



Sexual and Reproductive Health Business Plan for the SADC Region

2011 – 2015

Version 3

July 2012

Foreword

Acknowledgements

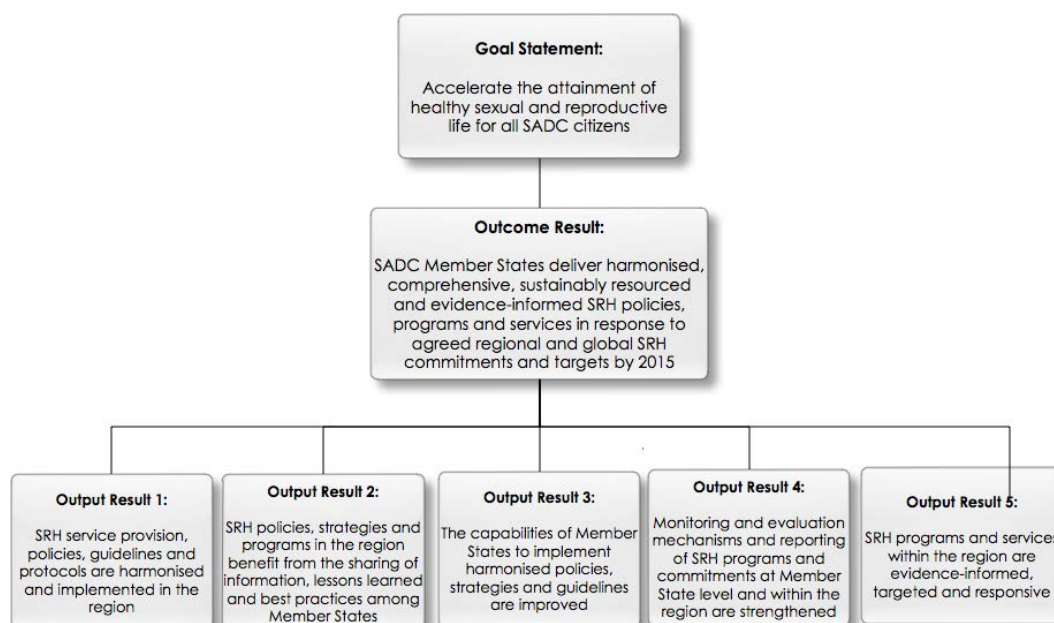
Executive Summary

This SRH business plan (2011 – 2015) is based on the SADC Sexual and Reproductive Health Strategy for the SADC region (2006-2015). The Strategic plan captures five key objectives to obtain the goal of a healthy sexual and reproductive life for all SADC citizens. The Business plan is the plan of the SADC secretariat to support the realization of the changes envisioned in the Strategic plan, and is grounded on the regional comparative advantages of SADC to advocate and influence the envisaged changes.

The burden of unmet need in sexual and reproductive health remains significant in the region. It is estimated that three-quarters of maternal deaths can be prevented by increasing women's access to comprehensive reproductive health services, including antenatal care, skilled attendants during childbirth, emergency obstetric care (including post-abortion care), maternal nutrition, postpartum care for mothers, and family planning. Early engagement in sex, early marriage, and low use of contraceptives are key precursors to early childbearing, high fertility, high child mortality, and low levels of female education. A study by WHO (2007) found that pregnancy is the leading cause of death among young women aged 15-19 worldwide, with complications during childbirth and unsafe abortions being major risk factors. Also the lack of financial resources is one of the key factors undermining progress towards universal access to SRH and safe motherhood services in sub-Saharan Africa.

In addressing the above and other priority SRH needs in the region, the business plan focuses on a number of key priorities including deliberate efforts needed to reposition family planning and making services more accessible, guaranteeing safe motherhood, preventing of abortion and management of complications resulting from unsafe abortion, integrating SRH with HIV and AIDS, TB and Malaria including PMTCT and nutrition, targeting vulnerable groups including orphans, vulnerable children, youth and their carers; and enhancing sexual reproductive health services for adolescent and youth who constitute the majority of people in the region. Many of these actions are also based on the various global and regional commitments that MS have signed including the MDGs, SADC Protocol on Health (2004) and the Maputo Plan of Action (2006).

The business plan has the goal to '**Accelerate the attainment of healthy sexual and reproductive life for all SADC Citizens**' that is derived from the SRH Strategic framework and an outcome result, supported by five output result areas. These are illustrated below:



The output results are based on the comparative advantages of the Secretariat that includes coordinating regional interventions, policy development and harmonization, advocacy, capacity development, information sharing, facilitating regional M&E and reporting, tracking progress; and resource mobilisation.

The business plan covers a five-year period to 2015 and has an indicative budget of USD 2,516,744.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	ARV therapy
ARV	Antiretroviral
AU	African Union
CCM	Country Coordinating Mechanism
CoM	Council of Ministers
CS	Civil Society
CSO	Civil Society Organizations
CTX	Co-trimoxazole
EC	Executive Committee
ESA	Eastern and Southern Africa
GFATM	Global Fund for AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
ICP	International Cooperative Partners
ICT	Information and Communication Technology
IDU	Injecting drug users
M&E	Monitoring and Evaluation
MARP	Most at risk populations
MC	Male circumcision
MCP	Multiple and concurrent partnership
MDG	Millennium Development Goal
MP	Member of Parliament
MS	Member State
NAA	National AIDS Authority
NAC	National AIDS Council
NGO	Non-Governmental Organization
NSF	National Strategic Framework
ODA	Overseas Development Assistance
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RISDP	The SADC Regional Indicative Strategic Development Plan
SADC	Southern African Development Community
SADC PF	Southern African Development Community Parliamentary Forum
SG	Secretary General
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
TB	Tuberculosis
TRIPS	Trade Related Aspects of Intellectual Property
UN	United Nations
UNAIDS	Joint UN Programme on HIV and AIDS
UNDP	UN Development Programme
UNESCO	UN Educational, Scientific and Cultural Organisation
UNFPA	UN Population Fund
UNGASS	UN General Assembly Special Session on HIV and AIDS
UNICEF	UN Children's Fund
UNIFEM	UN Development Fund for Women
VCT	Voluntary counseling and testing
WHO	World Health Organization

1. Introduction

This business plan is based on the SADC Sexual and Reproductive Health Strategy for the SADC region (2006-2015). The Strategic plan captures five key objectives to obtain the goal of a healthy sexual and reproductive life for all SADC citizens. The Business plan is the plan of the SADC secretariat to support the realization of the changes envisioned in the Strategic plan, and it is grounded on the regional comparative advantages of SADC to advocate and influence the envisaged changes.

