STRATEGY
FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE SADC REGION

2019 – 2030

DRAFT 1 FOR FEEDBACK

4 October 2018

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Foreword

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AYSRHR	Adolescent and Youth Sexual and Reproductive Health and Rights
CMR	Child Mortality Rate
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
DRC	Democratic Republic of Congo
GBV	Gender-Based Violence
GNP	Gross National Product
FP	Family Planning
FWCW	Fourth World Conference on Women
HFA	Health for All
HIV	Human Immune Deficiency Virus
ICM	Integrated Committee for Ministers
ICP	International Cooperating Partners
ICPD/PoA	International Conference on Population and Development/ Plan of Action
IMR	Infant Mortality Rate
MMR	Maternal Mortality Ratio
MDGs	Millennium Development Goals
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	Postnatal Care
RIDSP	Regional Indicative Strategic Development Plan
RH	Reproductive Health
SADC	Southern African Development Community
SDGS	Sustainable Development Goals
SHDSP	Social and Human Development and Special Programmes
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNFPA	United National Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization
WHO/AFRO	World Health Organization/ Africa Regional Office

Glossary of Terms[1]

Adolescent: Persons aged 10-19 years

Adolescent and youth-friendly health services: Health services that are both responsive and acceptable to the needs of adolescents and youth and are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.

Comprehensive Sexuality Education: Refers to the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality.

Gender-Based Violence (GBV): Refers to all acts perpetrated against women, men, girls, and boys on the basis of their sex that cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to carry out such acts. GBV includes the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed or other forms of conflict

Gender mainstreaming[2]: Defined by the United Nations as the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes, in any area and at different levels. It is a strategy for making women's and men's concerns and experiences an integral dimension in the design, implementation, monitoring and evaluation of policies and programmes in all political, and societal spheres so that women and men benefit equally , and inequality is not perpetuated. The ultimate goal is to achieve gender equality.

Health care: Services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring and restoring health and preventing illness. Health is defined by the World Health Organization (WHO) as the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has many dimensions (anatomical, physiological and mental) and is largely culturally defined.

Health system: The sum total of all the organizations, institutions and resources whose primary purpose is to ensure delivery of quality services to all people, when and where they need them. WHO identifies six core components or 'building blocks' of a health system: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

Human Rights: Rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include civil, political, social and economic rights. For instance, these include the right to life and liberty,

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[1] Definitions are taken from existing SADC Policy and Strategy Frameworks unless otherwise stated

freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.

Human Rights-Based Approach[3]: The essential attributes of a human rights-based approach are that the development of policies and programmes should fulfil human rights. A human rights-based approach identifies rights holders and their entitlements, and corresponding duty bearers and their obligations, and works towards strengthening the capacities of rights holders to make their claims and of duty bearers to meet their obligations. Principles and standards derived from international human rights treaties should guide all development cooperation and programming in all sectors and in all phases of the programming process.

Key Populations: Groups who, due to specific higher risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviors that increase their vulnerability to HIV. For the purposes of this Strategy, key populations include: 1) men who have sex with men, 2) people in prisons, 3) people who use drugs, 4) sex workers and 5) transgender people. It includes young key populations who are increasingly vulnerable to HIV and have specific sexual and reproductive needs. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic.

Life cycle approach to SRHR[4]: Recognizes that the SRHR needs of people change and evolve over the course of their lives, which requires that SRHR services offer a 'continuum of care' that responds appropriately and adequately to people's changing needs.

Member State: As defined in the Treaty of the Southern African Development Community.

Multisectoral Response[5]: Multisectoral approach refers to deliberate collaboration among various stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, environment, and economy) to jointly achieve a policy outcome. By engaging multiple sectors, partners can leverage knowledge, expertise, reach, and resources, benefiting from their combined and varied strengths as they work toward the shared goal of producing better health outcomes.

People-centred health services[6]: Putting people and communities, not diseases, at the centre of health systems, and empowering people to take charge of their own health rather than being passive recipients of services.

Primary Health Care[7]: Essential health care based on appropriate, acceptable methods

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[3] OHCHR. (2006). Frequently asked questions on a Human Rights-Based Approach. United Nations. New York/Geneva

[4] UNFPA.

[5] Salunka, S & Lal, D.K. (2017). 'Multisectoral approach for promoting public health'. In: *Indian Journal of Public Health*, vol 61, pp. 163 - 168

[6] WHO. (2018) What are integrated people centered health services. Accessed from: http://www.who.int/servicedeliverysafety/areas/people-centred-care/ipchs-what/en/

and technology, made universally accessible through community participation.

Reproductive rights: Reproductive rights relate to the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. These rights include the right to the highest attainable standard of sexual and reproductive health and the right of all people to make decisions concerning reproduction free from discrimination, coercion and violence. Reproductive rights are articulated in SADC Member States' legislation as well as in international human rights documents.

Rights-based approach: is a conceptual framework for ensuring that human rights principles are reflected in policies and national development frameworks. Human rights are the minimum standards that people require to live in freedom and dignity. They are based on the principles of universality, indivisibility, interdependence, equality and non-discrimination. It means that the universally agreed rights of all citizens include the right to health services, products and information and that the individual Member States have an obligation to ensure that their citizens realize this right.

Sexual and reproductive health: A state of complete physical, mental and social well-being in all matters relating to the reproductive system and sexuality; it is not merely the absence of disease, dysfunction or infirmity. For sexual and reproductive health to be attained and maintained, the sexual and reproductive health rights of all persons must be respected, protected and fulfilled. Sexual and reproductive health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexual gender-based violence: Any sexual act or unwanted sexual comments or advances using coercion, threats of harm or physical force, by any person regardless of their relationship to the survivor, in any setting. Sexual gender-based violence is usually driven by power differences and perceived gender norms. It includes forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse and rape.

Sexual rights: Human rights which relate specifically to sexuality and which are articulated by national laws, international human rights documents and other international agreements. Sexual rights seek to ensure that all people can express their sexuality free of coercion, discrimination and violence.

Universal Health Coverage[8]: Defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Vulnerable populations: Groups of people who are particularly vulnerable to HIV

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[8] WHO (2016)

infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. This Strategy does not specifically address vulnerable populations but it does note the specific vulnerabilities of young key populations.

Young key populations: Individuals between the ages of 15 and 24 who due to specific higher risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. They also often have legal and social issues related to their behaviors that increase their vulnerability to HIV. For the purposes of this strategy, key populations include: 1) men who have sex with men, 2) people in prisons, 3) people who use drugs, 4) sex workers and 5) transgender people.

Young People: Individuals between 15-24 years.

DRAFT 1

Executive Summary

The development of the Draft SADC Regional Strategy on Sexual and Reproductive Health and Rights (2019 – 2030) and the Draft Scorecard was facilitated by the SADC Secretariat. This was done in line with SADC procedures through a consultative process, and with the technical support of the United Nations 2gther 4 SRHR Programme (UNAIDS, UNFPA, UNICEF and WHO), UNESCO and SheDecides. The process of development included:

i)   The establishment of a Technical Working Group to oversee the process and the development of the draft documents, led by the Ministries of Health for the Kingdom of Eswatini, Namibia and South Africa;

ii) A Regional Technical Consultation with representatives from Ministries of Health, Education, Gender and Youth from the SADC Member States, regional civil society partners and youth led organisations convened on 4-6 September 2018 to deliberate on the Draft Strategy and the Draft Scorecard;

iii) Review and endorsement of the drafts by NAC Directors during their annual meeting in Windhoek, Namibia, on 3 October 2018;

iv) Review and endorsement by senior officials of Ministries of Health and HIV related entities during their meeting in Windhoek, Namibia, on 5 – 7 November 2018.

The SADC Regional Strategy on SRHR (2019 – 2030) builds on the progress made in the region, guided by the *SADC Sexual and Reproductive Health Strategy (2006 – 2015)*, in improving sexual and reproductive health and rights (SRHR) during the period of the Millennium Development Goals. Gains included: reductions in maternal mortality, AIDS-related deaths and new HIV infections.

Yet despite this progress, more needs to be done to improve the SRHR needs of people, if the SADC region is to continue to reduce morbidity and mortality, unlock its human development potential, meet the Sustainable Development Goals (SDGs) and the targets of the African Union's Maputo Plan of Action 2016–2030.

Purpose: Provide a policy and programming framework for SADC Member States to accelerate the attainment of sexual and reproductive health and rights for all people living in the SADC region.

Scope: Builds upon the Programme of Action of the International Conference on Population and Development (ICPD), the SDGs, the Maputo Plan of Action 2016–2030, and the SADC SRH Strategy 2006–2015, informed by the most current thinking on SRHR as defined by the Lancet-Guttmacher Commission on Accelerating Progress: SRHR for All, and the Manifesto of the global SheDecides movement.

Vision   Ensure that all people in the SADC region enjoy a healthy sexual and reproductive life, have sustainable access, coverage and quality SRHR services, information and education, and are fully able to realize and exercise their SRH rights, as an integral component of sustainable human development in the SADC region.

Principles: (a) Member State ownership, leadership and resourcing through domestication and alignment with national frameworks;

(b) Complementing and augmenting existing strategies, instruments and national initiatives on SRHR for sustainable human development in the region;

(c) Active and meaningful participation of civil society, youth, communities and those most affected by specific SRHR issues in the design, implementation, and monitoring and evaluation of the strategy;

(d) A multi-sectoral approach to optimally harness the roles, responsibilities, resources and commitment across ministries, civil society, youth structures, development agencies, the private sector, and academic institutions;

(e) A gender-responsive, visionary, and transformative approach that takes account of gender-driven differences that causes negative SRH outcomes;

(f) A youth-facing and youth-friendly approach;

(g) Universal health coverage – "leaving no one behind" – and equity in access to health services, including in humanitarian settings, without the risk of financial hardship;

(h) A human rights-based approach to the provision of SRH services, including the right of all persons to the highest attainable standards of health;

(i) An inclusive life cycle approach that promotes the provision of integrated high quality, people-centered, comprehensive services that reaches those who are hardest to reach;

(j) Progressive realization of SRHR through the prioritization of reforms and strategic partnerships to address wider systemic challenges;

(k) Mutual accountability for results, recognizing that the success of this strategy requires Member States, civil society, networks of youth and key populations, and development partners to work together to drive the agenda forward.

Outcomes: To achieve this vision, SADC Member States will be required to fast track progress towards achieving the following outcomes:
1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG 3.1.);
2. Newborn mortality ratio reduced to fewer than 12 deaths per 1,000 births (SDG 3.2.);
3. HIV and AIDS ended as a public health threat by 2030 (SDG 3.3.);
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, eliminated (SDGs 5.1, 5.2 and 5.3);
5. Rates of unplanned pregnancies and unsafe abortion reduced;
6. Rates of teenage pregnancies reduced;
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable

populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6);

8. Health systems, including community health systems, strengthened to respond to SRH needs; (SDG 5.6);

9. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6);

10. Barriers – including policy, cultural, social and economic – that serve as an impediment to the realization of SRHR in the region removed (SDGs 5.1 and 5c).

