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SADC POLICY FRAMEWORK

1. INTRODUCTION

The Southern African Development Community (SADC), consisting of the Republic of Angola, the Republic of Botswana, the Democratic Republic of Congo, the Kingdom of Lesotho, the Republic of Malawi, the Republic of Mauritius, the Republic of Mozambique, the Republic of Namibia, the Republic of Seychelles, the Republic of South Africa, the Kingdom of Swaziland, the United Republic of Tanzania, the Republic of Zambia and the Republic of Zimbabwe, decided in August 1997 to include health in its Programme of Action by creating a Health Sector. The rationale for this was the realisation that regional co-operation was critical to address the health problems of the region. It was decided that the Health Sector Co-ordination be assigned to South Africa who would provide the secretariat to co-ordinate activities.

The goal of the Health Sector is to attain an acceptable standard of health for all citizens by promoting, coordinating and supporting the individual and collective efforts of Member States. Within this goal are two aims:

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

In March 1998 the fourteen Members of SADC formulated and adopted Terms of Reference for the establishment of the Health Sector with twenty-three objectives. These are to:

1.1 identify, promote, co-ordinate and support those activities that have the potential to influence the health of the population within the Region;

1.2 co-ordinate regional efforts on disaster and epidemic preparedness, mapping, prevention and control of diseases such as malaria, measles, dysentery, polio, cholera, tuberculosis, HIV\AIDS and STDs, and to develop common strategies to address non-communicable diseases such as diabetes, hypertension and cancer;

1.3 ensure effective utilization of human resources for health in the Region, including the harmonization of curricula for the training of health personnel, and the accreditation of health professionals trained in Member States;

1.4 identify the potential and need for postgraduate training and research in each country; identify bilateral and multilateral facilitating mechanisms to be used rationally by Member States, to co-ordinate the placement of undergraduate and post-graduate students in Member States for the training of health, particularly

public health professionals, and to organize tertiary health education and training in selected Member States at reasonable cost;

1.5 facilitate the exchange of students and other health professionals and to ensure technical co-operation and consultancy services within the Region;

1.6 facilitate the sharing of information on health and research through, for example, seminars and exchange of reports;

1.7 facilitate the establishment of mechanisms for the referral of patients for tertiary care where appropriate and adequate facilities are not available in a Member State in a manner that will ensure that capacity is developed in the referring Member State in the medium to long-term,;

1.8 identify and develop centres of excellence in the region and organize the delivery of tertiary care and share vertical specialization in selected Member States for the whole of SADC;

1.9 adopt and facilitate the implementation of decisions taken by multilateral organizations of which SADC is a member, e.g. WHO and OAU;

1.10 foster co-operation in the area of health with other multi-lateral organisations;

1.11 promote and co-ordinate collaboration of laboratory services in Member States in quality control of food, blood products and drugs imported or produced in the Region;

1.12 develop and harmonize information, education and communication strategies to prevent morbidity and premature mortality;

1.13 harmonize the control and eventual elimination of illegal drugs, tobacco and alcohol abuse;

1.14 promote the standardization of medical equipment management along broad guidelines to ensure that equipment procurement, maintenance and general management can be done in a manner that promotes the principles of cost-effectiveness, efficiency and sustainability;

1.15 harmonize the legislation and practice regarding pharmaceuticals, including their registration, procurement and associated quality assurance;

1.16 harmonize the legislation and practice regarding port health;

1.17 develop common strategies to address women and child health needs with an emphasis on relevant international instruments, to which Member States are signatories;

1.18 promote reproductive health by improving services and accessibility in the Region;

1.19 promote environmental and occupational health in the Region;

1.20 develop strategies to address violence from a public health perspective, especially violence against women and children. This should include a focus on the promotion of elimination of landmines;

1.21 promote health systems research in the Region;

1.22 co-operate in mobilization of financial resources in addressing priority programmes of Member States; and

1.23 undertake any other health-related issues.

The attainment of these SADC Health Sector objectives will be in the context of World Health Assembly (WHA) Resolutions and Decisions. SADC countries, as members of the WHO, have adopted the following WHO global targets for Health for All to 2020.