2. Context of the Business Plan

2.1 SRH in Southern Africa

WHO estimates that of about 180 – 210 million pregnancies every year world-wide, about 30 million of those pregnancies are in Africa. It is also estimated that about 20 million women suffer from maternal morbidity. The Maternal Mortality Ratio (MMR) world-wide is estimated at 400 per 100,000 live births. The Sub Saharan Africa has an estimated MMR of 920 per 100, 000 live births. This difference poses a major challenge for Africa to meet MDG 5¹.

According to a report by the IPPF titled 'Enhancing progress towards universal access to Reproductive health and safe motherhood in Southern Africa'² unmet need in SRH is exceptionally high in the region. A few extracts below demonstrate the burden of unmet need in SRH. The report cites the ICPD+15 review, indicating that the population growth rate for Africa is high, with young people under 30 years constituting more than 70 % of the population. The total fertility rate (TFR) is highest in countries in Central, Eastern and Western Africa, at more than 5.0 children per woman and lowest in Southern Africa at 2.6 children per woman. Contraceptive Prevalence Rate (CPR) is lowest in Western, and Central Africa, while the levels are higher in Southern Africa. The high TFR and low CPR have implications for maternal, newborn and infant morbidity and mortality. Wide disparities in coverage of family planning services across and within countries represent a missed opportunity to improve the health of women and young children.

The Maternal Mortality Ratio (MMR), that estimates the number of maternal deaths per 100,000 live births, is the ultimate indicator of the disease burden associated with high-risk pregnancies and childbirth. The SADC region has the lowest maternal mortality burden of the three RECs; the 2008 MMR estimates were 455 for SADC, 540 for EAC, and 560 for ECOWAS. It is estimated that three-quarters of maternal deaths can be prevented by increasing women's access to comprehensive reproductive health services, including antenatal care, skilled attendants during childbirth, emergency obstetric care (including post-abortion care), maternal nutrition, postpartum care for mothers, and family planning (WHO and UNICEF, 2010). Deliveries assisted by Skilled Birth Attendants (SBA) and Antenatal Care (ANC) are the primary interventions used to deliver services that help address maternal mortality.

Other diseases that are impacting on MMR, Newborn and child health are the high HIV prevalence rates in the region especially among female adults (ages 15-49). This calls for integration and strengthening linkages of SRH and HIV/AIDS/Malaria, Nutrition and TB activities. Many countries in Africa are experiencing crisis situations due to natural disasters like floods, earth quakes, droughts and both internal conflict and

¹ Quoted in Workshop report of the Sexual and reproductive Health: Addressing MDG 4,5 and 6 for the SADC Region, held 14 to 16 September 2010

² IPPF and Institute for Development Policy, 2011 – Enhancing progress towards universal access to Reproductive Health and Safe Motherhood in Southern Africa

conflict with neighboring countries. These situations directly impact on SRH and the welfare of pregnant women.

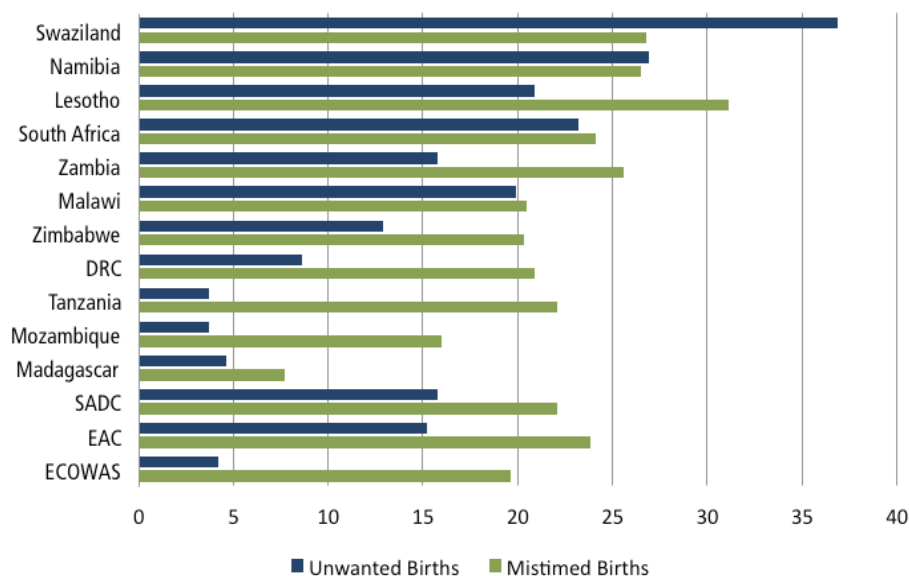
Except for South Africa, that has liberalized its abortion laws, all SADC countries have restrictive abortion laws. Considering that the removal of legal restrictions paves the way for the provision of safe abortion services that will save many women's lives, it is important for SADC countries to continue reforming their abortion laws. But having safe abortion services is not just about removing or relaxing legal barriers. It also entails addressing service-level challenges as well as stigma to ensure that women who legally qualify for safe abortion can access this service. Increasing access to FP is also cost-effective in reducing unplanned pregnancies, which drive many women to have unsafe abortions in circumstances where they cannot access safe abortion. Unsafe abortions are a concern and account for 9% of all maternal deaths and other long-term maternal disabilities in the Southern Africa region.

The level of unmet needs for FP shows the extent to which women who want to avoid or delay pregnancy are not using contraception and, therefore, at risk of having unwanted or unplanned pregnancies. Due to the high levels of unmet needs, women in the region reported that 40.4% of their recent deliveries were unwanted or mistimed - see figure 1. Swaziland had the highest level of unplanned births (63.7%), followed by Namibia (53.4%) and Lesotho (52%). Madagascar had the lowest (12.3%), followed by Mozambique (19.7%). For the remaining countries, the levels of unplanned births ranged between 25% and 47%: Tanzania (25.8%), DRC (29.5%), Zimbabwe (33.2%), Malawi (40.4%), Zambia (41.4%), and South Africa (47.3%).