Strategies: Four core strategies to drive progress to achieve the ten outcomes are proposed, as follows:

A) Innovative leadership that boldly accelerates the SRHR regional agenda. Member States should consider:

➢ Removing political, cultural, social and economic barriers so that all people, in particular women and girls, are able to make decisions about their bodies; including eliminating child marriage and gender-based violence, ensuring that people have access to SRHR information, education and access to quality integrated people-centered SRHR services (including contraceptives, and prevention and treatment of sexually transmitted infections (STIs), including HIV);

➢ Promoting gender equality by developing policies and strategies that also engage men and boys;

➢ Providing adequate financial and human resources to deliver quality people-centered, integrated SRHR services;

➢ Domestication of this strategy, in the context of their respective legal and policy environments.

B) Alignment of Member States policy and legal frameworks with global and regional commitments, and international human rights standards. Member States should consider:

➢ Engaging with beneficiaries, and traditional faith-based and community leaders on the legal and policy SRHR gaps, and involve them meaningfully in the resulting revisions, as well as their implementation, and monitoring and evaluation;

➢ Defining and scaling up a national minimum package of social, behavioural, structural and biomedical interventions for adolescents and youth to reduce early and unintended adolescent pregnancies, unsafe abortion, STIs and HIV;

➢ Advancing the SRHR of adolescents and youth through ensuring access to quality, people-centered SRHR services and build the capacity of health-care workers to deliver these services;

➢ Protecting adolescents from child marriage through limiting the age of consent to marriage to 18 years, irrespective of gender;

➢ Reducing the criminalization of adolescents engaging in consensual sexual relations through conducting national consultations that consider the harmful legal and service delivery implications of the age

of consent, and consider reducing the age of consent to 16 years, irrespective of gender, taking into consideration the rights of adolescents and youth to healthy consensual sexual relations based on their evolving capacity, and include close-in-age provisions (known as Romeo and Juliet Provisions);

➤ Defining and protecting the right of all people to protection from sexual and gender-based violence;

➤ Developing policies on the readmission and retention of pregnant girls in school so that they can reach their full potential;

➤ Promoting gender equality and develop policies, strategies and programmes that seek to engage men and boys as partners, and as persons with their own SRHR needs;

➤ Engaging on the need for safe abortion services as a human right for women, and explore ways in which the policy and legal environment can protect the health, lives, and rights of women and girls, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts.

C) Universal health coverage and strengthened health systems in Member States to incorporate the essential SRHR package. Member States should consider:

➤ Addressing the range of social, economic, cultural and systemic challenges so that all people have universal access to quality health-care services across their life cycle;

➤ Removing financial and other barriers to ensure equitable access to health-care services, including the full package of SRH interventions as defined by the ICPD;

➤ Removing barriers to education and creating economic opportunities, to break the cycle of inter-generational poverty and reap the benefits of the demographic dividend;

➤ Ensuring that services meet the specific SRHR needs of men and boys;

➤ Ensuring that adolescents and young people both in and out of school have access to good quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE), with linkages to SRH services that are youth friendly;

➤ Building the capacity of educators, peer educators, and so on, to deliver quality life skills-based CSE services;

➤ Investing in health-care systems to deliver people-centered, quality integrated SRHR services, including to: increase the number and build the capacity of health-care workers, in particular midwives; institute programmes that encourage youth to enter the health workforce; improve the health infrastructure; ensure that health facilities have the necessary equipment, commodities and supplies; strengthen health-care referral systems and establish linkages between health-care services and community structures.

D) Monitoring and evaluation for strengthened, evidence-based impact. Members States should consider:

- Prioritizing, fast tracking and reporting on progress through the annual scorecard, the M&E Plan and the evaluation of this strategy in 2021, 2025 and 2029;
- Establishing and/or strengthening national multisectoral monitoring, evaluation and reporting systems to track progress made, with data disaggregated by age, sex, population, socio-economic group and gender;
- Integrating various reporting tools, where possible, to reduce the burden of reporting on health-care workers;
- Investing in a national clearinghouse for all data to enable partners to come together, track progress, identify gaps and respond accordingly;
- Establishing a regional platform to strengthen data collection, analysis and reporting;
- Creating a regional knowledge-sharing network to (i) monitor trends, (ii) shape and accelerate responses to emerging issues, (iii) share good practices, and (iv) develop and inform a regionally responsive SRHR research agenda.

Implementation Modalities:	The strategy defines the roles and responsibilities of various stakeholders in the region to accelerate, advance and realize the the vision and outcomes of this SRHR Strategy for the SADC Region (2019 – 2030):

- SADC Member States, civil society, non-governmental organizations, adolescents and youth, and key populations are to be held mutually accountable for achieving this strategy;
- The SADC Secretariat and strategic partners are to support Member States in domesticating the SADC Regional Strategy on SRHR (2019–2030);
- The Secretariat and strategic partners are to monitor and support Member States to collect data and report on progress, using the Scorecard.

1. Introduction

Over the past decade, there has been significant progress by SADC Member States to improve sexual and reproductive health, notably reductions in maternal and child mortality, increases in the numbers of people living with HIV initiated onto treatment, fewer deaths from AIDS-related illness and life expectancy at birth steadily increasing across the region. In the SADC region, there were 42 per cent fewer deaths from AIDS-related illness in 2017 than in 2010 and 29 per cent fewer new HIV infections in 2017 compared to 2010, according to UNAIDS.[9] Despite this progress, the scale of the epidemic continues to be significant, maternal mortality ratios continue to be very high relative to Sustainable Development Goals (SDG) targets,[10] gender-based violence is a significant challenge and the need to accelerate the attainment of a healthy sexual and reproductive life of all SADC citizens[11] remains paramount.

The *Strategy for Sexual and Reproductive Health and Rights in the SADC Region* 2019–2030 will support the vision of the SADC Regional Indicative Strategic Development Plan (RISDP) 2015–2020 of a *shared future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom, social justice, peace and security for its peoples.*[12]

The SRHR Strategy supports this vision through providing a policy and programming framework to improve the sexual and reproductive health and rights (SRHR) of all people living in SADC and contribute towards Member States meeting the SDG and related commitments.

2. SRHR Context in SADC

Formed in 1992, SADC is a regional economic community comprising 16 states[13]. It is committed to regional integration within Southern Africa through economic development, peace and security.

The SADC *Sexual and Reproductive Health Strategy 2006–2015 and the related Business Plan 2011-2015* recognized the importance of addressing sexual and reproductive health needs and rights as a core element to realize this vision. Between 2011 and 2015, it focused its efforts on Member States delivering harmonized, comprehensive, sustainably resourced and evidence-informed SRH policies, programmes and services.

A number of global and regional policy and strategy directives informed the design and implementation of the SADC SRH Strategy 2006–2015: the Millennium Development Goals (MDGs), the Africa Health Strategy 2007–2015, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, the Maputo Plan of Action, the SADC Protocol on Health 1999, the SADC HIV and AIDS Strategic Framework 2010-2015 and the SADC Protocol on Gender and Development 2008.

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[9] UNAIDS, June 2018
[10] SADC Gender Protocol 2017 Barometer
[11] SADC Sexual and Reproductive Health Business Plan 2011-2015, Goal Statement
[12] SADC Regional Indicative Strategic Development Plan
[13] Angola, Botswana, Union of Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia and Zimbabwe

2.1   SRHR Context in the SADC Region

The total population of the SADC region was estimated to be 327.2 million in 2016. The population growth rate is 2.6 per cent[14].   There is huge inequality within countries in SADC sub-region. In twelve SADC countries, the average human development index (HDI) value is 0.57 and is 0.38 when adjusted for inequality.[15]

While no formal evaluation was conducted of the previous SRHR Strategy, the SADC region has shown considerable progress in meeting the SRHR challenges it confronts. Life expectancy at birth has improved over the last ten years, with variation across the region[16].

The total fertility rate per woman is varied, with a general downward trend in most countries, with Angola, Namibia, Seychelles and Zimbabwe being the exceptions.   The contraceptive prevalence rate (CPR) varies from a low of 13 per cent in Angola[17] to a high of 54.6 per cent in South Africa [18] and 66.5 per cent in Zimbabwe.[19] In the DRC, CPR increased from 6.8 per cent to 19 per cent[20]. According to UNAIDS, poor women, and women with low levels of education are least likely to access family planning[21]. Young women continue to face barriers to accessing SRHR services. Only three countries permit adolescent girls to access contraceptive services by the age of 12.

While sexually transmitted infections (STIs) are a significant public health challenge in the SADC region, comprehensive data regarding the prevalence of various STIs or STI syndromes are sparse.[22] According to WHO, syphilis in pregnancy leads to over 300,000 fetal and neonatal deaths globally each year; the human papillomavirus infection is responsible for an estimated $530,000$ cases of cervical cancer and $264,000$ cervical cancer deaths every year. STIs such as gonorrhea and chlamydia are important causes of infertility world-wide. [23] The presence of STIs such as syphilis, gonorrhea or herpes simplex virus greatly increases the risk of acquiring or transmitting HIV. [24]

Children and young people under the age of 24 constitute the majority of the population living in the region, with the exception of Mauritius and Seychelles. If the region is to reap the benefits of the demographic dividend, investments in sexual and reproductive health and rights, in particular of adolescents and young people, need to be prioritized to advance social and economic development.

A number of human development challenges undermine progress across the region in SRHR. These include high-levels of external debt as a percentage of GDP and low levels of domestic investments in the health expenditure. Malawi and Swaziland are the only

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[14] SADC Selected Economic and Social Indicators, 2016

[15] African Human Development Report, 2016

[16] https://www.sadc.int/about-sadc/overview/sadc-facts-figures/

[17] Multiple and Health Indicators Survey (IIMS) 2015 -2016

[18] South Africa Demographic and Health Survey 2016/2017

[19] Zimbabwe Demographic and Health Survey (2015)

[20] Input made by DRC during the Technical Consultation on SRHR, 4 -6 September 2018

[21] UNAIDS, Global AIDS Update, 2018.

[22] SADC *Framework for the Prevention and Control of Sexually Transmitted Infections in the SADC Region* 2010

[23] WHO, Global Health Sector Strategy on Sexually Transmitted Infections 2016 -2021

[24] Ibid,

countries in SADC that meet the Abuja Declaration target of 15 per cent as a percentage of general government expenditure spent on health.[25]

The region has made progress in addressing policy, legislation, and regional and national strategic and operational frameworks that promote gender equality.[26] Governments have introduced a range of gender equality laws and policies to address inequality and gender-based violence.[27] Commendable progress has been made in removing statutory discrimination against women,   opening the space to respond to gender inequality. Member States with constitutions that promote gender equality have increased from seven to thirteen, and Member States that promote gender equality have increased from nine to thirteen in the period 2009 - 2018.[28]

Despite these efforts, gender inequality remains pervasive. It is fueled by gender norms and belief systems that relegate women and girls to an inferior status and perpetuate constructions of gender that are destructive for all. Gender inequality underpins a range of negative SRHR outcomes, including high-levels of maternal and infant mortality, the disproportionate number of young women being infected with HIV, high-levels of early marriage, high-levels of adolescent pregnancies and unsafe abortion, low levels of contraceptive use and high-levels of gender-based violence.

