

4. Aim of the Strategy

The aim of the Strategy is to provide a policy framework and guidelines to accelerate the attainment of healthy sexual and reproductive life for all SADC citizens.

5. Objectives

Based on the challenges in provision of reproductive health services, the following objectives were identified:

- To strengthen the capacity of SADC Member States to deliver integrated and comprehensive SRH services

- To harmonise policies, guidelines and protocols for the provision of SRH services in SADC
- To enhance synergy and complementarity of strategies and programmes on SRH at national and regional levels
- To enhance sharing of information, experiences and best practices among Member States
- To ensure evidence based, targeted and responsive policies and programmes on SRH

6. Targets

- By 2008:
  - All Member States would have developed a *roadmap* for accelerated reduction of maternal and neonatal morbidity and mortality;
  - All Member States would have implemented legislation governing the expanded scope of practice of health professionals.
- By 2010
  - All Member States to have integrated SRH with HIV and AIDS and other related services
  - SRH policies and strategies would have been harmonized and standardized;
  - All countries to have met the Abuja target of governments apportioning 15% to the health budget. Increase budget provision for SRH;
  - Cooperation and coordination in the area of SRH with international organizations and cooperating partners fostered;
  - Surveillance system for SRH in place.

- By 2015
  - Maternal mortality ratios reduced by 75% in all SADC Member States;
  - Access to sexual and reproductive health services improved particularly for vulnerable populations (orphans and vulnerable children, people living with HIV and AIDS, people living with disabilities, older people, people living in rural and peri-urban communities);
  - Member States governments meeting the Abuja commitment of 15% of National budget allocation towards health programmes.

7. Priority Target Groups

The Maputo Plan of Action recognizes a holistic approach which encompasses the whole life span of an individual from conception to old age. Further, emphasis will be on men and women of reproductive ages, older people, newborns, young people, rural, mobile and cross boarder populations, displaced population and marginalized groups.

The African Youth Charter recognizes the needs of those mentally and physically challenged among other vulnerable youth. In the past few decades, the SADC region has witnessed an increasing number of orphans and other vulnerable children due to HIV and AIDS, poverty, violence and conflict situations. The definition of orphans and other vulnerable children spans from infancy upto seventeen years and sometimes upto 24 years. The older segment of this population (where relevant) lacks access to reproductive health services and increasingly, the majority of their caregivers are generally elderly women with inadequate reproductive health information to support OVC needs. In the case of child headed households, access to reproductive health education may be unavailable. Another vulnerable group whose needs are not adequately addressed are men and women living with HIV and AIDS.

8. Strategic Priorities for Action

8.1 Health Systems Strengthening

A fully functional health system is a prerequisite for delivering good quality reproductive health services. Requirements for effective health systems may vary but some of the basic elements to be put in place include;

- a well-performing health workforce
- coherent organization and management (effective leadership and governance)
- good health financing systems to raise adequate funds for health, and to ensure protection for financial risks
- a well-functioning health information system that ensures the production, analysis, dissemination and use of reliable and timely information
- equitable access to quality essential pharmaceutical and health products and technologies
- Also consider infrastructure; equipment, and SRH commodities

8.2 Quality of Reproductive health services

The SADC Audit Report on reproductive health and related mortality and morbidity identifies lack of quality of services to account for poor utilization of services as well as poor health outcomes. Delivery of quality of services is a crosscutting theme for all areas of SRH. Basic elements of quality of care are access to commodities and supplies, relevant physical infrastructure, availability of technically competent service providers, interpersonal relations, provision of relevant information for patients of clients, and referral to other services.

8.3 Integrated Approach and Linkages

The Strategy calls for integration of different reproductive health services to maximize the effectiveness of resource utilization. The provision of comprehensive reproductive health services through integration of STI, HIV and

AIDS into other SRH services and into Primary Health Care is promoted. For Member States facing the new challenges increasing numbers of TB cases, there is a call for integration of TB into STI/HIV/AIDS services. In line with the Africa Health Strategy, there is a call for integration of nutrition into SRH services, especially for pregnant women and children by incorporating nutrition in the school curriculum, and institutionalization of food fortification.

The Strategy also promotes forging of strong linkages of between SRH with other relevant developmental and poverty reduction strategies to minimize individual risk and vulnerability to SRH challenges. In particular, the sexual and reproductive health needs of vulnerable groups such as orphans and other vulnerable children and youth, people living with disabilities, people living with HIV and AIDS are promoted. Challenges are noted in the region with regards to capacity for integrating and providing comprehensive SRH services. Efforts will be made to develop guidelines to support Member States in this regard.