Figure 1: Percentage of recent births that were mistimed or unwanted

Data source: ICF MACRO

Figure 3: Percentage of Recent Births that were Mistimed or Unwanted, (Latest Data), SADC



It is common knowledge that young people's SRH is a key determinant of the

economic and social development of their countries and communities. Early engagement in sex, early marriage, and low use of contraceptives are key precursors to early childbearing, high fertility, high child mortality, and low levels of female education. A study by WHO (2007) found that pregnancy is the leading cause of death among young women aged 15-19 worldwide, with complications during childbirth and unsafe abortions being major risk factors. Contrary to conventional thinking, the average age at first sexual experience in the SADC region increased slightly from 17.2 years to 17.4 years between 1992 and 2007, and it varied between a low of 16.1 years in Mozambique to a high of 19.3 years in Namibia

The link between high fertility and population growth is also evident. The population size will double by 2050 in all the seven countries where women have an average of 5 children (Angola, DRC, Malawi, Mozambique, Tanzania and Zambia). See figure 2.

In Malawi, Tanzania and Zambia, the population will grow by more than 300%. While big populations can facilitate economic growth because they are conducive to economies of scale, governments in the region should bear in mind the fact that it is difficult to accrue such potential benefits in weak and fragmented economies characterized by low educational levels, poor health, and vulnerability to environmental catastrophes; and the adverse effects of global warming.

Finally, lack of financial resources is one of the key factors undermining progress towards universal access to SRH and safe motherhood services in sub-Saharan Africa. However, assessing the amount of money spent on MDG5 and SRH is hampered by lack of data since only a few countries have undertaken detailed studies of sub-accounts of national health accounts to examine and track SRH budget lines.

2.2 Sexual and Reproductive Health Strategy for the SADC region (2006 – 2015)

The Sexual and Reproductive Health Strategy for the SADC Region (2006 – 2015) forms the basis of and directly informs the SRH business plan. The strategy is driven by the imperative to reinforce a holistic and integrated approach to the provision of reproductive health services in the region. The strategy is a direct response to the regional and global policy context that capture global and regional priorities and commitments to addressing among other, challenges that mitigate sexual and reproductive health in the region. Some of these policy directives refer to the Millennium Development Goals 4, 5 and 6; the Maputo Plan of Action and the SADC Protocol on Health of 2004.

The SRH strategy is briefly summarised below.

Figure 2: Fertility rates and population growth in SADC countries

	Fertility Rates (Latest Data)	Population Size ('000)			Growth Factor 2010 -> 2050
		1990	2010	2050	
Mauritius	1.5	1060	1299	1367	1.1
Seychelles	2.3	71	87	91	1
South Africa	2.4	36794	50133	56757	1.1
Botswana	3.2	1382	2007	2503	1.2
Lesotho	3.3	1639	2171	2788	1.3
Namibia	3.6	1415	2283	3599	1.6
Zimbabwe	3.8	10469	12571	20614	1.6
Swaziland	3.9	863	1186	1679	1.4
Madagascar	4.8	11281	20714	53561	2.6
Mozambique	5.1	13547	23391	50192	2.1
Tanzania	5.4	25479	44841	138312	3.1
Malawi	5.7	9381	14901	49719	3.3
Angola	5.8	10335	19082	42334	2.2
Zambia	6.2	7860	13089	45037	3.4
Democratic Republic of the Congo	6.3	36406	65966	148523	2.3
*Total	5.3	128675	220195	556358	2.3

Note: *The Fertility Rates and Growth Factor Columns are averages

Data sources: DHS, except for data for Mauritius (Ministry of Health)

2.2.1 Goal and objectives

The goal 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**. The goal is supported by five key objectives that form the foundation of the SRH business plan. The five objectives are:

1. To strengthen the capacity of SADC Member States to deliver integrated and comprehensive SRH services
2. To harmonise policies, guidelines and protocols for the provision of SRH services in SADC
3. To enhance synergy and complementarity of strategies and programmes on SRH at national and regional levels
4. To enhance sharing of information, experiences and best practices among Member States
5. To ensure evidence-based, targeted and responsive policies and programmes on SRH

The objectives seek to integrate capacity development with strategy and programme coherence in a harmonised and responsive policy environment, all underpinned by the sharing of information and best practices relevant to SRH. The overall intent of the strategy as articulated above is geared towards priority target groups that include men and women of reproductive ages, older people, newborns, young people, rural, mobile and cross border populations; displaced populations and marginalised groups.

2.2.2 Priorities for action

Nine priority areas of action have been defined in the strategy to be addressed by 2015. This is supported by key targets to be achieved by 2015. The priority action areas are briefly described in box 1 below:

Box 1: Priority actions of the SRH strategy 2006 - 2015

1. **Health systems strengthening** that refers to a well-performing health workforce, good health financing systems, a well functioning health information system, equitable access to pharmaceutical products and SRH commodities
2. **Quality of reproductive health services** that refers to reinforcing the basic elements of quality of care that include access to commodities and supplies, relevant physical infrastructure, technically competent service providers and referral to other services
3. **Integrated approach and linkages** that refer to the provision of comprehensive reproductive health services and the integration of these services into Primary Health Care, and the forging of linkages between SRH and other developmental and poverty reduction strategies
4. **Strengthening public-private partnerships (PPP)** that refer to partnerships, coordination and joint programming among government, civil society, the private sector and affected communities
5. **Mainstreaming gender into all reproductive health programmes** that refers the advocacy for gender integration at policy, programme and activity levels
6. **Surveillance systems for some diseases** that refer to facilitating the monitoring of short and long term effects of interventions for different reproductive health services
7. **Monitoring and evaluation** that refer to the adoption of the African Union African Monitoring, Evaluation and Reporting Tool and the development of regionally suitable tools for the monitoring and submission of periodic reviews and reports on SRH indicators regional and global indicators
- 2.3 8. **Resources mobilization** that refer to the mobilization of human, materials and financial resources including calls for SADC countries to honor the Abuja agreement that 15% of national budgets be devoted to health

A number of global, continental and regional policy frameworks, protocols and commitments provide the policy context for the business plan. Some of these are listed below.