Health Outcomes

- health equity indices, initially based on child growth measures, will be used within and between countries as a basis for promoting and monitoring equity in health by 2008;

- maternal mortality, child mortality and life expectancy targets agreed to in UN conferences will be met by 2015 (CMR less than 45/1000 population; life expectancy greater than 60 years for all countries);

- the percentage of stunted children less than 5 years of age will be below 20% by 2010;

- the elimination of the following diseases by 2020: polio; measles; Chagas disease; trachoma; and leprosy; and

- global control programmes will substantially reduce the impact of pandemics of TB, HIV, malaria, tobacco and violence/trauma by 2020.

Determinants of health

- safe drinking water, proper sanitation and food in sufficient quantity and quality will be available to all by 2015; and

- all countries will introduce legal and fiscal measures and programmes (school, community and media health education) that promote health and reduce the occurrence of the most harmful lifestyles by 2010.

Health system policies and functions

- all Member States will have developed and will be implementing and monitoring policies consistent with this HFA policy by 2005;

- all people will have access throughout their lives to quality, essential, comprehensive care, including child and reproductive health services by 2010;

- global surveillance and alert systems supported by the use of communications technology will rapidly and widely disseminate information about the current and pending transnational threats to health by 2010; and

- policies and institutional mechanisms, including ethical review processes, that support innovation in science and appropriate use of technology for health will be operational at global and country levels by 2010.

2. SITUATION ANALYSIS

Planning for health care service delivery requires knowledge of the current situation. This section will attempt to provide a broad view of some indicators of levels of development and of the health status of the peoples of the Region.

The precise figures quoted in this situation analysis should be treated with caution. Data that are reliable, standardised and complete have been difficult to find. The main sources used have been the World Health Organisation and the World Bank Reports, supplemented (as indicated in the tables) with some more recent national data. For any one indicator there are often significant differences in the figures given by different sources. One possible explanation for different figures for the same country is that there are often wide variations in health status and other indicators within a country. Country averages may be extrapolated from surveys conducted for other reasons, and all the averages mask the inequities that exist within most countries.

Another problem with, for example, World Bank data is that for many indicators they give an “average” for the Region, which can be very misleading. This “average” appears to be derived by summing the averages for each country and dividing by the number of countries. This methodology ignores the different population sizes (as well as the different birth rates) of the different countries. Averages across the Region have not been used in this analysis, partly for this reason and partly because they would mask the very great intra-regional inequities.

While some of the figures used in this analysis may be queried, the data do reflect the current status of health in the Region and do point to the areas, which should be prioritised. However, the importance of good baseline data cannot be overemphasised in order to set achievable targets. The establishment of a regional mechanism to collect and share reliable and comparable data has already been identified as one of the first priorities for the SADC Health Sector.

2.1 Demography and other development indicators

The Region has an estimated 190 million people or about 30% of all people living in Sub-Saharan Africa. Illiteracy rates are available for 11 of the 14 Member States (World Development Indicators, 1998). Mozambique has the highest rate of illiteracy, 60% for females and 42% for males. Without exception female illiteracy rates are higher than that for males. The impact of female illiteracy on health outcomes is well documented which implies that Member States would need to address this issue as a priority.

The average Human Development Index[1] for the region is 123. Of these only four members have an HDI below 100. These are: Seychelles (52); Mauritius (61); South Africa (90); and Botswana (97).

With respect to access to safe water and sanitation, there is wide variation between Member States with Angola (31%); and Congo DR (18%) having the lowest percentage of population with access to safe water and sanitation. At the other end of the scale nearly 100% of all citizens of Mauritius have access to safe water and sanitation. The basic indicators in Member States are shown in Table 1, demonstrating variations between Member States.