2.2.   Maternal Mortality Continues to be Unacceptably High

Two thirds of SADC Member States have made progress in reducing the   maternal mortality ratio (MMR), but the region is unlikely to meet the SDG targets without significant investments in health delivery systems. This includes human resources such as midwives to ensure safe deliveries; emergency obstetric services; increasing uptake of contraceptives; addressing cultural attitudes towards pregnancy, labor, and delivery; and improvements in the quality of care to address malaria and anemia[29].

In some countries, the MMR is particularly high. For example, DRC has an MMR of 846 per 100,000 live births. Zimbabwe has an MMR of 651 per 100,000 live births, with a lifetime risk of maternal death estimated as 1 in 37 women dying from pregnancy or child bearing[30].

Reducing distances to health facilities is a key priority to improve coverage, accessibility and ensure that deliveries are managed by health care professionals in the event of complications. In Tanzania, Malawi and Zambia, women reported the distances to health facilities, lack of funds for advice or treatment, and not wanting to go to the facility on their own as a key challenges in delivering in health facilities.[31]

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[25] Africa Scorecard on Domestic Financing for Health

[26] The SADC Declaration on Gender and Development (1997) commits Heads of State to placing gender firmly on the agenda of the SADC Programme of Action and Community Building Initiative; to repealing and reforming all laws, amending constitutions and changing social practices that subject women to discrimination and enacting gender sensitive laws; to protecting the human rights of women and children, and to recognizing, protecting and promoting reproductive and sexual rights of women and the girl child.

[27] UNECA *Policy Harmonization in addressing gender-based violence in Southern Africa* 2013

[28] SADC Gender Protocol 2018 Barometer

[29] SADC Gender and Development Monitor 2016

[30] Zimbabwe Demographic and Health Survey 2015

[31] Zambia Demographic and Health Survey 2013/2014

Deaths related to unsafe abortion contribute significantly to maternal mortality in SADC. The highest number of deaths relating to abortion globally are in Africa,[32] where an estimated 3.9 million unsafe abortions take place annually among girls aged 15–19 years, leading to deaths and lasting health problems[33]. The proportion of all pregnancies ending in abortion in Southern Africa is 24 per cent. In Botswana, complications relating to post-abortion care were the third leading cause of maternal deaths.[34].

WHO (2018) has highlighted that adolescent pregnancy remains a major contributor to maternal and child mortality and to intergenerational cycles of ill health and poverty. Pregnancy and child birth complications are the leading cause of death among 15 to 19-year-old girls globally, with low and middle-income countries accounting for 99 per cent of global maternal deaths of young women in this age group.

2.3. Antenatal, Intrapartum and Postnatal Care

Across the region, a large percentage of pregnant women attend at least one antenatal service, but less than half of pregnant women attend all four visits. Many countries are not on track to reach the targets for neonatal mortality.

Neonatal mortality rate across countries in the region is varied and range from a high of 34 deaths per 1,000 live births to a low of 12 per 1,000 live births in South Africa and 8 per 1,000 live births in Mauritius.

A needs-based analysis of the available Sexual, Reproductive, Maternal, Neonatal, Adolescent Health (SRMNAH) workforce shows that Mauritius and South Africa, have enough health workers with the right skill mix to meet all the need for essential SRMNAH interventions. Lesotho reports an increase in the proportion of women aged 15-49 who received ANC from a skilled provider from 90 per cent in 2004 to 95 per cent in 2014. [35] Tanzania reports that while 98 per cent of pregnant women aged 15-49 received ANC from a skilled provider, only one in four had their first visit in the first trimester.[36]

According to WHO, approximately half of still births in 2009 were intrapartum deaths, which could be prevented by good quality obstetric care. Infections and complications of pregnancy are key contributory factors towards neonatal mortality. A deficit of skilled personnel, including a shortage of medical specialists skilled birth attendants, a shortage of medical supplies and equipment, and inefficient referral systems leading to delays in managing complications, contribute towards the levels of maternal and neonatal mortality in the region.

In Zimbabwe, 68 per cent of mothers received a postnatal check but only 57 per cent had it within two days of delivery (the safe motherhood standard), while 32 per cent did not have any postnatal check, with significant geographical variations.[37] In Tanzania, one third of women received a postnatal check within two days of delivery while 63 per cent did not receive a postnatal check within 41 days of delivery.[38] In Malawi, 42 per cent of

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[32] In 2014 at least 9per cent of maternal deaths in Africa were from unsafe abortion.
[33] WHO 2018
[34] Melese T, Habte D, Tsima BM, Mogobe KD, Nassali MN (2018) Management of post abortion complications in Botswana -The need for a standardized approach. PLoS ONE 13(2): e0192438. https://doi.org/10.1371/journal.pone.0192438
[35] Lesotho Demographic Health Survey, 2014
[36] Tanzania 2015 – 2016 Demographic Health Survey and Malaria Indicator Survey
[37] Zimbabwe Demographic and Health Survey 2015
[38] Tanzania 2015 – 2016 Demographic Health Survey and Malaria Indicator Survey

mothers had a postnatal check within the first two days after birth, but 50 per cent did not receive any postnatal check.[39]

2.4.   Levels of HIV and AIDS in the region continue to have a significant impact on all SRH outcomes

New HIV infections in the SADC Region declined from 950,000 [800,000–1.2 million] in 2010, to 680,000 [570,000–820,000] in 2017, a reduction of 29 per cent. South Africa, Mozambique and Tanzania are the countries with the highest number of new HIV infections (children and adults), comprising 68 per cent of all new infections in the region. Although the number of new infections in Madagascar is low, the 154 per cent increase in new infections since 2010 is a matter of concern, as is the 6 per cent increase in Botswana.

Adolescent girls and young women continue to bear the brunt of the epidemic. The incidence rate among adolescent girls and young women in South Africa is 1.51 per cent compared to 0.49 among adolescent boys and young men,[40] but it is young men who are most likely to die of AIDS -related illnesses. The number of new infections among AGYW is 170000 (98000- 130000), according to UNAIDS 2018 estimates. New infections among adolescent girls and deaths among young men are driven in particular by harmful gender norms, age-disparate relationships, low levels of knowledge of comprehensive HIV prevention, low levels of condom usage, and declining investments in primary prevention. HIV prevalence amongst MSM and sex workers far outweighs those among the general population, fuelled by social stigma, exclusion, lack of access to services and punitive laws and measures.

AIDS-related mortality in the SADC region declined by 42 per cent between 2010 and 2017, from 540,000 [43, 000– 70, 000] to 320,000 [250,000 – 410,000]. The main reason for the decline in AIDS-related mortality in the region is the expansion of antiretroviral therapy (ART) coverage of people living with HIV, with 64 per cent [58–72 per cent] of people living with HIV receiving ART, or about 10.4 million people. It is in treatment and the attainment of the 90-90-90[41] targets where the region has made its most gains. According to UNAIDS, at least four SADC Member States have already achieved the first 90.[42] Seven countries have achieved the second 90.[43] Two countries, Botswana and Lesotho, have achieved the third 90. Nine countries[44]have ensured that pregnant women living with HIV receive treatment to prevent mother to child transmission, although the DRC and Angola are lagging far behind. Angola is the only country with increasing AIDS-related mortality of 29 per cent, HIV transmission rate from mother to child at 26 per cent and ARV coverage for pregnant women at 34 per cent.[45]

Driven by the Global HIV Prevention Coalition, Member States are defining strategies to accelerate the reduction of new infections, including the setting of targets. Several have

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[39] Malawi Demographic and Health Survey 2015 -2016
[40] HSRC. (2018). The Fifth South African National HIV prevalence, incidence, behaviour and communication survey, 2017. Pretoria.
[41] 90per cent of all people living with HIV knowing their HIV status, 90per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. 90per cent of all people receiving antiretroviral therapy will have viral suppression.
[42] Eswatini, Malawi, Namibia and South Africa, source: UNAIDS Global AIDS Update 2018.
[43] Botswana, DRC, Eswatini, Lesotho, Mozambique, Namibia and Zimbabwe, Source: UNAIDS Global AIDS Update, 2018.
[44] Botswana, Eswatini, Lesotho, Malawi, Namibia, South Africa, Uganda, Zambia, Zimbabwe, Source: UNAIDS Global AIDS Update, 2018.
[45] UNAIDS Country Fact Sheets Angola, 2017

defined packages of interventions to address the vulnerability of adolescent girls and young women. However, these strategies will only be effective if they recognize the linkages between HIV and SRHR.

Despite these gains, the region is far from achieving the prevention targets of the United Nations Political Declaration on HIV (2016), and it is unlikely to meet these targets, unless there are initiatives to accelerate the progress made across the region.

2.5. Gender-based violence is a significant challenge despite policy and legislation

Gender-based violence (GBV) is a major challenge across SADC Member States, despite most countries having legislation in place to respond to it. The level of legal response is varied. Botswana, Eswatini, Lesotho, Malawi, South Africa, Tanzania, Zambia and Zimbabwe have developed Sexual Offences Legislation to address sexual violations and the sexual abuse of women and children, including defining sex with minors below the age of consent as sexual assault. [46] A study undertaken in six Member States[47] indicates that the prevalence of GBV ranges from 50 per cent to 86 per cent over the course of a woman's life time, and intimate partner violence from 49 per cent– 69 per cent in five of the six countries.[48]

The Zimbabwe Demographic and Health Survey (DHS) 2015 reports intimate partner violence at 35 per cent. The South Africa DHS 2016 reports that one in five women had ever experienced physical violence by a partner, with younger women and women who are divorced or separated more likely than other groups to experience physical violence. The Malawi DHS 2015/2016 shows an increase from 28 per cent in 2010 to 34 per cent of women in Malawi who have experienced physical violence since the age of 5 years.

Domestic violence is the most prevalent form of GBV. It mainly takes place in the home and arises from deeply held patriarchal belief systems and norms which perpetuate the idea of women having an inferior social status, driven by toxic constructions of masculinity that engender notions of superiority and sanction violence within relationships and families. It is recognized that gender-based violence has an economic cost to countries. A study conducted in Mauritius in 2017, with support from UNFPA, revealed that the economic cost of intimate partner violence represented 0.6 per cent of the country's GDP, or 5.7 million US$[49].

The normative character of gender-based violence in the region feeds into the low levels of reporting and a lack of adherence to legislation.[50] It also highlights the importance of a multisectoral response in which governments, civil society and communities work collaboratively to eradicate harmful belief systems, practices and all forms of GBV.

Reported cases are not an accurate reflection of the extent of the problem. Reported cases of GBV across thirteen of the SADC states reflect uneven levels of GBV reporting and

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[46] SADC Gender and Development Monitor, 2016

[47] Botswana, Lesotho, Mauritius, South Africa, Zambia, Zimbabwe.

[48] SADC Gender Protocol Barometer, 2016

[49] R.Sultan. (2017). A quantitative Assessment of Intimate Partner Violence and Associated Economic Costs in Mauritius. Accessed from: http://gender.govmu.org/English/Documents/2018/domestic %20violence_final_draft_RS_July_2017%20(7).pdf

[50] SADC Gender and Development Monitor 2016

serious shortcomings in data availability.[51] Mauritius has set up a Domestic Violence Information System to address problematic data collection and to ensure the tracking and follow-up of reported cases.