2.3.1 International Conference on Population and Development (ICPD) – Cairo, September 1994. The ICPD represented a paradigm shift in perspectives related to population and development challenges. The focus on the quality of individual lives and the centrality of the individual to development shifted the focus of government and civil society away from the preoccupation with demographic targets.

2.3.2 Recommendations of the Fourth World Conference on Women (FWCW - Beijing, September 1995 – the Beijing Platform of Action:

The relevant recommendations related to sexual and reproductive health contained in the Beijing Platform of Action under the Women and health strategic objectives:

1. Increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services
2. Strengthen preventative programmes that promote women's health
3. Undertake gender sensitive initiatives that address STDs, HIV and sexual and reproductive health issues
4. Promote research and disseminate information on women's health
5. Increase resources and monitor follow-up for women's health

2.3.3 Millennium Development Goals (MDG) – Millennium Summit, September 2000

The relevant MDG goals to the implementation of the SRH strategy are the following:

Table 1: MDGs 4,5 and 6 and targets

Goal 4: Reduce child mortality	Target: ✓ Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Goal 5: Improve maternal health	Targets: ✓ Reduce by three quarters, between 1990-2015, the maternal mortality ratio ✓ Achieve by 2015, universal access to reproductive health
Goal 6: Combat HIV/AIDS, malaria and other diseases	Targets: ✓ Have halted by 2015 and begun to reverse the spread of HIV/AIDS ✓ Achieve by 2010, universal access to treatment for HIV/AIDS or all those who need it

2.3.4 SADC Protocol on Health , ratified in August 2004

Article 16 on Reproductive Health of the SADC Protocol on Health states:

'States Parties shall formulate coherent, comparable, harmonized and standardized policies, strategies, programmes and procedures for reproductive health, particularly in -

- a) Developing a surveillance system for monitoring maternal mortality;
- b) Developing strategies to reduce maternal mortality;
- c) The reduction of genetic and congenital disorders leading to birth defects; and
- d) Empowering men, women and communities at large to have access to safe, effective, affordable and acceptable methods for the regulation of fertility.'

2.3.5 The Africa Union Continental Policy Framework on Sexual and Reproductive Health and Rights (2005) and the Maputo Plan of Action (2006)

This framework seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. It addresses the reproductive health and rights challenges faced by Africa and calls for strengthening of the health sector component by increasing allocations to health, in order to improve access to services. Mainstreaming gender issues into socio-economic development programmes and SRH commodity security is also addressed. It also recommends that SRH be part of the six top priorities within the health sector. It builds on the following action areas:

- Integration of SRH services into primary health care
- Re-positioning family planning
- Developing and promoting youth friendly services, unsafe abortion, quality safe motherhood
- Resource mobilization
- Commodity security
- Monitoring and evaluation

The role of the Regional Economic Commissions were identified as:

- Providing technical support to Member States including training in the area of reproductive health
- Advocate for increased resources for sexual and reproductive health
- Harmonize the implementation of national Plans for Action
- Monitor progress
- Identify and share best practices

2.3.6 Africa Union Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) 2009

CARMMA focuses on three key areas: 1) positive messaging; 2) encouraging achievements and strides made in some countries in reducing maternal mortality and seeking to replicate them; 3) intensifying actions aimed at reducing maternal and infant mortality. The goal of CARMMA is to contribute to further advancement of social development in the continent through proactive support to national efforts and national leadership aimed at reducing maternal mortality. Its main objective is to accelerate the availability and use of universally accessible quality health services including those related to reproductive and sexual health which are critical for reducing maternal mortality. This would be achieved through strengthening health systems with a view to reaching the MDGs and other targets and related national goals, and recognizing maternal mortality as a key indicator of health systems effectiveness.

CARMMA raises awareness and builds links with international campaigns, and strengthens and integrates health systems through high-impact interventions in selected countries. It promotes sustainable financing and publicizes the issues through media and other support. It sets up monitoring and evaluation frameworks and work with partners including health ministries. The majority of SADC Member States have domesticated CARMMA or are in the process of doing so.

3. Sexual and Reproductive Health Business Plan

3.1 Comparative advantages of the SADC Secretariat

The business plan essentially gives expression to the SRH Strategy and is a plan that is driven by the SADC Secretariat. The Plan is based on the comparative advantages of the Secretariat and specifically its added value in helping Member States and the region achieve the imperatives and targets that have been agreed regarding SRH. The SADC Secretariat is held accountable for the priority implementation actions outlined in this plan that are consistent with its comparative advantages. In this respect, the results framework of the SRH business plan is outlined using the SRH Strategy as its foundation.

The work of the Secretariat is based on its regional comparative advantages that include the following:

- Coordinating regional interventions – policy development and harmonization, capacity development, information sharing
- Facilitate regional M&E and reporting – tracking progress; regional level synthesis reports
- High level Advocacy at regional, continental and international platforms
- SRH Policy review, development and harmonization, commitments and protocols
- Exchange learning and sharing best practices
- Resource mobilisation
- Identifying and referring technical assistance to support Member States (through implementation of the SADC Placement programme of the SADC Human Resources for Health Strategic Framework 2007-2019)

In view of the above, the business plan represents the outcomes and actions that the Secretariat can be held accountable for.

3.2 Priorities of the business plan

The priorities reflected below are a synthesis of the priorities outlined in the SRH Strategy and the agreed priorities that emerged from the 'Workshop on Sexual and Reproductive Health: Addressing MDGs 4,5 and 6 for the SADC Region'³ that was held in South Africa in September 2010; and then a subsequent regional meeting in Johannesburg in July 2012.

Adding to the priorities defined in the SRH Strategy is the need to mainstream gender into all reproductive health programmes, to drive an advocacy and policy development programme for all new and current issues and challenges in SRH; and to mobilize resources. The above priorities are informed by critical challenges facing the region as discussed at the above mentioned workshop and articulated in the communiqué. Despite progress made, critical challenges tend to compromise the achievement of key SRH imperatives. One of the challenges relates to the underfunding of the SADC Secretariat that in turn compromises efforts to address and meet regional targets. This also impacts on monitoring, evaluation and capacity building activities for Member States.