8.4 Strengthening Public-Private-Partnerships (PPP)

The Strategy promotes partnerships, coordination and joint programming and service delivery among stakeholders, namely, governments, civil society, the private sector and affected communities to ensure integrated, holistic and comprehensive provision of SRH services. Specifically, the following linkages will be promoted with,

- Traditional medical practitioners have been acknowledged as important players in the management of different aspects of SRH, especially STI, HIV and AIDS.
- Community involvement and strengthening: Community involvement could be through community groups, community workers, traditional birth attendants and volunteers.
- Relevant government ministries, multi-lateral and bilateral agencies, International Cooperating Partners at national and regional levels.

Partnerships will be part of planning, execution, resource mobilization, advocacy, monitoring and evaluation of the Strategy.

8.5 Mainstreaming gender into all reproductive health programs

To mainstream gender means that the SADC secretariat will facilitate and advocate for gender integration at policy, programme and activity levels. The State of the African Population Report of 2006 points out that achievement of the "eight MDGs will be greatly dependent on the achievement of MDG1 on poverty eradication and MDG 3 on gender equality". In the past decade, reproductive health literature has noted the growing poverty levels among women and this phenomenon is characterized by reference to "the feminization of poverty".

Unfortunately, the same situation is now obtaining with respect to HIV and AIDS where the HIV epidemic is affecting females more disproportionately compared to males and this is also referred to as the "feminization of HIV and AIDS".

Many initiatives recognise problems associated with lack of gender equity and support the call to promote helpful traditional practices and eliminate those that are harmful, for example, female genital mutilation (FGM). Innovative work on gender has started but a lot more remains to be done.

Specifically, the Member States could consider

- conduct research on women's specific health issues and equal involvement of both men and women in health related research
- Promote male involvement in provision of services such as care and information on sexual reproductive rights and maternal issues at household and community level
- Address the negative cultural practices
- Promote programmes on population education and sexual and reproductive rights or issues

8.6 Surveillance systems for some diseases

To monitor the short and long term effect of interventions for different reproductive health services, there is need to support and strengthen existing surveillance systems or to develop new ones. While Member States may have information based on surveys and small scale studies, there is a gap of a surveillance system that is for the region and covers private and public sectors. There is need for Member States to identify key reproductive health issues that need to be monitored through surveillance systems with standard data items for all countries. The Member States will need to agree on a definition of a set of indicators, tools and processes. Surveillance systems will have to be sensitive to tracking SRH challenges among specific vulnerable groups, namely people living with HIV and AIDS, people living with disabilities, children and youth, the poor and people living in rural and hard to reach communities.

8.7 Monitoring and Evaluation

Examine the African Monitoring, Evaluation and Reporting tool developed by the AU Commission and the possibility of is adoption to suit the needs of the SADC Secretariat and region. Alternatively , tools will be developed and agreed upon in the region, and Member States will be required to submit periodic reports on specifically agreed upon SRH indicators, based on international/global indicators. There will also be periodic reviews at regional levels conducted. The Secretariat will facilitate the development and monitoring of key progress indicators.

Many reports have identified the SADC region to be lacking in data on many aspects of SRH, and this calls for more resources to strengthen the capacity of Member States in the use of health management information systems. Strategies identified by the plan may require the region to conduct operations research to test strategies that work in their circumstances and can feed into service delivery programmes.

Potential areas of evaluation include investigating ways of integrating different services, addressing health systems' challenges, using partnerships for effective service delivery. At regional level, a mechanism has to be devised to identify and disseminate best practices to Member States.

A comprehensive review will be undertaken at the end of the ninth year (2015) by external reviewers and Partners.

8.8 Resources Mobilization

The implementation of this Strategic Plan will require resources. These will be in the form of human, material and financial resources. Member States will contribute in the form of staff time and by financing their attendance at meetings where funds have not been secured. Member States should also endeavor to budget for the implementation of some of the interventions that need financial support. Member States will also contribute towards funding for the SRH programme of work through staff time and covering costs for attending some of the activities/meetings of the programme.

The Secretariat will be responsible for ensuring that funds are mobilised from all parties, including co-operating partners, to implement regional activities. For the Secretariat to implement this Strategy, there is a need to strengthen the SADC Secretariat by recruiting additional personnel to facilitate the implementation of this Strategy.