Table 1: Basic Indicators

Member State	Pop Size m.	[2]Literacy %			% Pop with access safe water 1990-95	% Pop with access to sanitation 1990-96
		F	M	T		
Angola	12.65*			49.7*	31*	39*
Botswana	1.533*	70.3*	66.9*	68.9*	70	65
Congo DR	43.50			77	42	18
Lesotho	1.96*	34*	54*	44*	56	28
Malawi	10.00			56		
Mauritius	1.11*			85*	99.6*	99
Mozambique	18.00			40	63	54
Namibia	1.7*	76*	78*	76*	65*	42.9*
Seychelles	0.08					
South Africa	41.86			81	81*	50*
Swaziland	0.95				50	59
Tanzania	29.00			67		
Zambia	9.7			78	46.8*	64
Zimbabwe	12.8*			80*	77	66

2.2 Health Status

The health status of our people needs to be considered within the historical, economic and social context of the Region. Poverty, under-development, unemployment, and poor social and physical living conditions have had a negative impact on health status. In addition, health programmes have been vertical, diseases-focussed and based on theoretical frameworks that are not sympathetic of community perspectives.

[1] Human Development Index(HDI)
Measures human progress as reflected by longevity, knowledge, and standard of living. HDI does not reflect disparities among regions and population groups within countries.

[2] **Sources of data for Table 1, 2, 3, and 5**

i) * Recent national data on adult literacy rates from Member States.
ii) The World Health Report, 1998:Life in the 21st Century A vision for all.
iii) World Development Indicators, 1998, Washington D.C., World Bank.
iv) Human Development Report, 1997, New York: Oxford UP.

The importance of base line data cannot be overemphasised in order to set achievable targets. The establishment of a regional mechanism to collect and share reliable data should be prioritised by the Sector. The health status in Member States is shown in Table 2, again demonstrating large variations between Member States.

Table 2: Health Indicators

Member State	Life Expectancy %			Maternal Mortality Ratio per 100 000 live births (1990-96)	% Pop with access to health services (1990 – 95)
	F	M	T		
Angola			47	770*	
Botswana			69.9	326	87.0
Congo DR		51			26
Lesotho	57*	54*	58	610	80
Malawi	42	41	41	620	
Mauritius	74*	67*	71	52*	100
Mozambique	48	45	46	1500	39
Namibia	63	59	61	225*	59
Seychelles	73	67	71		
South Africa	67	61	64	54*	
Swaziland	71	56	58	214	70
Tanzania	52	49	50	530	
Zambia	47*	44*	42	649*	
Zimbabwe			61	283*	85

Life expectancy ranges from 41 years to 70 with an average for the region of 56 years (WHO, 1998). Female life expectancy ranges from 42 to 74 with an average of 58 years whilst male life expectancy ranges from 41 to 71 with a regional average of 59 years. According to UNAIDS, this modest life expectancy is also put under severe strain by the impact of HIV/AIDS with a decrease of ten years projected in some Member States

There is wide variation in maternal mortality per 100 000 live births with none reported in the Seychelles in 1996 whilst Mozambique is estimated to have 1500 maternal deaths (World Development Indicators, 1998). The average for the 12 Member States reported is 486 maternal deaths per 100 000 live births. The Seychelles ascribes their lack of maternal deaths to lowering of the fertility rate and thus the burden on women.

The average maternal mortality rate in Member States compares favourably with that for the rest of the continent (832) but unfavourably with other regions in the world. The average for NAFTA is 43 (with Mexico the highest with 110), while the rates for the EU, MERCOSUR and ASEAN are 12, 181 and 273 respectively**.**

There is wide variation in access to health care in the Region. According to the World Bank (1998) the percentage of the population with access to health care in Member States in 1993 ranged from 24% to 99% with a mean of 69%. This implies that with some exceptions the majority of citizens of the Region can expect to be treated for common diseases and injuries within one hour's travel. These figures compare with the rest of the continent and NAFTA (excluding the US for which data was not available) as follows: rest of the African continent 48% and NATFA 95%. While on average SADC citizens appear to have better access to health services than those of other African countries the variation within SADC should be noted.

Country averages tend to hide intra-country variations as illustrated by maternal mortality rates in South Africa. Maternal mortality amongst whites is seven times lower than amongst blacks, with even higher variations between urban and rural especially women headed households in the rural areas.

2.2.1 Communicable Diseases

All communicable diseases pose a potential threat to the Region, especially when the increased mobility of the population allows great distances to be travelled in short time periods, allowing for possible wider transmission of communicable diseases. Diseases of particular public health importance are HIV, tuberculosis, malaria, poliomyelitis, measles, hepatitis B, diphtheria, pertussis, cholera, dysentery, schistosomiasis and plague.