Post-conflict situations in Angola, DRC and Mozambique, where rape and sexual violence, specifically of girls and women, took place during the conflict, present particular challenges of providing rehabilitation and psychosocial support to survivors, suffering from disrupted livelihoods and severe psychological trauma.[52] Prolonged droughts and food insecurity of recent times have shown that GBV tends to be aggravated in all its types - domestic, sexual, psychological violence, sexual exploitation and abuse - compounded with reduced access to essential and emergency maternal and new-born health-care services.

2.6.   The policy and social environment has a particularly negative impact on AYSRHR

Young people and adolescents in the region face many SRHR challenges. Seven countries in SADC have set the age of consent to sexual activity at 16, four at 18, four at 14, with Tanzania at 12 and Comoros at 13[53]. In Angola there is a two-year gap between the age of consent for females and males, and a four-year gap in DRC, with the age of girls being set as lower than that for boys. This perpetuates gender inequality and reinforces unhealthy gender norms that disempower girls.

Some SADC countries, such as Namibia,[54] have set the legal age of consent to marriage at 18 years for both females and males, but other countries have gender differences in the age of consent to marriage, such as Seychelles, Tanzania, Angola and DRC, which have set it out as 15 years for females and 18 for males. On the other hand, in Mauritius, the legal age of consent to marriage is 18 but an adolescent can marry at the age of 16 with the consent of the parents, and subject to the validation of a Court of Law.

Even where the age of consent to marriage is 18, many girls are married before the age of 18. In the DRC, it is 12 per cent for girls younger than 15 and 39 per cent for those aged 15–18 years. In Malawi one in every two girls are married before the age of 18 years, and in Madagascar, four in ten women aged 20-24 year were married before the age of 18 years[55].

The adolescent fertility rate in the region ranges from 2 per cent in Mauritius to 7 per cent in Comoros and South Africa to over 16 per cent in Angola and Mozambique, with levels over 12 per cent in DRC, Madagascar, Malawi, Tanzania and Zambia. Teenage child bearing in Tanzania shows significant regional variations, ranging from 5 per cent in Mjini Magharibi to 45 per cent in Katavi[56].

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[51] SADC Gender and Development Monitor 2016

[52] Ibid.

[53] She Decides Scorecard in partnership with NDOH South Africa and UNFPA ESARO, 2017

[54] Married Persons Equality Act sets a clear minimum age of 16 years and procedures for civil marriages involving children

[55] ENSOMD 2012 -2013

[56] Tanzania 2015-2016 Demographic and Health Survey and Malaria Indicator Survey

According to the SADC Gender and Development Monitor 2016, the increasing rate of teenage pregnancy and the imperative to examine the causes is a growing concern for the region. Early pregnancy related to a range of social, cultural and economic factors that render adolescent girls particularly vulnerable to early sexual debut and forced early marriages. Early childbearing contributes to the high-levels of maternal mortality in Member States. According to the IIMS 2015-2016, the percentage of women in Angola aged 15-19 who become pregnant for the first time is 4.7[57]. The teenage pregnancy rate in Madagascar is greater than 40 per cent.

The adoption of the ESA Commitment by Ministers of Health, Education and Youth in December 2013 has galvanized action around Comprehensive Sexuality Education (CSE): (i) 12 out of 15 SADC countries report that CSE/ Life Skills is being provided in at least 40 per cent of primary and secondary schools; (ii) in all countries, CSE training programmes for teachers are in place; (iii) 13 countries have institutionalized youth-friendly SRH service training programmes for health and social workers, (iv) 10 countries offer the standard minimum package of AYFSRH services[58]. Another positive outcome is the increased uptake of antenatal clinic services by teenage mothers in some health facilities. The roll-out of CSE, with a strong emphasis on integrating rights into the curriculum while linking with AYSRHR services, is a critical element of an accelerated response to SRHR in SADC.

2.7. Poor resourcing and health system capacity challenges are a significant barrier to the realization of SRHR in SADC

Inadequate resourcing and related broader health system challenges present a barrier to the realization of SRHR in the region. Current health expenditure (percentage as a proportion of GDP) in the SADC region is uneven. A number of countries reflect a decrease, such as Angola and the Seychelles, while others, such as Mozambique, Namibia, Lesotho, and South Africa, have increased their expenditure[59]. Generally. economic development is constrained by relatively low growth, high unemployment, and huge social demands. With lower public revenue from taxes, health budgets have been placed under pressure by other competing demands on the fisci.

Poor and unfriendly infrastructure limits access to quality SRH services and the region grapples with ways to respond to these issues. For example, SADC has developed tools to support Member States with the process of integration of health services in their countries. Through the development of the SADC Minimum Standards for Integration of HIV and Sexual and Reproductive Health in the Region 2015 and the SADC HIV, SRH, TB and Malaria Programmes Integration Business Plan 2016, strategic guidance has been provided to support the process of strengthening integration and cost-effectiveness. Strategies such as task shifting to expand access and address bottlenecks, while working

[57] Instituto Nacional de Estatística (INE), Ministério da Saúde (MINSA), Ministério da Planeamento e do Desenvolvimento Territorial (MPDT) and ICF, 2017. *Key Findings of the 2015-16 Angola IIMS.* Luanda, Angola. Rockville, Maryland, U.S.A.: INE, MINSA, MPDT and ICF.
[58] UNESCO Fulfilling our Promise to Young People Today 2013 – 2015 Progress Review – *The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people* 2016
[59] AU Scorecard on Domestic Financing for Health based on 2014 data. Accessed from: https://au.int/sites/default/files/newsevents/workingdocuments/34086-wd-au_scorecard_-_final_english.pdf

with communities to harness their capacity to provide important SRHR information and support, offer some short-term solutions to the wider health system challenges.

DRAFT 1

3. The SADC SRHR Strategy 2019-2030

The SADC SRHR Strategy 2019-2030 builds upon the progress made by Member States in achieving the MDG targets, while addressing gaps and critical challenges that continue to shape poor sexual and reproductive health outcomes and act as a brake on sustainable human development in the region.

The Strategy seeks to align the regional efforts to improve the sexual and reproductive health of all people to global, continental and regional developments and to promote an integrated and comprehensive response. These include the Sustainable Development Goals (2015) and its related targets, the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, the targets of the Political Declaration on HIV/AIDS in 2016, the International Covenant on Economic, Social and Cultural Rights, Agenda 2063, the Revised Maputo Plan of Action 2016–2030, the Global Strategy for Women, Children's and Adolescent Health 2016-2030, resolution AFR RC66-9, the ESA Commitment, the Minimum Standards for Integration of HIV and Sexual and Reproductive Health in the SADC Region, the SADC HIV Prevention Scorecard and the SADC Regional Gender Based Violence Strategy and Framework for Action 2019–2030.[60]

This Strategy for SRHR in SADC (2019–2030) aims to support Member States to strengthen their SRHR programming towards the achievement of regional SRHR outcomes and to create a common framework for development partners and civil society partners to align their interventions.

This Strategy is evidence informed, based on the priorities identified by the Member States, and aligned to global, continental and regional commitments. It is supported by the political commitment and leadership by Ministers of Health, Education, Gender and Youth to advance a multisectoral response that promotes and accelerates the SRHR of all people in the SADC region. A regional score card has been developed alongside the Strategy as a high-level strategic tool to track progress at a political level across the SADC region in the implementation of the Strategy.

Process of Developing Strategy and Score Card

The process to develop this strategy and corresponding scorecard is as follows:

(1) A technical committee oversaw the development of the Strategy for SRHR in the SADC Region 2019–2030 and the scorecard, led by the "Troika" comprising of the Ministries of Health for Eswatini (outgoing SADC Chair), Namibia (incoming SADC Chair) and South Africa (SADC Chair), the SADC Secretariat, representatives from UNAIDS, UNFPA, UNICEF and WHO, UNESCO, SheDecides, and representatives from youth-led organizations and civil society. Additional technical support for the development of the scorecard was provided through the East African Community Secretariat and the Health Information Systems Programme, University of Oslo, Norway. The Technical Committee provided strategic direction

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[60] See Appendix One

and inputs to the appointed consultant to revise the SADC SRH Strategy 2006–2015 and to develop a SRHR scorecard aligned to global, continental and regional commitments.

(2) The Strategy was informed by a desk review of available global, continental and regional commitments, strategies and guidelines, and national reports to identify the progress made in achieving the strategic objectives and priorities of the SADC SRH Strategy 2006-2015, and to identify the key issues to be addressed in this Strategy. The corresponding scorecard is informed by global, regional and continental commitments, and builds from a prototype prepared with SheDecides in 2017. It is intended as a tool for peer review and accountability to fast track SRHR in the region.

(3) A Technical Consultation on the Strategy for SRHR in the SADC Region (2019–2030) and Scorecard was convened from 4–6 September 2018. It comprised officials responsible for SRHR drawn from Ministries of Health, Education, Gender and Youth and relevant M&E Officers from the Ministers of Health, representatives from SheDecides, regional civil society and youth-led organizations . The inputs from the Technical Consultation were reviewed and incorporated by the Technical Committee at a meeting held in Johannesburg from 26–27 September 2018. The final draft of this strategy and its corresponding scorecard was sent to the participants to the Technical Consultation to convene national consultations to engage on the final draft.

(4) The Strategy and Scorecard was presented to the SADC meeting of the National AIDS Council Directors held in Windhoek, Namibia on 3 October 2018, and presented to the SADC Senior Officials for validation.

Purpose

This Strategy provides a policy and programming framework for Member States to accelerate the attainment of sexual and reproductive health and rights for all people living in SADC.

Scope and Coverage of the SADC SRHR Strategy

The Strategy for SRHR in the SADC Region (2019–2030) builds upon ICPD framework, the SDGs, the 2016 Political Declaration on HIV/AIDS , the Maputo Plan of Action 2016–2030, the SADC SRHR Strategy 2005–2016, amongst others, and is informed by the most current thinking on SRHR as defined by the Lancet-Guttmacher Commission on Accelerating Progress: SRHR for All, and the Manifesto of the global SheDecides movement. This strategy:

➤ Emphasizes a multisectoral approach to SRHR and its importance for the sustainable development, gender equality and the SRHR well-being of all people in the SADC region.[61].

➤ Emphasizes the need for strong political commitment and adequate human and financial resources, so that all people, in particular adolescent girls and young people, women, men and boys, key populations, migrants, refugees, mobile

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[61] The Lancet Commission *Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher- Lancet Commission* May 2018

populations and people with disabilities can exercise their SRH rights to make decisions that govern their bodies, free of stigma, discrimination, violence and coercion, based on their specific life cycle needs.

➢ Provides guidance on what is required to accelerate the SRHR agenda[62], within the context of the relevant legal and policy frameworks of the Member States.

➢ Calls upon Member States to provide SRHR information and services that are accessible and affordable to all individuals who need them regardless of their age, marital status, socioeconomic status, race or ethnicity, sexual orientation or gender identity;

➢ Adopts the life cycle approach to SRHR;

➢ Acknowledges the critical role of education and social protection as important enabling and protective factors that impact positively on key SRHR indicators;

➢ Recognizes the following key elements of SRHR: maternal health and new-born care; comprehensive safe abortion care (including post abortion care); family planning; prevention and management of sexually transmitted infections including HIV; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing mid-life concerns of all; health and development; the reduction and prevention of gender-based violence, including intimate partner violence, sexual violence and sexual exploitation; community mobilization, interpersonal communication, counselling and comprehensive sexuality education.