³ The three-day workshop was held at Birchwood Hotel in Johannesburg South Africa (14 – 16 September 2010) and brought together delegates from the SADC Technical Committee on SRH, most Member States, African Union, UN family, youth organizations, the SADC Secretariat and partners (NGOs, foundations). The objectives of the meeting among other, were to share updates on new developments and key issues on SRH at all levels, provide a platform for sharing experiences in monitoring maternal, child and neonatal mortality, facilitate regional consultations on the development of the SADC SRH business plan and SRH annual report; and to launch the SADC SRH Partnership Forum.

Poverty, the burden of disease and high illiteracy rates contribute to the low status of women and poor health particularly for women and children. The efforts of the SADC SRH Technical Committee (established in 1999) and the SADC Partnership Forum (consisting of Government, Civil Society including Youth Organisations and Partners operating in SRH in Member States and the Region) established in 2010 have been facilitating the sharing of good practices among MS but this needs to be extended. The lack of capacity for comprehensive, holistic and integrated SRH in different sectors of development, poor planning and lack of sharing of resources among different sectors and partners are leading to the 'verticalisation' of the delivery of SRH services resulting in poor SRH outcomes. The region lacks adequate leadership for concerted and harmonized efforts in the response to SRH and in addition, there are serious information gaps to inform policies, decisions and programming on SRH at both national and regional levels. These frustrate efforts for achieving a universal position, joint voice and common platform for reporting on regional progress and challenges in the implementation of SRH commitments at regional, continental and global levels.

A key priority that underpins all of the above is the need to achieve MDGs 4, 5 and 6 and there is clear consensus on the thematic priorities that relate to SRH. Critical SRH priorities across Member States include the following:

- Deliberate efforts needed to reposition family planning and making services more accessible
- Guaranteeing safe motherhood
- Preventing of abortion and management of complications resulting from unsafe abortion
- Prevention and treatment of reproductive tract infections and sexually transmitted infections
- Integrating SRH with HIV and AIDS, TB and Malaria including PMTCT and nutrition
- Skilling birth attendants
- Greater access to emergency obstetric and new-born care and services
- Reliable maternal and newborn health data
- Engendering SRH interventions and ensuring human rights based programming
- Resource mobilization and ensuring predictable financing for health
- Targeting vulnerable groups including orphans, vulnerable children, youth and their carers
- Improving health system-wide approaches including reproductive health commodity security
- Maternal, newborn and child death reviews
- Strengthening the early diagnosis and treatment for reproductive health cancers
- Promotion of education and support for exclusive breastfeeding
- Prevention and subsequent treatment of sub-fertility and infertility
- Active discouragement of harmful practices such as female genital cutting
- Enhancing sexual reproductive health services for adolescent and youth who constitute the majority of people in the region
- Prevention and management of gender-based violence.

3.3 Results framework

3.3.1 Goal statement

The goal statement comes from the SRH strategy and provides the frame of reference for the business plan.

'Accelerate the attainment of healthy sexual and reproductive life for all SADC citizens'

3.3.2 Outcome and output results

The outcome result for the business plan speaks to evidence-informed, harmonised and comprehensive policies, services and programmes in the SADC region in line with agreed regional and global SRH commitments. The outcome result to be achieved over the next four to five years is supported by five outputs result areas that are more directly informed by the five objectives of the SRH strategy (see 2.2.1 Goal and Objectives).

Outcome result:

SADC Member States deliver harmonised, comprehensive, sustainably resourced and evidence-informed SRH policies, programmes and services in response to agreed regional and global SRH commitments and targets by 2015

Outcome results derived from the SRH strategy objectives

The outcome result is supported by five output result areas that form the basis of the implementation strategies and plans outlined further on in this business plan. These are outlined below and are in synergy with the five objectives of the SRH strategy.

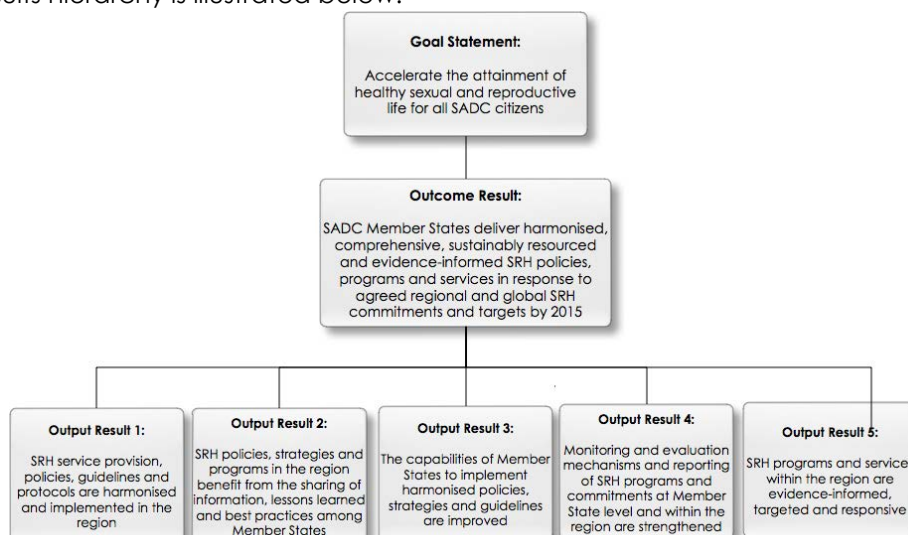
Output result areas

The output results represent the changes desired in sexual and reproductive health at both the national and regional levels and are in concert with the comparative advantages of the Secretariat.

The Five output results are outlined below:

1. ***SRH service provision policies, guidelines and protocols are harmonised and implemented in the region***
2. ***SRH policies, strategies and programmes in the region benefit from the sharing of information, lessons learned and best practices among Member States***
3. ***The capabilities of Member States to implement harmonised policies, strategies and guidelines are improved***
4. ***Monitoring and evaluation mechanisms and reporting of SRH programs and commitments at Member State level and within the region are strengthened***
5. ***SRH programmes and services within the region are evidence-informed, targeted and responsive***

The results hierarchy is illustrated below:



3.3.3 Output results and actions

Strategy considerations

Poverty and high levels of illiteracy in many SADC countries have contributed to the low status of women and poor health seeking behavior of communities which negatively affect women's and children's health. Emphasis is needed on equity in reaching the poorest and most vulnerable populations in the rural areas and other vulnerable communities while implementing MNCH/SRH mortality reduction and health financing strategies. While countries have made good progress in achieving high coverage for some selected interventions such as antenatal care, the quality of services still remains poor. Standards of care and management protocols need to be developed, disseminated and implemented particularly regarding the management of the major obstetric causes of maternal deaths as a minimum intervention.