The HIV/AIDS epidemic, by virtue of its magnitude, constitutes a threat to humanity. Its spread is affecting societies and inflicting irreparable damage on families and communities. Although the epidemic affects all people without distinction, women, children and the youth are affected disproportionately. The epidemic is hindering social and economic development and increasing disparities within and between countries. Rapid communication between Ministries of Health in the Region will be increasingly important to facilitate appropriate responses and to provide timely information to prevent apprehension and the diversion of investment.

While accurate figures are hard to come by, the percentage of women attending antenatal clinics with the virus is increasing. Four Member States more than 25% of women attending antenatal clinics are HIV positive. These Member States are: Botswana, Malawi, Zambia and Zimbabwe.

There are indications that HIV/AIDS prevalence rates in the Region could be as high as 1 in five people (20%) in some places. This makes HIV/AIDS the single largest threat to survival of society in the Southern Africa region. The impact of this epidemic on life expectancy in the Region is a matter of wide ranging discussions.

The link between HIV and STDs has further increased the need to control STDs. In addition to the fact that the same risk behaviour leads to both STD and HIV infection, it has been shown that the presence of a sexually transmitted infection increases, by 3 to

5 fold, the risk of acquiring HIV infection and that the risk of HIV transmission is reduced by about half if STDs are properly treated.

The rising HIV/AIDS epidemic has also resulted in increased rates of other secondary infections such as TB, pneumonia, neurological infections and diarrhoea. Drug resistance increasingly complicates effective treatment.

According to the World Development Indicators (1998) the average reported TB incidence rates per 100 000 population for the region is 264 (data from 11 of the 14 countries). At least four Member States have rates higher than 400 per 100 000 population indicating the magnitude of the problem.

In some areas improved strategies, facilitated by the WHO, have been put in place. The control of these diseases is important for economic and human development in the Region. Efforts must be made to strengthen and reinforce initiatives to learn from Member States and work synergistically to improve the control of disease such as HIV, TB, malaria, cholera, dysentery, eradication of polio and measles.

Table 3: % infected with HIV in SADC Member States

Country	HIV % Infected [3]	% of Infected Women Attending Antenatal Clinics
Angola	**24.7**	**1.0**
Botswana	**14**	**34.2***
Congo DR	**30.3**	**4.6**
Lesotho	**15,2**	**6.1**
Malawi	**78.0**	**32.8**
Mauritius	**0.8**	**0.0**
Mozambique	**24.0**	**10.5**
Namibia	**2.6***	**15.4**
Seychelles		
South Africa		**16.01**
Swaziland	**20.0***	**15.24 – 19.4**
Tanzania	**49,5**	**13.9**
Zambia	**19,0***	**27.9**
Zimbabwe	**21,0***	**35.2**

[3] Figures for High Risk Urban Areas only.

Source

The World Bank Development Indicators, 1998 (except for * Namibia, South Africa, Swaziland, Zambia and Zimbabwe).

2.2.2 Non-Communicable Diseases and Cancer

Member States are faced with a challenge of reducing high incidence of Non-Communicable Diseases (NCD), including diabetes, hypertension, cardiovascular and circulatory diseases. Many NCDs are associated with urbanisation, over-crowding, industrialization, changing life style, and other risk factors e.g. obesity and hereditary factors. Addressing these problems could have a major positive impact on health status in the Region.

While it may be difficult to change demographic trends it might be possible to reduce overall burden of these diseases through:-

- health promotion, elimination of risk exposure and disease prevention;
- management and control of non-communicable diseases; and
- an improved life-style approach to health care.

The WHO estimates that all NCDs, many preventable, account for at least 40% of all deaths in developing countries. By the year 2000 cardio-vascular diseases will possibly be the leading cause of death in many developing countries. Focusing on mortality exclusively, however obscures the years of suffering, the origins of the disease, the socio-economic factors and behavioural elements that influence these diseases.

There is a lack of reliable epidemiological data about NCDs and their determinant's in SADC. Incidence in particular is very difficult to measure, because of the etiology of these diseases, that is the latent period is often between 3-4 decades.