Substantial resources will have to be mobilised for implementation of SRH programme and projects. The Strategy calls for SADC countries to implement the Abuja agreement that 15% of national budgets should be devoted to health. At this point, the SADC Secretariat does not have readily available data to monitor how far this goal being achieved by Member States and how much of the budget is devoted to SRH.

Key stakeholders in the health sector (for example, Partners, UN Agents i.e UNFPA and WHO) have bilateral agreements with SADC and Member States. These stakeholders may undertake to support the specific areas and tasks for specific sectors.

The required resources for the implementation of this plan will be costed at the later stage. Meanwhile, the Secretariat and the Technical Committee will solicit funds for implementation.

8.9 Advocacy and Policy Development

Member States, to varying degrees, are implementing activities that address different aspects of sexual and reproductive health. To implement comprehensive reproductive health programmes, there is need to initiate advocacy activities for new issues (for example infertility and sub fertility issues, PLHA, OVC), and to strengthen advocacy and policy development where some activities are already in place. While Member State governments are usually the target group, communities will increasingly play crucial roles in addressing reproductive health needs of new groups coming into the scene because of HIV and AIDS. For instance, a large number of orphans and vulnerable children are in need of different services as they grow from infancy, through adolescence and childhood. Similarly, PLHA have sexual and reproductive health needs of which Member States are still not experienced to deal with. Policy formulation and guidance for providing services for these groups will need to be developed and experiences shared between Member States.

9. Institutional Framework

In aligning this Strategy to the Implementation Plan of the SADC Protocol on Health, this Strategy will use the institutional framework as outlined in the implementation Plan and it is outlined below.

- **SADC Ministers of Health (Subcommittee of ICM)**

  The SADC Ministers of Health, constituted as a Subcommittee by ICM, will review, approve and propose the SRH Strategy for adoption by the ICM and monitor the implementation thereof.

- **Senior Officials**

  All meetings of Ministers of Health will be preceded and supported by a meeting of senior officials at the level of at least Directors of Health Services.

- **Technical Committee on SRH**

  Technical Committees consists of eight Member States. It is chaired by Swaziland with the following Members: Angola, Botswana, Malawi, Mozambique, South Africa, Tanzania and Zimbabwe. The Committee will be required to assist with development of detailed programme and project plans and to monitor the implementation of these.

- **Directorate Social and Human Development and Special Programmes**

  The Directorate is responsible for overseeing SADC's response to social and developmental issues. Within the Directorate there is a Health Programme responsible to coordinate and facilitate the implementation of this Strategy.

- **National Health Ministries**

  National Health Ministries will support the implementation of the SRH Strategy through timely responses to requests by the SADC Secretariat. They will lead implementation of programmes at a national level and will support the process through assigning resources, including human resources when appropriate. The ministries will be required to report progress regarding the implementation of SRH Strategy through relevant national structures.