4. Strategic Approach

Vision

The vision of this strategy is to ensure that *all people in SADC enjoy a healthy sexual and reproductive life, have sustainable access , coverage and quality SRHR services, information and education and are able to fully realize and exercise their SRH rights, as integral to sustainable human development in SADC.*

Beneficiaries

This strategy is intended to meet the SRHR needs of all people in the SADC region including: Adolescent girls and Young Women, Women of a reproductive age, Men and Boys, Key populations including sex workers, people who inject and use drugs, prisoners, MSM and LGBTQI, Migrants, Refugees, Mobile Populations, People living with Disabilities and victims of sexual exploitation.

Principles

The principles underpinning this SRHR Strategy to guide Member States are:

- *Member State ownership, leadership* and resourcing through domestication and alignment with national frameworks.
- *Complementing and augmenting existing strategies*, instruments and national initiatives on SRHR for sustainable human development in the region.

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[62] Ibid.

- **Strong partnerships** that are critical for the implementation, monitoring and evaluation of this Strategy, including the a***ctive and meaningful participation of civil society, youth,*** communities, those most affected by specific SRHR issues and bilateral and multilateral development partners.
- **A multisectoral approach** to optimally harness the roles, responsibilities, resources and commitment across ministries, civil society, youth structures, development agencies, the private sector and academic institutions.
- *Fostering* **mutual accountability** *for the realization of the strategy outcomes* by Member States, civil society, youth structures, development partners and all relevant stakeholders.
- A ***gender-responsive, visionary, and transformative approach*** that takes account of gender-driven differences that cause negative SRH outcomes, protects and ***promotes bodily integrity and autonomy of all,*** and prioritizes service delivery so that no one is left behind.
- **A youth-facing and youth-friendly** approach so that the region will capitalize on the demographic dividend and involve those most affected in matters that affect their own health and well-being and accelerate its economic and social development.
- Universal health coverage – ***leaving no one behind*** –and ensuring equity in access to integrated health services, including in humanitarian settings, without the risk of financial hardship.
- **A human rights approach** to the provision of SRH services, including the right of all persons to the highest attainable standard of health.
- An inclusive life cycle approach that promotes the provision of integrated ***high quality, person-centred, comprehensive services that reaches those hardest to reach***
- ***Progressive realization of SRHR*** through the prioritization of reforms and strategic partnerships to address wider systemic challenges and facilitate evidence-based, tailor-made interventions that responds to gaps in the region.

SRHR Outcomes for the Region by 2030

To achieve this vision, SADC Member States will fast track the following outcomes:
1. Maternal mortality reduced to less than 70 deaths per 100,000 live births. (SDG 3.1.)
2. Newborn mortality reduced to 12 per 1,000 births in every country. (SDG 3.2.)
3. HIV and AIDS as a public health threat is ended by 2030. (SDG 3.3.)
4. Sexual and gender-based violence and other harmful practices, especially against women and girls, are eliminated. (SDG 5.1; SDG 5.2.; SDG5.3)
5. Rates of unplanned pregnancies and unsafe abortion are reduced.
6. Rates of teenage pregnancies are reduced.
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, is ensured. (SDG 3.7; SDG 5.6)
8. Health systems, including community health systems, are strengthened to respond adequately to SRH needs. (SDG 5.6)

9. An enabling environment is created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being. (SDG 4.7; SDG 5.6)

10. Barriers, including policy, cultural, social and economic, that serve as an impediment to the realization of SRHR in the region, are removed. (SDG 5.1; SDG 5 c)

5. Framework to Fast Track the SRHR Outcomes

The Framework below defines the core strategies that will fast track the attainment of the strategic outcomes, and the high-level outputs that Member States would need to implement to achieve the ten strategic SRHR outcomes by 2030.

A. Innovative leadership that boldly accelerates the SRHR regional agenda

A.1. A multisectoral response, including active strategic partnerships with civil society, youth and communities has driven the roll-out of the Strategy.

Achieving the vision of this Strategy requires *a multisectoral response*. This recognizes the critical role that Ministries of Health, Finance/Economic Development, Education, Youth, Gender, Social Development and Justice have to play if all people are to attain their SRHR. The realization of these rights will only be achieved through strategic partnerships between governments, private sector, civil society, academia, youth and communities working together to re-shape and accelerate the response.

A.2 Social and political momentum is harnessed around the agency of all, particularly women and girls, to make decisions about their bodies through removing social, cultural and economic barriers.

Member States should affirm the rights and agency of all people to make decisions about their bodies, health and lives. Member States should deliberate on legislation, policies and strategies to be developed, implemented, monitored and evaluated so that all people can exercise these rights, and eliminate harmful practices, such as early child marriage, female genital mutilation, and gender-based violence. Leaders should also ensure that all people have access to information, education and quality integrated people-centered services based on human rights principles, enabling universal access to services to reduce maternal deaths, universal access to contraceptives, and prevention and treatment of new STIs, including new HIV infection.

Policies, strategies and programmes should be developed that work with men and boys as partners, SRHR clients, and as agents of change to challenge and change unhealthy dominant norms of masculinity and patriarchy, and turn the tide on maternal mortality, HIV incidence, GBV and other poor SRH health outcomes across SADC. Addressing gender inequality as a fundamental driver of poor SRHR outcomes is central to boldly accelerating the regional SRHR agenda.

A.3. Commitments to SRHR are reflected in national budgets.
Governments and all partners should ensure that adequate financial resources are provided and investments made so that adequate human resources with the required

skills are available, and all people can access information, education and quality SRHR services.

A.4. Regional and global commitments are domesticated.
SADC Member States should accelerate the domestication of this Strategy through reviewing their national SRHR strategies and programmes. They should ensure that all efforts are made to periodically review and report on progress made in relation to the indicators agreed upon in corresponding and related scorecards, such as the SADC Scorecard on HIV prevention and the AU Scorecard on Domestic Funding for Health.

Member States should ensure the domestication of related SADC documents that will assist in fast tracking the implementation of this Strategy, including the Minimum Standards for the Integration of SRHR and HIV; the SADC Key Population Strategy; SADC Protocol on Gender and Development (in particular Articles, 20, 21, 23, 24, 25, 26 and 27), and the SADC Regional Gender Based Violence Strategy and Framework for Action 2019–2030.

B. Alignment of Member States policy and legal frameworks with global and regional commitments and international human rights standards

B1. National laws and policies that protect and promote the SRHR of adolescents and young people, particularly adolescent girls and young women, are adopted, harmonized and implemented.

Fast tracking progress in the region requires a commitment to address the legal and policy gaps that obstruct the realization of SRHR for all people. Member States should consider the meaningful involvement of those that laws, policies, and strategies are intended to serve, in their design, implementation, monitoring and evaluation. All stakeholders should work collaboratively to define a national minimum package of social, behavioral, structural and biomedical interventions that will reduce early and unintended adolescent pregnancies, unsafe abortion, STIs and HIV among adolescents and youth, and to scale up this package of interventions.

Member States are encouraged to advance the SRHR of adolescents through:
(i) ensuring that all adolescents are able to access people-centered integrated SRHR services, including HIV services (testing, counseling, accessing treatment), information, contraceptives, safe abortion, build the capacity of health-care providers to provide services with respect to privacy and confidentiality;
(ii) protect adolescents, and particularly adolescent girls, from child and forced marriages, sexual exploitation and limit the age of consent to marriage to 18 years, irrespective of sex[63];
iii) conduct national consultations to review the legal implications of the age of consent for sexual activity, and consider reducing the age of consent to sexual activity to 16 years of age, irrespective of gender, taking into consideration the rights of adolescents and youth to healthy consensual sexual relations based on their evolving capacity. This may

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[63] See Article 20 of the SADC Revised Protocol on Gender and Development (2019 – 2030): Member States to enact and enforce legislation prohibiting all forms of gender based violence; (b) develop strategies to prevent and eliminate all harmful social and cultural practices, such as child marriage, forced marriage, teenage pregnancies, slavery and female genital mutilation; ensure that perpetrators of gender based violence, including domestic violence, rape, femicide, sexual harassment, female genital mutilation and all other forms of gender based violence are tried by a court of competent jurisdiction.

include close age provisions (known as Romeo and Juliet Provisions) to reduce criminalization of adolescents engaging in consensual sex and access to SRHR services for all adolescents;

iv) Member States are encouraged to amplify their efforts with respect to the SADC Model Law on Child Marriage and related interventions to shift community norms and attitudes that entrench this and any other cultural practices that undermine the SRHR of girls, based on their specific context;

v) Member States are encouraged to define and protect the right of all people to safety from sexual and gender-based violence, and to strengthen national systems for social security and protection that facilitate individuals making decisions that ensures their safety;

vi) Member States should consider policies on readmission and retention of pregnant girls in schools so that they can reach their full potential.

B.2. National laws and policies that provide an enabling context for the realization of SRHR for all are adopted and optimally implemented

Laws and policies should enable the realization of SRHR, promote gender equity and equality and contribute towards protecting the dignity, health and lives of all living in SADC, particularly women and girls. At the same time, deliberate efforts must be made to facilitate policy development on the SRHR needs and priorities for men and boys in the region. Member States should facilitate changes in laws and policy to protect the SRHR of all people, taking into consideration their national context. Where laws and policies are in place to advance the SRHR of all people, but are not being optimally implemented, Member States should identify barriers to the optimal implementation of these laws and policies, which should include ensuring that duty bearers have the relevant skills and knowledge. Member States should meaningfully engage beneficiaries, traditional, faith-based and community leaders when considering changes to laws and policies to create an enabling social, cultural and legal environment for SRHR. The role of law enforcement and measures to facilitate access to justice, for example, in cases of SGBV, are key.

In 2010-2014, the estimated incidence of abortion in Africa and Southern Africa was 35 per 1,000 women of reproductive age. Three-quarters of the estimated 6.9 million annual abortions in Africa were classified as unsafe and nearly half (48 per cent) were classified in the category 'least safe', which was associated with the highest levels of global case fatality.[1,2] In 2008, the latest year with estimates, Africa had the highest rate (22 per cent) of unsafe abortions among adolescents (15-19 years of age) in the world.[3] In Botswana 23% of maternal deaths were attributed to unsafe abortions.

Unsafe abortions are often the result of the policy and legal barriers that women and girls in the region face when they require safe abortion services, which is a significant contributory factor towards the high-levels of maternal mortality in the region. Engaging with the need for safe abortion services as a human right for women and exploring ways in which the policy and legal environment can protect the health, lives, and rights of women and girls is an important area, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts.

A policy approach that will facilitate a multisectoral approach, defining the roles and responsibilities of respective ministries and stakeholders within Member States and within the region, will provide important guidance for the roll-out of this Strategy.

C. Universal health coverage and strengthened health systems in Member States incorporate the essential SRHR package

Universal health coverage (UHC) is defined as ensuring that all people have equitable access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[64] UHC is key to meet the SRHR outcomes of this Strategy.

C 1. Improved realization of quality, comprehensive, integrated SRH, GBV and HIV/AIDS package that meets the needs of all women, men, adolescents, youth and key populations in SADC.