The cancer burden in developing countries is significant. As a result of medical advances one-third of all cancers are treatable if diagnosed sufficiently early. Cancer of the reproductive system, particularly cancer of the cervix and breast are common in Member States. They are one of the leading causes of morbidity in the Region and results in isolation and pain over many years.

2.3 Nutrition

The availability of food and nutrition in the Region has shown a steady decline, with droughts, food shortages high rates of maternal and child malnutrition, Vitamin A deficiency, nutrition anaemia, and iodine deficiency disorders. (Using Eastern, Central, Southern Countries (ECSA) document. A review of the food and nutrition situation in the Region reported in a ECSA report indicates that:-

- The prevalence of malnutrition is high (average 26% in the Region, see Table 4).
- Stunting rates are high, affecting about one-third of young children in ECSA (regional average of 34%).

- Over 40% of women suffer from iron deficiency and other forms of malnutrition, leading to high mortality and low birth weight for children born to these mothers.

- Diet related non-communicable diseases are becoming a major health problem.

- The decline in production and consumption of indigenous foods is leading to household food insecurity.

Table 4: Nutrition Status

Member State	Malnutrition[4] Under 5s -%	% of Under 5s (moderate to severe stunting)[5]
Angola	42*	
Botswana	14	44
Congo DR	34	45
Lesotho	21	44
Malawi	28	48
Mauritius	16*	10
Mozambique	47	55
Namibia	29*	28
Seychelles		5
South Africa	9	23
Swaziland		33*
Tanzania	29	42
Zambia	29	42*
Zimbabwe	11*	21

*** recent national data**

Protein Energy Malnutrition (PEM) and micronutrient deficiencies (iodine, Vitamin A, and iron) have been identified as the leading nutrition problems in the Region. Salt iodisation, distribution of iron tablets and vitamin capsules, mounting of child feeding programmes, and promotion of nutrition health education are being promoted by most Member States in an effort to address the nutrition problems.

Preventable communicable and non-communicable diseases are also caused by contaminated food. A poor food intake, aggravated by loss of nutrients from vomiting,

[4] The World Bank's World Report Development Indicators, 1988.
[5] Unicef 1998 (State of World's Children).

malabsorbtion and fever over an extended period leads to nutritional deficiencies with serious consequences for the growth and immune system of infants and children.

2.4 Reproductive Health

Reproductive health is identified as one of the essential components of integrated health services to be delivered in the context of the primary health care philosophy. Reproductive health services in the Region are poor, with access to contraception technology being low. According to the World Bank Report, maternal mortality ratios, an indicator of the quality of maternal health care in the Region, and indirectly an indicator of access to health care services, range between 52 to 1500 deaths per 100 000 live births. There is wide variation in the Region with regard to the percentage births supervised by trained attendants. With the exception of Mauritius and South Africa, the percentage is below 70, with some as low as 17%. The absence of trained attendant at birth is associated with perinatal and maternal mortality and morbidity.

Access to contraception, measured by contraceptive prevalence rates, range from 18 to 75 percent. Total fertility rates range from 2.1 to 6.8. Anaemia among pregnant women ranges from 7 percent of pregnant women to over 70 percent. With women constituting over 50% of the population, improvements in reproductive health has the potential to make significant contribution to economic development.

Reproductive tract infections are also common in the region, with HIV becoming a major cause of mortality in women. Menopause and andropause have not been uniformly attended to in the Region. Cancer of the cervix is occurring in a younger age group, with a history of sexually transmitted infections and multiple partners becoming important factors. The control of these conditions could significantly reduce suffering among women.

Reproductive health is crucial for development of communities within Member States. Priority areas are on strengthening safe motherhood, medical genetics, reproductive, sexual and perinatal health.

2.4.1 Genetic Disorders

The incidence of birth defects in developing countries is not well documented due to under reporting, misclassification and a lack of recognition of genetic disorders.
According to estimates in developed countries, approximately 3% of children have birth defects.

The integration of genetic services into primary health care services, with a focus on primary prevention, management and counselling will address the needs of people with birth defects and inherited disorders in the SADC region.