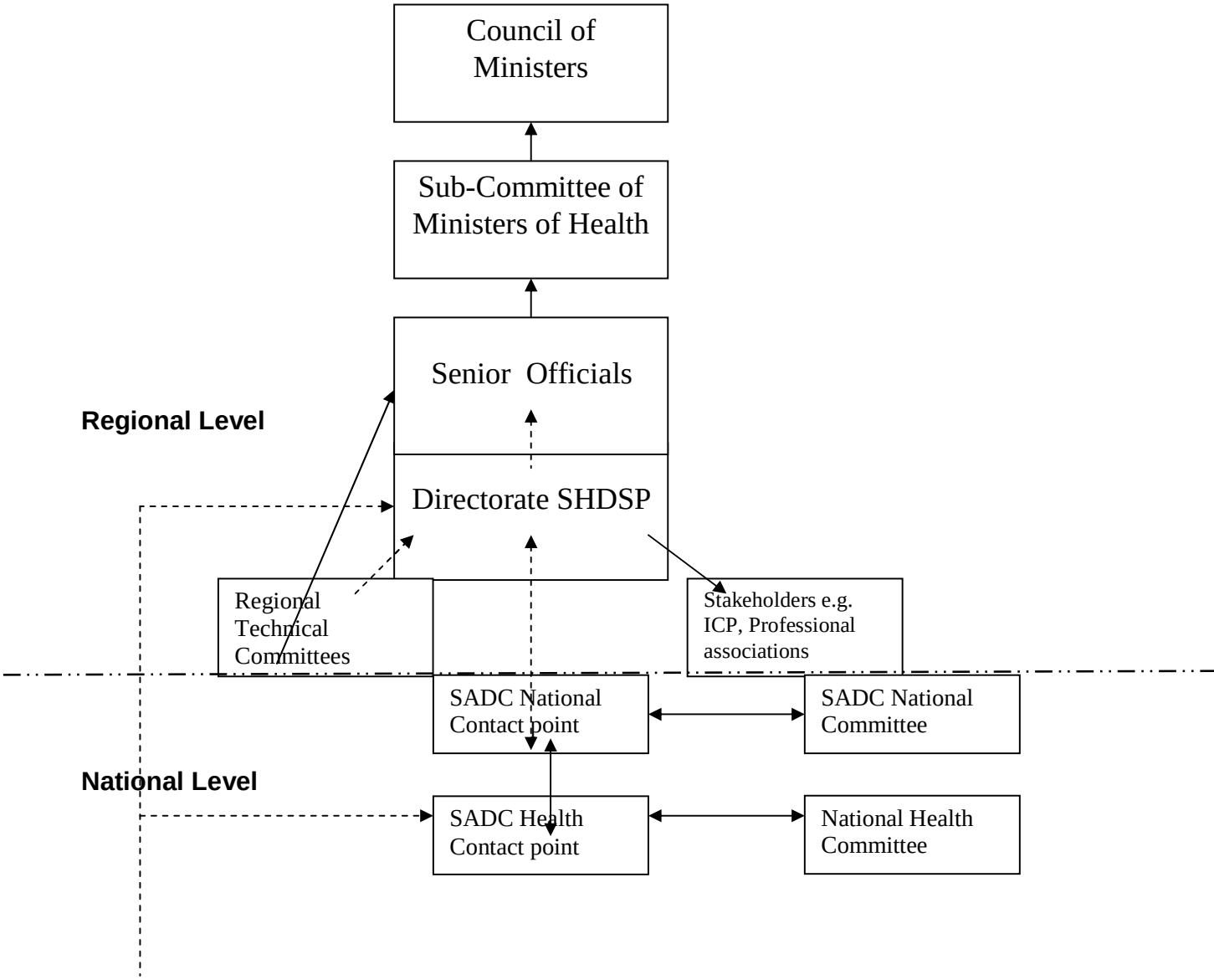
- **Stakeholders**

  Stakeholders include the following:

  a) Communities
  b) UN Organisations
  c) Research Institutions,
  d) Teaching Institutions,
  e) NGOs,
  f) Professional Councils and Associations,
  g) Regulatory Authorities
  h) International Cooperating Partners

  All stakeholders are essential for the successful implementation of this SRH Strategy. Their role will include identifying areas of co-operation that require their expertise and competency and to assist with implementation of the same. Stakeholders may offer advice, technical assistance, coordination in an area, and material and/or financial resources. Relevant stakeholders shall be invited to major fora to monitor progress in the implementation of this Strategy.

A diagrammatic illustration of the proposed institutional framework is in Figure 1 below.



10. SADC SRH STRATEGY IMPLEMENTION PLAN 2006-2015

Note: 1.
The two strategic areas of sexual and reproductive health elements on active discouragement of harmful practices such as female genital cutting and prevention and management of gender-based violence have been combined into one element. `Promotion of education and support for exclusive breast feeding and HIV has been integrated
The integration of PMTCT services is also integrated into safe motherhood

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
	Service Delivery		
1.To strengthen the capacity of SADC Member States to deliver integrated and comprehensive SRH services	1.1 Safe Motherhood	1.1.1 In consultation with partners, (e.g., UNFPA, WHO) develop a monitoring tool and assess progress in implementation of the national MNH Roadmaps	Tool exist
		1.1.2 Monitoring the implementation of standards of care for EmONC at all SADC countries	Standards exist. EmONC Process Indicators defined. EmONC Needs Assessments to be conducted each five years in each country
		1.1.3 Define and monitor the implementation of minimum packages for maternal and neonatal care	Number of countries implementing minimum package
		1.1.4 Facilitate the establishment and implementation of maternal & neonatal death reviews at referral and community levels.	Maternal and neonatal death reviews institutionalized in all SADC countries