There is need to strengthen collaboration with SADC universities, training institutions and professional associations, so that they adapt their training curricula to include care of the newborn and the high impact interventions for SRH and child health in pre-service and in-service training. The Nurse/Midwifery councils need to be targeted particularly in those countries where they have not yet embraced the added responsibilities of reskilling midwives (and doctors) for the provision of basic emergency obstetric care.

The provision of PMTCT services during antenatal, intra partum and postnatal care provide a platform for delivering interventions for prevention and treatment of HIV in women and newborns. The opportunity for this integration is largely under-utilized, and should be addressed as a matter of urgency by all MS.

Care of low birth-weight infants and management of neonatal illness are critical for preventing neonatal deaths. This care can be provided through strengthening the quality and coverage of emergency neonatal care and integrated management of childhood illness at first level facilities. Extra care for low birth weight infants must also be provided at home and health facilities.

In order to scale-up health system performance and outcomes in SRH, an effective knowledge management approach, grounded in best practice documentation and sharing is imperative. The need to streamline the right knowledge for the right people (policy makers, SRH implementers, programme managers, and service providers) and in the right format is vital for strengthening SRH systems and improved health outcomes intended by Member States. Much of the SRH knowledge in the region is not always tapped in a systematic manner and underscores the need for adopting a systematic approach to pooling and sharing evidence-based knowledge on SRH experiences of "what works" and subsequent lessons learnt.

Finally, the SADC Annual SRH report will be used for the provision of information for policy and decision-making. The report will also be used as an advocacy tool, for sharing of best practices, tracking progress at the regional level; and will enable the SADC secretariat to report at continental and global levels.

The actions associated with the output result areas are outlined below:

Output result 1:

SRH service provision policies, guidelines and protocols are harmonised and implemented in the region

Key actions:

- 1.1 Identify and update SRH policies, guidelines and protocols and minimum standards in the region that relate to among other, repositioning family planning, prevention of abortion and management of complications, treatment of STIs, SRH Human Resources, linkages with other critical areas including HIV and AIDS, Nutrition, Malaria, TB and access to quality SRH services
- 1.2 Convene regional level meetings of Technical Committee and regional SRH partners; map out plan of action to revise/integrate/change/update the Health/SRH strategies, guidelines and protocols
- 1.3 Facilitate the mainstreaming of gender into SRH programs and policies
- 1.4 Assess progress related to regional and Pooled/ joint procurement of SRH commodities and essential medicines as part of the Pharmaceutical program of SADC
- 1.5 Facilitate policies and programmes that respond to the SRH needs of priority populations at risk, especially migrants, youth, people living with HIV and refugees
- 1.6 Develop regional minimum standards (ratios) for SRH service provision
- 1.7 Facilitate the scale-up of SRH information and services for young people
- 1.8 25% of country health budget to be allocated for SRH and earmarking 10% of the SADC HIV and AIDS Fund for SRH Regional activities

Output result 2

SRH policies, strategies and programmes in the region benefit from the sharing of information, lessons learned and best practices among Member States

Key actions:

- 2.1 Encourage partnership building and networking with Civil society, Research networks and institutions, Private sector, UN – ICPs and SADC HIV unit, SADC PF, Communication Networks, Youth Networks
- 2.2 Develop guidelines for documenting Best Practices in the implementation of SRH Programs in the Region;
- 2.3 Facilitate the documentation of Best Practices in the implementation of SRH Program
- 2.4 Strengthen the participation of MS in the SRH Regional program, Annual Partnership Forum and SADC SRH Technical Committee meetings
- 2.5 Support MS to develop systems for information generation, management and sharing to guide effective planning and implementation of SRH strategies
- 2.6 Establish and utilize the SADC SRH partnership to ensure regular update to partners on progress on implementation of SRH Business plan, integration of SRH strategies in countries, and mobilize and maintain partnerships
- 2.7 Establish and maintain a knowledge and information Portal on SRH

Output result 3.

The capabilities of Member States to implement harmonised policies, strategies and guidelines are improved

Key actions

- 3.1 Provide direct support to ALL Member states to revise/integrate/change/update the Health/SRH strategies that are integrated, gender responsive, human rights based and with clear and time bound deliverables on SRH
- 3.2 Sensitize and train sector program managers on the integration of SRH into sectoral Regional Guidelines and Standards

- 3.3 Strengthen capacities of MoH on planning and procurement in order to ensure SRH commodity security and to ensure SRH commodities are included in the National Essential Medicines' List
- 3.4 Rapid assessment of TA on SRH available in the region and incorporate into a data base of technical resources
- 3.5 Advocate that systems requirements related to SRH service delivery at country level form part of efforts towards health systems improvement including human resources challenges
- 3.6 Identify the Regional SRH Ambassador and submit proposals to Ministers for consideration
- 3.7 Assist MS to translate regional, continental and international SRH commitments into national legislation
- 3.8 Develop sustainable financing strategy, disseminate to MS and mobilize resources for SRH for the region specifically for MDGs 4 and 5 and for the secretariat
- 3.9 Strengthen eMTCT services

Output result 4.

Monitoring and evaluation mechanisms and reporting of SRH programs and commitments at Member State level and within the region are strengthened

Key actions

- 4.1 Support the research agenda on SRH in the region - identify gaps, encourage research, and ensure access to research findings
- 4.2 Facilitate the establishment of reliable mechanisms for maternal / neonatal and child death reviews including community verbal autopsy; and data collection through strengthening national M&E systems and Special Committees
- 4.3 Support MS to harmonize reporting systems and tools to monitor SRH implementation in the region
- 4.4 Produce the annual SADC status and progress report on SRH in the region - incorporating CARMMA and Maputo Plan of Action implementation
- 4.5 Advocate the SADC Parliamentary Forum to mainstream SRH into all its HIV and Health programs targeting Parliament and Members of Parliament
- 4.6 Midterm and summative evaluations of the SADC SRH Strategy and business plan

Output result 5.