2.5 Children and Adolescent

All the Member States are signatories to the United Nations Convention on the Rights of the Child. However, health services for children and adolescent are not always available in appropriate times. Children from Member States are often rushed into adulthood through poverty, crime, wars and being orphaned. Some children are forced into early marriages and pregnancies in order to sustain themselves. The AIDS epidemic has also created a large number of orphans, with many households in some Member States being headed by children.

Children have special needs and also special rights. Member States that have accepted and ratified the UN Convention on the Rights of the Child have a responsibility to place children at the top of the priority list. The most vulnerable children must have first call on resources and efforts within the SADC Region.

Table 5: State of Region's Children

Country	IMR / 1000 live births	Under 5s Mortality / 1000	% of Children Under 12 Months Immunised	
			Measles	DPT
Angola	166*	209	46*	24*
Botswana	39*	49.0	75*	75*
Congo DR	90		18	35
Lesotho	85*	55-60*	56	58
Malawi	133	217	58	98
Mauritius	20.3*	22.5*	87*	90*
Mozambique	123	214	56	57
Namibia	57	83*	61	71*
Seychelles	9			
South Africa	49	66	74	81
Swaziland	98		93	95
Tanzania	86	144	59	79
Zambia	109*	197*	87*	84*
Zimbabwe	53*	76*	83*	80

* **recent national data**

Infant mortality ranges from 133 deaths per 1000 live births to a low of 9 with an average of 80. This compares with an average of 105 for the rest of the continent, 15 for NAFTA, 6 for the EU, 30 for MERCOSUR and 45 for the ASEAN members. Clearly, while on average SADC has a lower IMR than the rest of the continent it lags behind other regions of the world.

Immunisation coverage for measles and DPT average 66% and 78% respectively(see Table 5). However there is again wide variation between Member States with coverage in Swaziland being 93% for measles and 89% for DPT while Congo DR has coverage of

18% and 35% respectively. Many Member States will have to prioritise immunisation to reach the WHO target of 80% coverage. For those that have reached the 80% target the next target should be 90-100% coverage.

2.5.1 Teenage Pregnancy

Some children are forced into early marriages and teenage pregnancy introduces and perpetuates poverty both for the individual child, the family and the country by impacting on the educational and economic potential of these young people. It often results in dropping out of school, sub-optimal care of her child or unsafe termination of pregnancy with its attendant morbidity and mortality. This is further complicated by the HIV/AIDS epidemic, with young people being the group that is increasingly affected. Adolescent fertility rates, according to the World Bank, range from 42 per 1000 live births in Mauritius to 221 per 1000 live births in the Democratic Republic of Congo.

2.6 Neglected Problems

2.6.1 Violence

The impact that violence has had in the Region is enormous. Wars, violent crime, domestic abuse especially on women and children and substance abuse related violence have had devastating effects on Southern African countries. Violence is one of the major causes of both mortality and morbidity in the Region. In addition to the many people who have died, many more still bare the physical and psychological scars of violence. The immense social and personal cost of violence is matched by the financial toll it takes, measured by the extent to which it is draining the health budget. The services provided to the victims of violence consume the bulk of many hospital budgets.

Recognition of violence, including motor vehicle accidents, wars, rape, women and child abuse, as a leading worldwide public health problem led to the adoption of WHA Resolution 49.25 “Prevention of Violence: A Public Health Priority” at the World Health Assembly in 1996.

2.6.2 Disabilities

Identifying impairments is useful in the planning of health interventions and the provision of technical aids through rehabilitation programmes. This would normally include efforts to remove all barriers to social integration and participation and the training of rehabilitation personnel.

There is a serious lack of reliable information on disabilities and there has been a failure to integrate disability into mainstream government statistical processes.

The United Nation Development Programme (UNDP) in 1990, estimated that 5.2% of the world population experienced moderate to severe disability. This ranged from 7,7% in developed countries to 14,5% in less developed areas. It is critical to note that disability does not only affect the disabled individual but also the family and the

immediate community. Another factor that must be taken into account is the tendency for society to view people with disabilities as a single group. This ignores the diversity of disability and the variety of needs of people with different types of disability.