Member States should take concrete actions to address the range of social, economic, cultural and systemic challenges that prevent all women, men, adolescents, key populations, migrants, refugees, mobile populations and people with disabilities from attaining their SRHR across their life cycle.

This includes removing any financial and other barriers to ensure universal access to the full package of sexual and reproductive health interventions as defined by the ICPD: (i) comprehensive sexuality education; (ii) counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; (iii) antenatal, childbirth and postnatal care, including emergency obstetric care and newborn care; (iv) safe abortion services and treatment of complications of unsafe abortion; (v) prevention and treatment of HIV (including the use of PrEP for key populations and those most at risk) and other sexually transmitted infections; (vi) prevention, detection, immediate services and referrals for cases of sexual and gender based violence, including the provision of post exposure prophylaxis (PEP) and emergency contraceptives; (vii) prevention, detection and management of reproductive cancers, especially cervical cancer; (vii) information, counselling and services for sub fertility and infertility and (viii) information, counselling and services for sexual health and mental well-being, and (ix) Involving women, men, adolescents, young people, key populations, and people with disabilities in humanitarian situations to ensure universal access to services that meet their SRHR needs.

Given the levels of economic inequality in the region,[65]accelerating the response to SRHR needs to focus on making SRHR services accessible to all and removing any financial and other barriers that prevent access. Cognizant of the economic context and health system challenges of the region, Member States should find ways to address systemic challenges through the integration of services, using appropriate models that respond to their unique situation, and building strategic partnerships to address systemic issues.

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[64] WHO, 2018
[65] The World Bank Report (2018) reports that six of the top ten countries with the highest Gini coefficient are in SADC viz. South Africa, Namibia, Botswana, Zambia, Lesotho and Eswatini

Member States should ensure that SRHR interventions: (i) meet the age-specific needs of all people, in particular adolescent and young people, (ii) remove the barriers to education and create economic opportunities to break the cycle of inter-generational poverty and reap the benefits of the demographic dividend;[66] (iii) meet the specific SRHR needs of men and boys, including the need for contraception, prevention and treatment of HIV and other STIS, sexual dysfunction, infertility and male cancers, and break unhealthy gendered patterns that impact on male health-seeking behaviours and facilitate a better understanding of the role that needs to be played by men and boys as partners.

C.2. Accelerated and improved delivery of quality comprehensive sexuality education for in and out of school youth by the education and youth sectors.

Member States should ensure that young people and adolescents are prepared, supported and provided with education and all the information and skills to make safe and healthy decisions about their life and future. This includes ensuring that adolescents and young people in-school and out-of-school have access to quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE) with linkages to youth-friendly sexual and reproductive health (SRH) services and the youth sector more broadly. This will contribute towards addressing the disturbingly low levels of knowledge of HIV infection among adolescents and young people; reducing early and unintended pregnancies; eliminating GBV and child marriage and raising awareness and responding to the sexual exploitation of children and adolescents.

Strengthening the capacity of educators at all levels specifically to provide age, gender and culturally appropriate rights-based CSE that includes core elements of knowledge, skills and values as preparation for adulthood and, wherever possible, making in school CSE programmes intra-curricula and examinable is key. Building and strengthening the skills of those working in wider youth and community interventions will expand the capacity within Member States to reach out-of-school youth. Creative approaches should be explored to build the capacity of different forms of media, including radio, to reach out-of-school youth.

C.3. Strengthened health systems to deliver quality, integrated SRHR services within a conducive environment.

Member States should ensure that a conducive environment is created to enable the delivery of quality people-centred integrated SRHR services. This includes i) investing in the capacity of health-care providers to deliver quality integrated people-centred health care services, ii) ensure the provision of good quality care, including the Minimum Initial Service Package (MISP) for SRHR in humanitarian situations; iii) institute programmes that encourage young people to enter the health work force, and increase the numbers of health-care providers, in particular skilled birth attendants; iv) ensure that all health facilities have the required commodities, supplies and equipment to deliver the full package of SRHR services, v) invest in expanding the health infrastructure, addressing infrastructural weaknesses in facilities that impede on the dignity and confidentiality of persons, and strengthening community engagement, outreach and service delivery vi)

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[66] UNFPA Strategy on Adolescents and Youth

ensure that the delivery of health care services are embedded in human rights, are accessible to all including those with disabilities, and are gender-responsive[67].

Strengthening public-private partnerships is an important enabler to respond to the range of health capacity challenges that the region faces, including skills, infrastructure and related resourcing constraints. Effective referral mechanisms across the health system is a key element to facilitate a conducive environment for accessing the necessary health-care services. All six building blocks of health system strengthening (service delivery, health work force, health information systems, access to essential medicines, financing and leadership) provide the foundation for improving SRH outcomes at a regional, national and facility level.

The realization of SRHR requires a multisectoral response, not only at national level, but also at the level of service delivery, where linkages should be established between the delivery of health-care services, schools, tertiary institutions and youth movements with law enforcement agencies, in particular in relation to GBV, with civil society, and with active faith-based, traditional and community-based organizations. Cascading the multisectoral response at both national, subnational and community level will make a bigger impact in the medium to long term, and optimally position Member States to meet the targets of this Strategy.

D. Monitoring and Evaluation for strengthened Impact and evidence-based policy, programming and service delivery.

The implementation of this SADC SRHR Strategy will be monitored and evaluated using the SADC SRHR Scorecard, the M&E Plan and periodic evaluations. Ministries of Health will assign a focal person responsible for monitoring and evaluation that will work with other Ministries, civil society, youth-led organizations, people living with HIV and networks of key populations, supported by United Nations agencies, to collect, analyse and report on progress being made at the national level to the SADC Secretariat.

D1. Targets identified in the SADC SRHR Strategy 2019-2030 are prioritized and fast tracked by Member States

The SADC SRHR scorecard is a high-level peer review accountability tool to track progress towards the attainment of the targets of this Strategy. The scorecard will be presented to the SADC Ministers of Health Meeting, on an annual basis, to accelerate the attainment of the global, continental and regional commitments.

The M&E Plan includes a range of indicators to monitor progress with the implementation of this Strategy, drawing upon results-based management principles. Baseline data will be collected in 2019 and progress will be measured through the evaluations of this Strategy.[68]

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[67] Global Strategy, 2016 - 2030

[68] Adapted from Guiding Principles Section 3.3. 12 *SADC Policy for Strategy Development, Planning and Monitoring and Evaluation,* 2012

D2: Strengthened evidence-based integrated multisectoral national monitoring and evaluation systems

Member States are encouraged to prioritize the establishment and strengthening of integrated multisectoral national monitoring, evaluation and reporting systems to gather the evidence to strengthen policy, programming, resourcing and service delivery.

Member States should strengthen data collection, making sure that all national data is disaggregated by age, sex, population, and socioeconomic group and include a gender analysis.

Member States should reduce the reporting burden on health-care workers through exploring ways to integrate various reporting tools that enable health-care workers to demonstrate the extent to which clients are receiving integrated people-centred services that respond to their individual SRHR needs.

Member States should invest in a national clearing house for all data that enables partners to come together and track progress, identify gaps and respond accordingly. The National Situation Rooms that are being piloted in six countries could play a key role within this process.

Member States are encouraged to evaluate the implementation of national SRHR strategies and programmes and to document lessons learnt that can be amplified across the region. SADC and its development partners will evaluate this strategy in 2021, 2025, and 2029, aligned with the RISDP evaluation, regional and global SRHR processes.

D3: National and regional responses strengthened through the sharing of experiences, best practices and information.

The SADC Secretariat, in partnership with bilateral and multilateral development partners, academic institutions, regional civil society, youth-led organizations and networks of people living with HIV and key populations, should establish a regional platform to strengthen data collection, analysis and reporting across Member States. A regional knowledge-sharing network should be created to monitor trends (i) shape and accelerate the response to emerging issues in the region including through south-south cooperation; (ii) share good practices; (iii) develop and inform a regionally responsive SRHR research agenda.

6. Implementation modalities to accelerate, advance and realize SRHR commitments

6.1 SADC Member States, civil society, non-governmental organizations, adolescents, youth and key populations are mutually accountable to achieve this Strategy.

This Strategy recognizes that to achieve its vision requires a multisectoral response and mutual accountability by all stakeholders. Effective implementation of the Regional Strategy will require the participation and ownership of a wide range of stakeholders, including Member States, civil society organizations, communities, research institutions, development partners and the SADC Secretariat.

Member States

a) Establish a multisectoral coordinating entity that includes civil society, networks of youth, adolescents and key populations, and development partners, to domesticate, implement, monitor and evaluate their national SRHR Strategy.

b) Champion the SRHR outcomes and strategies through bold and innovative leadership that takes up the respective country-specific challenges.

c) Ensure that the ICPD-defined SRHR package as outlined in the document is provided.[69]

d) Ensure that the legal and political environment is conducive to the realization of SRHR for all sections of the population.

e) Increase national budgets and resourcing for the realization of SRHR, across relevant Ministries while optimizing the use of existing resources and mobilizing additional resources, as required.

f) Support the design and implementation of capacity development interventions across relevant sectors, and specifically within the health, education and youth sectors.

g) Build and bolster multisectoral strategic partnerships and networks, and proactively engage civil society, including young people, networks of key populations and communities in the design, implementation, monitoring and evaluation of national SRHR Strategies.

h) Actively promote SRHR as key for the realization of SDG targets, the protection of all those living in SADC and the realization of gender equality. Meeting the needs of persons affected by disasters, migrants and human trafficked persons is key to ensuring good SRHR for all persons in the region.

i) Generate and share strategic information representing the views of their stakeholders to inform the development of policies, laws, and strategies for policy and programme formulation, implementation, monitoring and evaluation.

j) Submit on an annual basis completed versions of the scorecard to the SADC Ministers of Health Meeting.

k) Participate in evaluations of the SADC SRHR Strategy, as agreed to, in 2021, 2025 and 2029.

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[69] This is outlined under Pillar C

Civil society/non-governmental organizations

a) Engage within Member States and across Member States towards integrating the strategies and high-level outputs into their programming and advocacy interventions.
b) Advocate and promote the adaptation, domestication, implementation and resourcing of the regional strategy.
c) Develop targeted messages to address social and cultural barriers to the realization of SRHR, particularly as it relates to the sexual and reproductive autonomy of women and girls and gender equality more broadly.
d) Support capacity development processes, across respective sectors.
e) Ensure that communities and those most affected by the issues, are integrally involved in the design and roll-out of programmes.
(f) Ensure civil society organizations can deliver services, integrated and linked with the national SRHR plan
g) Advocate for the necessary resource mobilization to address key systemic barriers to the realization of SRHR.
i) Generate and share strategic information representing the views of their stakeholders to inform the development of policies, laws, and strategies for policy and programme formulation, implementation, monitoring and evaluation.

Adolescents, youth and key populations

a) Adolescents, youth and key populations should engage in provincial, national and multisectoral fora to make sure that their voices, concerns and issues are considered and addressed.
b) Support adolescents, youth and key populations to be meaningfully engaged in the process of generating evidence, the design and implementation of programmes and interventions, including the minimum package of services, that are meant to benefit them, and in the process of M&E.