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
		1.1.5. Define a HR model for SRH and develop policy, strategy and plan for HR development and management	HR development and management plan for SRH developed and implemented in all SADC countries
		1.1.6 Update pre-service & in-service training curricula & approaches to be evidence based	Updated pre service curricula
		1.1.7 Strengthen pre-service training institutions to provide the number of health professionals which are needed, with the necessary skills and competences	Institutions identified and staff trained
		1.1.8 Mobilize resource for SADC to implement MNH activities	Resource mobilization for SRH strategy developed and implemented and funds raised in all SADC countries
		1.1.9 Scale up integration of PMTCT into ANC services	Countries with functional integrated services
	1.2. Family Planning	1.2.1 Mobilize political will and leadership for universal access to family planning services which are gender and culture sensitive	Gender & culture sensitive services exist
		1.2.2. Ensure integration of FP services with Maternal health services (ANC, Childbirth and post-partum), HIV services, Child and Adolescent health services and Immunization services	FP services integrated with other programmes
		1.2.3. Establish FP services accessible and offering the full scope of modern FP methods including condoms	Increase number of users; Reduction of unmet needs
		1.2.4. Ensure FP methods distribution at community level and community mobilization for birth spacing/family planning	FP community-based distribution systems in place
	1.3.Post Abortion Care	1.3.1. Ensure access to Abortion services to all women, when legal	Abortion services in place as authorized by law
		1.3.2. Compile and disseminate data on the magnitude & consequences of unsafe	Report on unsafe

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
		abortion	abortion for SADC
		1.3.3 Compile and disseminate data on the magnitude & consequences of unsafe abortion	Report on unsafe abortion for SADC
		1.3.4 Initiate bulk procurement of MVA kits for post abortion care for SADC countries (pilot study	System exists for bulk procurement
		1.3.5 Support development of policies and frameworks to reduce unsafe abortion	Common policy and frameworks exist for SADC Member States
	1.4. STI/HIV and AIDS	1.4.1 To coordinate with the SADC framework on control of sexually transmitted infections To facilitate the integration of new STI, HIV prevention technologies into programs (e.g., male circumcision)	Established coordinated mechanism with STI, HIV and AIDS unit
	1.5. RH cancers	1.5.1 Coordinate development of regional policy guidelines on the management of RH cancers (e.g. cervical, breast & prostate)	Policy guidelines exist
		Coordinate development of regional policy guidelines for the integration of cancer of cervix screening into HIV and AIDS activities	No. of countries with integrated guidelines and services for RH cancers
	1.6. Sub-fertility and infertility	1.6.1 Create a database for infertility to use for mapping out future plans	Database exists on sub fertility and infertility
	1.7. Adolescent and Youth sexual & reproductive health	1.7.1 Conduct an assessment of adolescent and youth SRH needs and challenges, policies and types of Youth Friendly Services (YFS) provided by Member States	As assessment for SADC member states conducted
		1.7.2 Research and develop strategies to address early childhood marriages and harmful traditional practices	An Assessment for SADC exists
		1.7.3 To strengthen capacity for delivery of comprehensive SRH services for adolescents and youth	Countries with policies and offering RH friendly services for adolescents and youth
	1.8. Strengthen services for victims	1.8.1 Develop SADC data base on magnitude of all types of violence to map a common way forward	SADC coordinated data base exists

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
	of violence		
		1.8.2 Advocate for PEP for survivors of sexual assault	SADC countries offering PEP
		1.8.3 Facilitate the development of policy guidelines on PEP	Policy guidelines developed and disseminated to SADC Member States
		1.8.4 Monitoring the implementation of the policy guidelines on PEP	"
	Health Systems Strengthening		
	1.9 Strengthen Health Systems	1.9.1 Develop monitoring mechanisms for health systems strengthening	
		1.9.2 Advocate for improved conditions of services	
		1.9.3 Identification of specific skills which need to be facilitated	
		1.9.4 Facilitate the development of human resource plans at member state level	
		1.9.5 Monitor implementation of human resource plans	
		1.9.6 Provide technical expertise to Incorporate the SADC Human Resource plan into health strategic plans of Member States	
		1.9.7 Promote voluntarism among youth and adolescent participation in SRH	Number of youth and adolescent volunteer programmes in SADC
	Gender mainstreaming		
	1.10 Mainstream gender into RH	1.10.1 Accelerate advocacy programmes on gender	
		1.10.2 Facilitate development of gender mainstreaming guidelines (tools) for SRH	Gender mainstreaming tools
		1.10.3 Initiate regional programmes that involve "men as partners" in reproductive health	MS with programs of "men as partners" in RH
		1.10.4 Monitor the implementation of programmes mainstreaming gender	
	Quality of RH Services		
	1.11 Improve quality of RH	1.11.1 Facilitate establishment of minimum standard of key quality of care elements for different SRH services	Guiding document of minimum quality of care