2.6.3 Aging

The demographic changes taking place in both developed and developing countries have created an unprecedented imbalance between the young and the old. According to WHO developing countries estimates, for every baby born today there are two people over 65 years. By the year 2020 there will be four people over 65 years for every newborn. By the year 2020 the over- 65 population is projected to increase by 110% in the least developed and developing countries. A major challenge will be to address the special health needs of elderly women. Mutual co-operation and support in improving the conditions of the elderly within and between Member States and harmonised policies which will assist the elderly population to remain in good health, disability free and productive are critical.

2.7 Human Resource Development

The importance of efficient human resources within health systems is widely recognised because the workforce has the ability to make health services effective and because of the high proportion of health expenditure dedicated to personnel costs. This is of particular significance to Member States given the size of the economies and the impact of health on the economic status of the Region. The workforce can be the single most important factor influencing the success or failure of health sector reforms.

Human resource development (HRD) is concerned with the different functions involved in planning, managing and supporting the development of the health personnel within a health system. HRD aims at getting 'the right people with the right skills and motivation in the right place at the right time'.

There are several fundamental constraints to the realisation of SADC objectives for human resources, for example;

- the shortage of human resources e.g., highly trained professionals, managers and policy analysts;
- the absence of a supportive environment to reward good performance;
- the migration ('brain drain') of highly trained and mobile human resources to other SADC, OAU or industrialised countries;
- ad hoc human resource retrenchment or employment systems not necessarily linked to job performance or systematic human resource planning;
- the absence of a regional HR policy to ensure that the available health human resources are adequately utilised and distributed;

- a clear strategy of regional HR cooperation;
- inadequate personnel mix and numbers;
- inadequate skills mix in the public sector;
- low salaries and poor overall working conditions for health workers.
- lack of proper monitoring and evaluation of HR needs in relation to service delivery;
- absence of skilled personnel in HRD to forecast demand and supply; and
- rural and urban discrepancy in health personnel distribution.

2.8 Financing the Health System

Most SADC member states are faced with an array of health care financing problems that leave their health systems far from achieving the objectives of good health status, equity, efficiency, acceptability and sustainability. Health expenditure in the Region averages US $109 per capita for the six countries reported on in the World Bank Development Indicators (1998). The principal problem identified by most Member States in SADC is a shortage of government budgetary resources for health care relative to an increasing demand and need for care.

Health expenditure in Member States is higher than the rest of Africa ($23) but lower than that other regions with NAFTA spending on average $1903, the EU spending $1417, MERCOSUR $321 and ASEAN $205.

Of the Member States 3 are in the top 5 of the list of **low-income countries** and 7 (50% of Member States) are classified as low-income economies (World Development Report, 1997). The above correlates with the region's GNP per capita which is low and ranges from US$80 in Mozambique to more than $3000 in Member States like Botswana, Mauritius and South Africa (World Development Report, 1997). The GNP per capita of Seychelles is the highest at more than US$6000.

Generally, in Africa, private out-of-pocket expenditure for health account for more than 40 percent of total expenditures, government expenditures account for about 37 percent of total health expenditures and are financed largely by import duties, sales and income taxes. Donors and charitable contributions account for the remainder. Most donor funding goes to maintain capital or development budgets rather than to finance recurrent operating expenses such as salaries, drugs, equipment, and maintenance. This general pattern is true of SADC Member States although there are some inter-country variations.

2.9 Support Services

2.9.1 Pharmaceuticals

The availability and accessibility of medicines are parameters for measuring the quality of health services, which should be addressed collectively inter- and intra-regionally.

Reform of the Drug Supply Systems within the Member States present opportunities for the possible improvement of efficiencies and waste reduction to ensure access to essential medicines. Limited and partial data is a concern and may impact on attempts to improve these systems.

It is estimated that 96% of all pharmaceutical products in Africa are imported mainly from Europe and North America. Greater self-sufficiency in the production of pharmaceutical products should be prioritised. The biggest challenges to the Region are the technological limitations. There have been several initiatives aimed at harmonising labelling requirements. Collaboration with respect to control and registration of drugs needs to be strengthened between Member States.