SRH programmes and services within the region are evidence-informed, targeted and responsive

Key actions

- 5.1 Review national health strategies to identify challenges and gaps, and highlight opportunities for SRH integration with the submission of annual reports
- 5.2 Undertake cost estimates of SRH service provision in region for reaching targets by 2015
- 5.3 Actively advocate participation by MoH and other relevant SRH partners in processes related to law review of obstacles to fulfillment of reproductive health rights and service delivery in country (gender, human rights, children, marriage, abortion, HIV, sexual orientation etc) that includes the removal of all discriminatory, punitive laws and legislation that have a bearing on SRH.
- 5.4 Facilitate policies and programs that respond to the SRH needs of priority populations at risk, especially migrants and refugees
- 5.5 Support MS with the development and provision of IEC materials on SRH as the basis for all national and regional advocacy processes, social marketing programs and education

4. Implementation of the business plan

4.1 SADC Secretariat accountability

All of the above mentioned strategic intervention areas with their output results and actions form part of the interventions of the SADC Secretariat towards helping to achieve the five objectives that have been defined in the SADC SRH Strategic Framework. The achievement of the five objectives reflected at the impact level involves a myriad of partners and stakeholders at regional and national levels. The strategic focus areas are the Secretariat specific actions and it is these actions and results that the Secretariat needs to be held accountable for regarding results.

4.2 Roles and responsibilities at the political, operational and stakeholder levels

At the MS level there are a number of role players that assume critical roles in addressing SRH. These include the political principals at country level, the various operational and technical bodies, civil society and International Cooperating Partners. These role players constitute the institutional framework of SADC that will help to implement the Strategic Framework and Business plan. Figure 4 below illustrates the institutional framework relevant to SRH.

At the political level:

The Committee of Health Ministers and SADC will provide policy guidance and leadership for implementation. The SADC Secretariat will provide regular progress reports to the Ministers for policy decision-making. The final policy approval will be through the Council of Ministers who will receive regular reports and input from relevant Ministries. Where Ministers of other sectors meet in SADC fora, the SHD&SP and other Directorates will ensure that their agenda's consider SRH issues relevant to their sectors. The Secretariat will advocate for a proposed regional inter-ministerial task force, forum or symposium that will meet on a regular basis to help accelerate the mainstreaming of SRH issues and strengthen cross-sectoral collaboration and joint programming for holistic and comprehensive service delivery.

At the operational and technical levels:

The SADC Secretariat, through the Health programme in the Directorate of Social and Human Development and Special Programmes, will facilitate and coordinate the implementation of the business plan in collaboration with key national structures; and Regional and International partners. The Secretariat will fulfill this function through planning and management of programmes, resource mobilisation and coordination and development of harmonized policies and programmes. The SADC Secretariat will also coordinate monitoring and evaluation of implementation of regional policies and programmes.

At the stakeholder partnership level

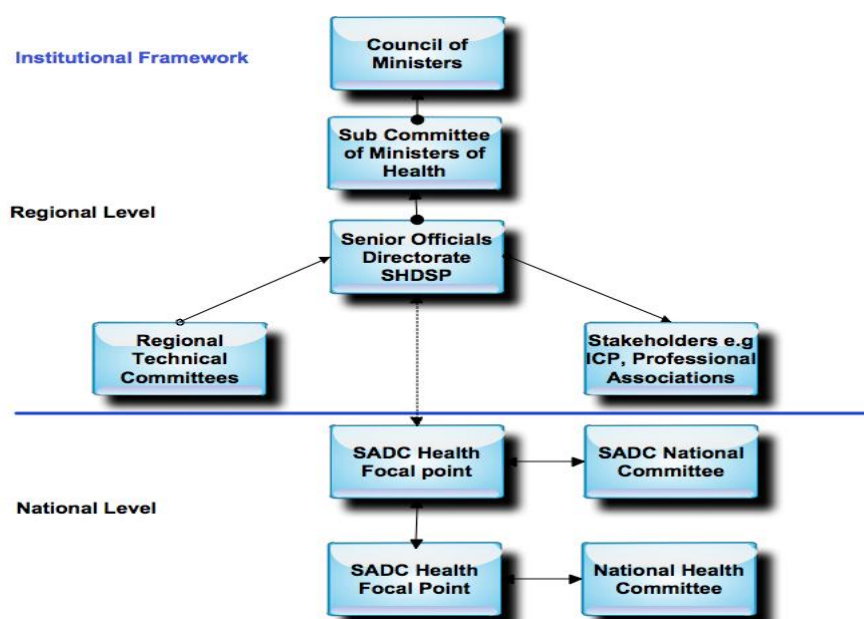
The **SRH Partnership Forum** involving sectors and regional actors from civil society, the public and the private sectors, and development partners will provide a formal, representative structure for discussion, information sharing, consensus building and mutual support for all partners pertaining to SRH at a regional level. In addition, the Partnership Forum will be used to broker coordination arrangements and identify and mobilize assistance. Further, the Forum will be used as an accountability structure for all partners. Special sub-forums will be facilitated on an ad hoc basis where needed with specific interest groups /stakeholders such as the private sector, media, children and youth, people living with HIV and AIDS and other to enhance their contributions towards addressing SRH challenges in the region. Regional Civil Society Organisations and research institutions will serve a dual role as both implementing partners and in some cases technical advisors. Comparative advantages of individual institutions will be considered in assigning responsibilities. International Partners are expected to play

a key role in providing technical assistance and resources for the implementation of the Strategic Framework and the business plan.

At the programme level

At the programme level, the SADC Secretariat is responsible for strategic management of programmes and for ensuring that regional programmes deliver on their objectives, serving the interests of the region. The Secretariat will mobilize funds for programmes and therefore is responsible to International Cooperating Partners, MS and stakeholders to ensure appropriate and efficient use of funds.