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
	Services		standards and indicators
	Advocacy and Policy Development & mobilization		
2. To harmonise policies, guidelines and protocols for the provision of SRH services in SADC	2.1 Harmonise policies, guidelines and protocols for the provision of SRH services in SADC	2.1.1 Review of policies governing scope of practice of health professionals to accommodate newly envisaged expanded scopes of practice in light of added RH areas	
		2.1.2 Facilitate consultation with professional councils	
		2.1.3 Monitoring the implementation of the policy review	
		2.1.4 Harmonisation of policies and legislation for better implementation	
		2.1.5 Countries to come up with a comprehensive Health Policy which addresses all health issues including SRH issues and then develop policy guidelines	Policy guidelines in SRH
		2.1.6 Establish monitoring tools to track progress on implementation in SADC countries	Monitoring tool exists
		2.1.7 Advocate policies for multi-sectoral effort to create a supportive environment for promotion of comprehensive national SRH policies and service delivery programs	# of countries with policies on PPO on SRH developed an implemented
	Integrated Approach and Linkages		
3. To enhance synergy and complementarity of strategies and programmes on SRH at national and regional levels	3.1 Enhance synergy and complementarity of strategies and programmes on SRH at national and regional levels	3..1.1 Strengthen partnerships through legal entities such as Memorandum of Understanding (MOUs)	
		3.1.2 Provide technical support for integration of different SRH services between each other (STI, HIV, TB , nutrition) and other services Provide technical support for integration of SRH into key national health policy documents, plans and delivery of services	Number of countries pursuing the integration agenda
		3.1.3 To integrate SRH into the SADC HIV and AIDS framework	A mechanism for integrating implementation of SRH and HIV and AIDS

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
			frameworks
		3.1.4 Advocate for resources for strengthening the referral system between different SRH services	
		3.1.5 Collaboration between the health and the transport (roads) unit at SADC secretariat	
	Strengthening Public-Private-Partnerships (PPP)		
	3.2 Strengthening Public-Private-Partnerships (PPP)	3.2.1 Strengthening partnerships at member state level be it bilateral, private sector and NGO involvement	
		3.2.2 Advocate for policies that promote involvement of civil society, private sector (e.g., traditional health practitioners) in SRH service delivery	
		3.2.3 Establish & commemorate SRH week in all SADC countries (proposed last week of July, 2008	
		3.2.4 Strengthen and expand South-South & North-South collaboration	No. of programs indicating S-S & N-S collaboration
	Resource Mobilization		
	3.3 Mobile resources	3.3.1 Facilitate resource mobilization for different aspects of the Strategy	
		3.3.2 Mobilize resources for commodity, equipment and infrastructure	
		3.3.3 To advocate for equitable distribution of resources for different programs at all levels of care	
		3.3.4 To advocate to donors to honour their pledges	
		3.3.5 SADC to lobby SADC Governments to honour Abuja targets for resource allocation for health, to devote 15% of government expenditure/budget on health	No of countries honoring the Abuja targets
		3.3.6 Lobby SADC Governments to allocate resources for the implementation of SADC SRH Programme	
		3.3.7 Prioritize & increase budget allocation for SRH services	No of countries increasing SRH budgets

Issues	Strategic Area	Activities	Suggested Monitoring Indicators
		3.3.8 Countries to submit timely annual reports of implementation of International agreements to relevant reporting organizations	
4. To enhance sharing of information, experiences and best practices among Member States	4.1 Facilitate learning and sharing of best practices	4.1.1 Coordinate the identification of some learning site as "a pathfinder for strengthening SRH	
		4.1.2 Facilitate regional information exchange and disseminate best practices on SRH	Different mechanisms for information exchange in place
		4.1.3 Facilitate learning and sharing of information and experiences on adolescent and youth SRH	
5. To ensure evidence based, targeted and responsive policies and programmes on SRH	**Monitoring, Evaluation & Surveillance**		
	5.1 Conduct research, monitoring and evaluation	5.1 1 Conduct and fund regional studies/research on SRH	No of evaluation studies
		5.1.2 Development of standardized data collecting tools	Existing standardized tools
		5.1.3 Develop monitoring tools and target group specific and indicators, including adolescents and youth, on all areas of SRH indicators for SADC countries	Existing standardized monitoring tools
		5.1.4 Strengthen ongoing surveillance systems and establish new ones where necessary	No. of surveillance systems strengthened.

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