6.2. SADC Secretariat and its strategic partners support the domestication of the SADC SRHR Strategy 2019–2030

The SADC Secretariat, in collaboration with its strategic partners, should support the multisectoral response and mutual accountability for achieving the outcomes of this strategy.

SADC Secretariat

a) Ensure and encourage region-wide adaptation of the Regional Strategy.
b) Develop a dissemination and implementation plan for the Regional Strategy.
c) Facilitate strengthened integration between the SRHR strategy and related strategies such as the Gender Based Violence Strategy, Youth Development Strategy and the Key Population Strategy at the level of monitoring and evaluation.
d) Provide technical support to Member States in the implementation and costing of the roll-out of the strategy.
e) Facilitate resource mobilization (financial and technical) and strategic partnerships around key targets.

f) Establish and coordinate implementation of the Regional Strategy and monitoring of progress, using the SRHR Scorecard and M&E Framework, with an Evaluation Team that can provide technical support and feedback to Member States.

h) Facilitate documenting and information-sharing on good practices.

Development Partners

a) Support regional, national and subnational action to implement the Regional Strategy and monitor progress with the Strategy and scorecard.

b) Support capacity development of government (including health-care providers, educators, social workers and law enforcement agents), civil society organizations, youth and adolescents and key population groups to play their specific role in implementing the Strategy.

c) Support evidence-based advocacy and national policy and programme formulation for key population- focused and adolescent and youth- focused SRH and HIV services.

d) Support civil society organizations in formulation of advocacy strategies.

e) Facilitate South-South learning and exchange on the developing of standardized packages and advocating for change in the legal and policy environment.

6.3. The Secretariat and its strategic partners monitor and support Member States to collect data and report on progress using the scorecard

All partners, Member States, SADC Secretariat, development partners, civil society, youth and representatives of key populations have a responsibility to monitor the implementation of this Strategy, report upon and against progress made, and ensure that periodic updates are provided to Ministers of Health in the region, as agreed upon in the Strategy.

7. Implementation

The implementation and review of this Strategy is aligned with the five-year time intervals of the RISDP. The evaluation of this Strategy will take place at time intervals aligned with the RIDSP, namely, 2023, 2028 and 2030 at the time of the review of SDG targets. The development of the SRHR Strategy 2019–2030 has been aligned with the development of a scorecard, which will serve as an important tool to facilitate peer Member State accountability through having a common frame of reference to measure and monitor progress toward mutually agreed goals and targets as identified in this SRHR Strategy. The scorecard will facilitate comparative inquiry across the region, which can further inspire good practice and more coherent lesson learning between countries. It will also provide a common strategic framework around which countries in the region could rally.

A comprehensive Implementation Plan and M&E Framework will be developed and will be aligned with related SADC M&E frameworks such as the Gender Based Violence Strategy and Gender and Development Protocol Frameworks.

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DRAFT 1

1. **Annexures**

Annexure One: Locating the SRHR Strategy 2018 -2030 within regional, continental and global frameworks

1. <u>**SADC Policies and Frameworks**</u>

1.1. <u>SADC Protocol on Health (1999)</u>

The SADC Protocol on Health set out to *harmonize and rationalize resources in the implementation and the attainment of the health objectives in the region* and was supplemented by an *Implementation Plan* to operationalize its implementation. Article 10 on HIV and AIDS and Sexually Transmitted Diseases, Article 16 on Reproductive Health and Article 17 on Childhood and Adolescent Health are the three components directly relating to SRHR that formed the backdrop to the previous Strategy. The sections set the stage for a range of the SADC SRHR-related policies and strategies that focus on integration, harmonization, developing strategies to reduce maternal and newborn mortality and to empower men, women and communities to have access to safe, effective, affordable and acceptable methods for the regulation of fertility[70].

1.2. <u>Minimum Standards for Integration of HIV and Sexual and Reproductive Health in the SADC Region</u>

The importance of linking SRH and HIV became increasingly clear in the context of harmonization, collaboration, the call for increased accountability, resourcing challenges and the pressure for SADC Member States to achieve the MDGs. The Minimum Standards are a framework that provides guidance to Member States on programming for services around SRH and HIV. The Minimum Standards address the social determinants of health that hinder access to and uptake of SRH and HIV services and provides guidance on the integration of SRH and HIV at the policy, systems, facility and community level[71]. It sets out to benchmark and harmonize the provision of integrated SRH and HIV interventions and services among SADC Member States, with a view to accelerating the effective delivery of quality and comprehensive health and related social services for all people, irrespective of age, sexual orientation, marital state and gender.

1.3. <u>SADC HIV Prevention 2020 Scorecard</u>

The SADC HIV Prevention 2020 Scorecard is a tool, developed and endorsed by Ministers in the region, to facilitate the work of the SADC Secretariat with national AIDS authorities to fast track the prevention agenda and align national prevention targets with the 2016 High-Level Meeting on HIV[72]. Noting that progress has not been fast enough in reducing new HIV infections, a focused approach through the development of a scorecard to monitor prevention was introduced to hold Member States accountable. A joint results

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[70] SADC Protocol on Health 1999
[71] SADC Minimum Standards SRH and HIV Integration
[72] SADC HIV Prevention Scorecard Guide

framework for implementation at the regional, national and subnational levels has served as the basis for monitoring progress and ensuring accountability. The indicators are set at the following levels: impact, process, coverage, output, outcome, policy and finance.

1.4. SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations

The purpose of the Strategy is to guide the adoption and institutionalization of a standard comprehensive package that addresses the unique challenges in providing equitable and effective HIV and SRH rights and services to key populations in the SADC region[73]. It aims to increase or ensure availability of SRH and HIV prevention, treatment and care services to all key populations; to design and implement holistic strategies covering the policy, legal, institutional and facility level; to increase access to quality and comprehensive HIV and SRH services for key populations so that 90 per cent of members of key populations are accessing services, and to ensure adequate and sustainable resource mobilization and utilization for HIV and SRH services for key populations. Its anticipated results are strategically aligned to a wider SRHR agenda for the region: (i) Stigma and discrimination against key populations at service provision points is eliminated; (ii) Violence against key populations is significantly reduced; (iii) SRH and HIV prevention, treatment, care and support programmes are scaled up for key populations and especially young key populations, as per the core package of services, are evidence-informed and results-oriented, and (iv) a reduction in legal, policy and cultural barriers that impede key populations' access to HIV and SRH services.

1.5. SADC HIV, SRH, TB and Malaria Programmes Integration Business Plan 2016 – 2020

The SADC HIV, SRH, TB and Malaria Programmes Integration Business Plan is a tool that will guide implementation of regional activities to enhance implementation of HIV, SRH, TB and malaria in an integrated and cost-effective manner.[74] It sets out a regional response aimed at creating an enabling environment for the SADC Secretariat to coordinate the provision of integrated programmes and services among SADC states in order to accelerate the effective delivery of quality and comprehensive health and related social services for all people in SADC. SADC's integration agenda is focused on addressing health challenges in ways *that foster cooperation,* given the high burden of both communicable diseases such as HIV, malaria and TB, and non-communicable diseases such as cancer. Integration brings together in a holistic manner, at the levels of legislation, policy, programming and service delivery, to ensure comprehensive services are provided in an efficient and effective way.

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[73] SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Rights Among Key Populations
[74] SADC HIV, SRH, TB and Malaria Programmes Integration Business Plan 2016 - 2020

1.6. <u>SADC Protocol on Gender and Development</u>

The SADC Protocol on Gender and Development sets out to (i) provide for the empowerment of women, to eliminate discrimination and to achieve gender equality and equity through the development and implementation of gender responsive legislation, policies, programmes and projects; (ii) to harmonize the implementation of the various instruments on gender equality and equity to which SADC Member States have subscribed to at a regional, continental and international levels; (iii) to address emerging gender issues and concerns; (iv) to set realistic, measurable targets and time frames for achieving gender equality and equity; (v) to strengthen, monitor and evaluate the progress made by Member States towards reaching the targets and goals set out in the Protocol, and (vi) to deepen regional integration, attain sustainable development and strengthen community building.[75] Part Six on Gender Based Violence and Part Seven on Sexual and Reproductive Health and Rights are particularly relevant for this Strategy . Articles 20, 21, 23, 24, 25, 26 and 27[76] are particularly pertinent. An M&E framework has been developed to track progress on the respective articles in the Protocol.

> The frameworks listed above provide an important road map for the ways in which SADC has continued to deepen its increasingly integrated and expanded response to sexual and reproductive health challenges in the region. It also foregrounds the need for an **accelerated** response that fosters **strengthened accountability by Member States** and improved commitment to the realization of SRHR and the attainment of gender equality, as fundamental to achieving positive SRHR outcomes.

2. <u>Continental Response to SRH</u>

2.1. <u>Africa 2063: The Africa We Want</u>

In May 2013, the African Union re-dedicated itself to the vision of a pan-African, integrated, prosperous and peaceful Africa, driven by its own citizens and representing a dynamic force in the international arena.[77] Key transformational outcomes and targets that relate directly to SRHR are: (i) *Improvements in Living Standards:* malnutrition, maternal, child and neonatal deaths as at 2013 to be reduced by half; access to antiretroviral to be automatic and the proportion of deaths attributable to HIV/AIDS and malaria to be halved and (ii) *Empowered women, youth and children:* all forms of violence against women to be reduced by one-third in 2023; all harmful social norms and customary practices to end by 2023 and child labour, exploitation, marriage, trafficking and soldiering to end by 2023. It provides an important sustainable human development framework on the continent that foregrounds the importance of SRHR.

2.2. <u>Campaign for Accelerating the Reduction of Maternal Mortality in Africa (CARMMA)</u>

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[75] SADC Protocol on Gender and Development
[76] Article 20 – Legal; Article 21 – Social, Economic, Cultural and Political Practices; Article 23- Support Services; Article 24 – Training of Service Providers; Article 25 -Integrated Approaches; Article 26- Sexual and Reproductive Health and Rights and Article 27 – HIV and AIDs
[77] Agenda 2063 *First Ten Year Implementation Plan 2014-2023*

The Campaign for the Accelerated Reduction of Maternal Mortality in Africa was launched by the African Union in May 20. It aims to achieve the following: (i) *building ongoing efforts*, particularly best practices, which means reporting, collecting and sharing information on various strategies and initiatives that countries have implemented to address maternal mortality; (ii) *generating and providing data on maternal and newborn deaths*, which means that all countries have to produce up to date data on maternal and infant mortality and report regularly to AU health fora about this; (iii) *mobilizing political commitment and supporting key stakeholders,* including national authorities and communities, to mobilize additional domestic resources in support of maternal and newborn health; (iv*) mobilizing communities* around their role in improving maternal and child health and reducing maternal and child deaths, which means that efforts around maternal and child mortality cannot just remain in the realm of policy and legislation, but need to include creative engagement at a community level and (v) *accelerating actions aimed at the reduction of maternal, infant and child mortality in Africa,* which means that, given the proposals coming from best practices, governments will be urged to take concrete steps to reform and improve their health systems appropriately.