Figure 4: Institutional Arrangements



The Secretariat has access to above important forums, committees and meetings and can use these platforms to do the following:

- Reinforce the need for policy adoption based on regional policy frameworks, protocols and guidelines regarding SRH
- Reinforce the need for proper research and assessments; M&E systems that must provide the evidence of change regarding the myriad of indicators relevant to SRH
- Use the peer pressure approach to force non-cooperating MS to comply in the case of regional and global commitments
- Use the various platforms to advocate further resource investments in SRH such as the SADC HIV and AIDS Fund, funding by development partners and national funding
- Use the various platforms to drive key SRH advocacy messages and creating and maintaining a regional platform for regional engagement and voice
- Use the strategic platforms to share strategic information such as best practices, SRH reports, monitoring and data reports to name a few

The above platforms and mechanisms provide the basis of the comparative advantages the secretariat has in driving and advocating better harmonized, resourced, and capacitated approaches, policies and practices regarding SRH at both regional and national levels.

4.3 Institutional arrangements of the SRH unit

The SRH unit is a small unit that creatively uses the resources within the SADC secretariat and partnerships to achieve the imperatives of the SRH framework and business plan. The unit will use the administrative personnel and overhead costs (except for salaries) to cover its running costs. The unit is located in the Directorate of Social and Human Development and Special Programmes (SHD&SP) and apart from engaging with the HIV and AIDS and gender units, will engage all the Directorates within the Secretariat. The business plan in lieu of the aforesaid makes provision for two professional staff members of the unit that will drive the SRH regional imperatives.

These posts include:

- SADC Regional SRH Coordinator
- SADC Regional Capacity Development and Knowledge Management Officer

5. Monitoring and evaluating of the business plan

A monitoring and evaluation framework and plan will be further refined to capture in detail the M&E activities in support of the Strategic Framework for HIV and AIDS, and the Business Plan. This will include establishing indicators and targets to assess the performance of SADC. M&E will include quantitative and qualitative information; also disaggregated by gender.

Capacity development is central to the response and it is essential that the SADC M&E Plan address this key concern. All monitoring and evaluation projects and programmes will incorporate a capacity development strategy that can ensure their feasibility and sustainability.

The M&E plan will:

- Ensure that progress towards the Framework's targets is documented.
- Act as early warning in cases where targets are unlikely to be achieved;
- Provide regular information to all stakeholders on progress in implementing the plan;
- Ensure the continuous sharpening and focusing of strategies and appropriate interventions

A key focus of M&E is to monitor all the global and regional commitments made by MS with reference to SRH such as Universal Access, MDGs and other. A major feature of the timeframe leading up to 2015 will be MS reporting on the meeting of Universal Access targets and MDGs by 2015. These are evaluation processes that will be happening at MS level.

The SRH business plan will be subject to a midterm evaluation in 2013, and an end of programme evaluation (summative) in 2015 that will assess the impacts achieved over the business plan timeline.

The SRH unit will actively encourage and call for the coordination of research on SRH in the region among academic institutions and organisations with areas of work focused on research or who are commissioned to do research. All relevant research on SRH commissioned by multilateral institutions, bi-lateral donors, organisations of civil society, health institutions and other need to be coordinated in the region to minimize

duplication and overlaps. In this respect the SRH unit will act as a repository of research done at MS levels or regionally, in addition to commissioning its own research.

6. Cost Proposal

6.1 Unit costs

The cost proposal is summarized below and more detailed cost analysis forms part of the operational plan in annexure 1. The cost proposal budgets for each of the actions based on unit costs. Many of the unit costs are reflected as average costs and these are outlined below:

- Daily subsistence allowance is calculated using an average USD 250
- Flights costs in the region uses the average USD 1,500
- Technical Assistance where consultants are contracted uses the daily rate of USD 500
- Contributions are made towards regional meeting costs as it is not anticipated that the programme will cover all MS costs to attend meetings

The salary costs are calculated on a 13-month basis to take account of bonuses and other costs normally associated with salary such as benefits and other deductions. As noted above in 4.3, provision is made for the two professional posts as other administrative personnel and costs will be covered by the Secretariat. Implicit within the calculation logic is the fact that the two staff members will take responsibility for all of the actions especially with reference to advocacy, coordination, knowledge management and national, regional meetings.

6.2 Summary of costs

In table 4 below is a summary of costs spread over the five years for each of the outcome result areas.

Table 4: Costs of each of the outcome result areas

Output results	2012 – 2015 budget (USD)
<i>1. SRH service provision policies, guidelines and protocols are harmonised and implemented in the region</i>	160,000
<i>2. SRH policies, strategies and programmes in the region benefit from the sharing of information, lessons learned and best practices among Member States</i>	287,500
<i>3. The capabilities of Member States to implement harmonised policies, strategies and guidelines are improved</i>	322,750
<i>4. Monitoring and evaluation mechanisms and reporting of SRH programs and commitments at Member State level and within the region are strengthened</i>	722,000
<i>5. SRH programmes and services within the region are evidence-informed, targeted and responsive</i>	85,000
Total overhead cost **	924,524
Total cost	2,516,744

**** Note this amount includes the salary costs and equipment costs.**

The total indicative budget is **USD 2,516,744** for the four years with an average cost per annum of USD 609,193.

7. Operational plan

Tabulation of the Operational Plan

The operational plan is attached in annexure 1. The table tabulates all the output results needed to help achieve the outcome results (and therefore the strategic objectives of the SRH Strategic Framework), along with actions plotted over the five-year timeline. Indicators are defined for the actions as well as the indicative costs.

Annexure 1: Operational Plan

Annexure 2: Reference

Workshop report of the Sexual and reproductive Health: Addressing MDG 4,5 and 6 for the SADC Region, held 14 to 16 September 2010

IPPF and Institute for Development Policy, 2011 – Enhancing progress towards universal access to Reproductive Health and Safe Motherhood in Southern Africa

Multi-stakeholder policy dialogue on SRHR in Africa – towards the ICPD + 20 review and the Post MDG's Agenda Setting, Nairobi, September 2011

SADC, 2010 Regional Guidelines for Sexual and Reproductive Health (SRH) Best Practice Documentation and sharing in the SADC Region

SADC, May 2010 Framework for the Prevention and Control of Sexually Transmitted Infections

SADC, November 2008 Sexual and Reproductive Health Strategy for the SADC Region 2006 – 2015

SADC Communiqué, 14 – 15 September 2010 Meeting on Sexual and reproductive Health: Addressing MDGs 4,5 and 6 for the SADC region

UNFPA and National Department of Health, 2010 A Monograph of the Management of Postpartum Hemorrhage

Health Department of the Republic of South Africa, Saving Mothers – Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa – Expanded Executive Summary 2005 - 207