2.3. Global Strategy for Women's Children's and Adolescents' Health 2016 – 2030 Implementation in the African Region (AFR/RC66/9)

The Member States, through the Regional Committee Resolution AFR/RC66/9, recognize the disproportionate responsibility of having the highest burden of maternal, new-born and child morbidity and mortality that the continent carries and firmly align with the key changes that the Global Strategy introduces, i.e. the adoption of a health system-oriented, integrated, multisectoral approach to maternal, new-born, child and adolescent health programming with strengthened monitoring and accountability systems to guide the roll-out[78]. It recognizes that, despite many commitments made by Member States to improve the health of women and children, only 12 countries achieved MDG Target 4, two countries achieved MDG Target 5 A and none achieved Target 5B on universal access to reproductive health. Priority actions were proposed and adopted by Member States to facilitate achievement of globally agreed targets: (i) ensure government ownership and leadership of programmes and initiatives; [79] (ii) institute measures for health system strengthening [80] and (iii) enhance mechanisms for multisectoral action.

2.4. Maputo Plan of Action 2016 – 2030

The Revised Maputo Plan of Action (MPoA) 2016–2030 for the operationalization of the SRHR Continental Policy Framework works towards the goal of universal access to SRH services in Africa beyond 2015.[81] The Continental Policy Framework, adopted by African Heads of State in 2006 aimed to mainstream SRHR in primary health care to accelerate achievement towards the MDGs at the time; to encourage implementation of the Abuja

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[78] WHO- AFRO, AFR/RC66/9 June 2016
[79] This action includes ensuring that WCA issues are prioritized, ensuring that services are provided universally in a comprehensive, integrated, equitable and sustained manner, availing policies to improve the health of WCA, mobilising adequate resources and instituting national and sub national accountability processes for periodic review and monitoring or progress towards agreed national targets.
[80] This action includes ensuring high coverage of RMNCAH interventions, sustainable investment for health workforce, improved availability of essential medicines, supplies, infrastructure and equipment, improved availability of quality data to inform decision-making and addressing the critical social, behavioral, economic and environmental determinants of health.
[81] Maputo Plan of Action 2016 -2030 for The Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights

Recommendation to increase resourcing to the health sector; to strengthen the health, and specifically SRH component, in poverty reduction initiatives, and to mainstream gender issues into socio-economic programmes in order to improve women's health.[82] The MPoA also reflects the policy commitments articulated in the Maputo Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

The MPoA has nine action areas: political commitment, leadership and governance; health legislation; health financing/investments; health services strengthening/human resource development; partnerships and collaborations; information and education; accountability, monitoring and evaluation; investment in the vulnerable and marginalized populations and improved adolescent and youth SRHR.

The Plan is based on a comprehensive understanding of SRHR, as defined at ICPD and ICPD + 20. It includes adolescent SRH; maternal health and newborn care; safe abortion; family planning; prevention and management of STIs, including HIV; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing midlife concerns of men and women; health and development; the reduction of gender-based violence; interpersonal communication and counselling and health education.

2.5. Maputo Protocol on the Rights of Women in Africa

The Maputo Protocol on the Rights of Women in Africa has recognized that, despite the ratification of a range of African and international human rights instruments by the majority of State Parties and their solemn stated commitment to eliminate all forms of discrimination and harmful practices against women, women in Africa continue to be victims of discrimination and harmful practices.[83] The Protocol sets out to ensure that the rights of women in Africa are promoted, realized and protected, to enable women to enjoy fully all their human rights, as recognized and endorsed by respective international human rights instruments.[84]

Given the focus of the Protocol, many sections of the document have a bearing on the realisation of SRHR for women and girls. Particularly pertinent are Article 4 Section 2, Article (5) Elimination of Harmful Practices, Article (6) Marriage, Article (12) Section 1 © and (d) and Article 14 (1) and (2). Article 14 articulates a comprehensive political commitment to ensuring that the right to health of women, including SRHR, is respected and promoted.

2.6. ESA Commitment

In 2013, Ministers of Education and Health from twenty countries in East and Southern Africa agreed to work collaboratively towards a vision of young Africans who are global

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[82] African Union Commission *Sexual and Reproductive Health and Rights – Continental Policy Framework* 2006

[83] African Union *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*
[84] Universal Declaration of Human Rights, International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and its Optional Protocol, the African Charter on the Rights and Welfare of the Child and all other international and regional conventions and covenants relating to the rights of women being inalienable, interdependent and indivisible human rights

citizens of the future, who are educated, healthy, resilient, socially responsible, informed decision-makers, and who have the capacity to contribute to their community, country and region[85].

Two sets of targets were set to be achieved in 2015 and in 2020 respectively. By 2015, 12 of the 15 SADC states reported providing CSE/ Life Skills in at least 40 per cent of primary and secondary schools. All countries reported having CSE training programmes for teachers. Only two countries reported a lack of youth-friendly SRH service training programmes for health and social workers. Ten countries reported offering the standard minimum package of adolescent and youth-friendly health SRH services.[86]

The ESA Commitment has facilitated increasing acceptance of the concept of sexuality education. While most countries now include CSE in the curriculum, this often happens in the context of wider curriculum reform. The report notes the need to strengthen programmes reaching those not in school. While noting the progress in the ESA region, the report highlights the importance of leadership and ownership by countries, the need to strengthen CSE for all adolescents and young people in- and out-of-school, to work with parents and communities creatively to mobilize their support, to involve young people, and to prioritize the needs of adolescent girls and young women by enforcing laws, policies and norms that outlaw child marriage and other forms of discrimination.

> The frameworks listed above demonstrate *an acknowledgement of specific SRHR challenges that the African region continues to grapple* with. They show continental commitment and interventions to fast track the response to a range of critical areas such as *maternal mortality, HIV incidence, unsafe abortion and comprehensive sexuality education.*

3. Global Developments

3.1. The 2030 Agenda for Sustainable Development

The Sustainable Development Goals are a universal call to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. The global community in 2015 adopted the 2030 Agenda for Sustainable Development. Its 17 Sustainable Development Goals have expanded the targets that are relevant for SRHR and for this Strategy: (i) SDG 3 - *ensuring health lives and promote well-being for all at all ages;* (ii) SDG 5 - *ensuring inclusive and equitable quality education and promoting lifelong learning opportunities for all;* (iii) SDG 5 - *achieving gender equality and empowering all women and girls* and (iv) SDG 16 *promoting peace and inclusive societies for sustainable development, providing access to justice for all, and building effective, accountable and inclusive institutions at all levels.*

The SDGs ushered in a new *increasing urgency to turn the tide* towards sustainable human development, which influenced the language of regional instruments such as the SADC Gender Protocol. This is evident in the language on SRHR: a commitment to *eliminating*

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[85] *Fulfilling our Promise to Young People Today 2013- 2015 Progress Report* The Eastern and Southern African Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People
[86] Ibid.

rather than reducing maternal mortality, to *ending* rather than halving GBV, and to implementing programmes and policies on SRHR aligned to the ICPD and Beijing Platform for Action[87].

The targets set in the SDGs are key to informing this strategy: [88]

1. *SDG 3.1. Reduce maternal morta*lity to less than 70 per 1,00000 live births. It is a direct measurement of MNH and linked to ASRHR, GBV and safe abortion.

2. *SDG 3.2. End preventable deaths of newborns and children <5 yea*rs, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortality to at least as low as 25 per 1,000 births. It is a direct measurement of MNH and is linked to ASRHR, GBV, HIV/AIDS and other STIS and contraception.

3. *SDG 3.3. End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.* It is a direct measurement of HIV/AIDS and STIs and is linked to ASRHR, GBV, and contraception

4. *SDG 3.4. Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.* It links to reproductive health cancers.

5. *SDG 3.7.Ensure universal access to SRH care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.* This is a direct measurement for ASRHR, HIV/AIDS and others STIs, contraception and MNH. It is linked to GBV, safe abortion, infertility and reproductive cancers.

6. *SDG 3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all*. This is a direct measurement of HIV/AIDS and other STIs, contraception and MNH and is linked to ASRHR, safe abortion, infertility and reproductive cancers.

7. *SDG 4.7. Ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development.* This is linked to ASHRH and GBV.

8. *SDG 5.*1. *End all forms of discrimination against women and girls everywhere*. This is linked to Linked to ASRHR, GBV, HIV/AIDS and other STIs, contraception, MNH, safe abortion and reproductive cancers

9. *SDG 5.2. Eliminate all forms of violence against women and girls in public and private spheres, including trafficking, and sexual and other types of exploitation.* This is a direct measurement for GBV and is linked to ASRHR, HIV/AIDS and other STIS, contraception, MNH and safe abortion.

10. *SDG 5.3. Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation*. This is directly measuring GBV and linked to ASRHR.

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[87] SADC Gender Protocol Alliance *Policy Brief- The SADC Protocol on Gender and Development and Agenda 2030*   August 2017
[88] Stated means that it is explicitly stated in the target, while linked means that there is a linkage with the critical area, but it is not explicitly stated in the target

11. *SDG 5.6.* Ensure universal access to SRHR in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action, and the outcome documents of their review conferences. *This is a direct measurement of ASRHR, GBV, HIV/AIDS and other STIs, contraception, MNH and reproductive cancers*

12. *SDG 5.6.c Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels.* Linked to ASRHR, GBV *and safe abortion.*

13. *SDG 16.1 Significantly reduce all forms of violence and related deaths everywhere.* This is linked to ASRHR and GBV.

14. *SDG 16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children.* This is linked to ASRHR and GBV.

> The SDG targets ***provide important strategic direction*** and ***expand the focus*** to highlight the importance of addressing maternal mortality, neonatal and child mortality, adolescent sexual and reproductive health and rights, gender-based violence, HIV/AIDs and STIs, access to contraception and safe abortion. They point to the importance of focusing in a three-pronged way: (i) creating an enabling legal and policy environment; (ii) making the comprehensive standard package of SRHR services and interventions available and (iii) taking firm action to respond to all practices and norms that undermine the human rights of women and girls.

3.2. Global Strategy for Women, Children's and Adolescent Health

The Strategy aims to accelerate actions to save the lives and improve the well-being of women, children and adolescents.[89] Its objectives and targets are fully aligned with the *Sustainable Development Goals:* (1) Survive – endpreventable deaths, reduce global maternal mortality to less than 70 per 100,000 live births; reduce newborn mortality to at least as low as 12 per 1,000 live births in every country; reduce under five mortality to at least as low as 25 per 1,000 live births in every country; end epidemics of HIV, TB, malaria, neglected tropical diseases and other communicable diseases; reduce by one third premature mortality from non-communicable diseases, and promoting mental health and well-being; (2) Thrive – ensure health and well-being, which includes ensuring universal access to sexual and reproductive health-care services (including family planning) and rights, and (3) Transform – expand enabling environments, which includes eradicating poverty, and eliminating all harmful practices and all discrimination and violence against women and girls. As indicated, political commitment to the roll-out of this strategy in Africa is explicit in WHO- AFRO, AFR/RC66/9 June 2016.

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[89] Every Women Every Child *the Global Strategy for Women's Children's and Adolescents' Health (2016-2030)* 2015

The continental and global frameworks referred to above **affirm the need for accelerated action** and point to **the need to mobilize commitments into domestication and practice.** The scale of the SRHR challenges confronting the region, alongside elements such as stigma and discrimination implies **the need for empowered, active citizenry to be mobilized and seen as integral to accelerating an effective response**.

DRAFT 1