2.9.2 Quality Assurance

The quality of care offered in any one country has an impact on the services in the rest of the Region, particularly the immediately neighbouring country. Currently mobility of populations is exacerbated by socio-economic factors such as provision of essential services. For example, populations with a higher propensity for cross-border mobility are those with a bigger differential in the provision of services, and this is particularly true for health services. The differential is not only determined by access to service points, but to a large extent by the quality of the services offered. This factor however, is extremely vulnerable to over-use, requires constant maintenance, and generally has a significant initial outlay, even though in the long term the benefits far outweigh the investment. In order to limit cross boundaries movement Member States should collaborate to ensure the provision of high quality health services in all countries in the Region.

2.9.3 Health Laboratory Services

Laboratories are an essential part of diagnostic and curative services needed in the provision of effective health care- be it at the clinic or hospital level. Health workers, need effective laboratory services to ensure that treatment is effective. In addition, laboratory services are essential in such diverse fields as food control, pollution monitoring, water quality assessment ,etc. Making these services available within the Region so that economies of scale can be realized, especially for expensive technologies, will remain a major challenge.

2.9.4 Health Information Systems

The difficulty in accessing accurate data on health inputs, outputs and outcomes was demonstrated in attempting to develop a situational analysis for this document. Whilst various sources of information exist, there is wide variation in the figures reported. In addition to the variation in the reported data, there are many gaps in the available data and the accuracy of the data is often questioned. Health information is crucial to policy development and planning as well as monitoring and evaluation of services. Therefore it is imperative that Member States develop a strategy that will result in the generation and use of better quality data in the health sector and in other sectors which impact on health status.

2.9.5 Health Technology and Equipment

Member States acknowledge that whilst they carry the burden of responsibility for the health of their citizens, a regional, coordinated approach to the use of healthcare technology will add value to their individual efforts.

In the spirit of the Harare Declaration on Health Care Technology in Africa, the following principles will guide the development of these policies:

- Advances in healthcare technology can make substantial contributions to health promotion, disease prevention, treatment and rehabilitation;

- Appropriate policy and practice offers the best hope that technology and equipment will be procured and distributed according to need and affordability and will be utilised efficiently so that they do not make excessive or inappropriate contributions to the cost of health care;

- Healthcare technology management plans which cover the life cycle of medical equipment increases cost efficiency, improves quality of care and contributes to sustainable health services; and

- Equity in access to health care and health care technologies should be promoted by improving the utilisation and distribution of health care technologies within and between public and private sectors.

2.10 Interaction between the SADC Health Sector and other Multilateral Institutions

All SADC Member States are also members of UN organisations which impact on the health sector to varying degrees. For example the WHO works exclusively in the health sector, while others may house cross sectoral programs such as Health Promoting Schools (UNESCO), nutrition and food assistance (FAO), and substance abuse (UNDCP). In addition mechanisms to coordinate the efforts of such organisations also exist e.g. the activities of WHO, WTO, FAO are coordinated through the mechanism of Codex Alimentarius with respect to food and safety.

Many SADC countries, also belong to political entities such as the OAU, the Commonwealth and the Non-Aligned Movement all of which have a growing spectrum of health related activities.

In order to benefit from the multilateral system, SADC has to be an active and informed player in the policy setting fora. With the prospect of increasing inequity in access to drugs and modern biotechnology between developed and developing countries, it is likely that such issues will continue to feature on the international health policy agenda for the foreseeable future. Other major health issues include the impending WTO service sector negotiations which will include trade liberalisation in health services and the formulation of an International Framework Convention for Tobacco Control, both of which need to be finalised by the year 2000. In addition, poverty eradication is attaining international prominence, with 1996-2005 being declared as the International Decade for the Eradication of Poverty. Given the close relationship between poverty and health, the health sector must play a leading role in these policy decisions.

3. POLICY OVERVIEW

3.1 Background

The fourteen Member States of SADC decided in August 1997 to include health in their Programme of Action by creating a Health Sector. The rationale for this was the realisation that close cooperation in this sector is becoming increasingly essential in order to address the health problems of the 190 million people of the region efficiently and effectively.

A healthy population is a prerequisite for significant economic development. Economic integration can bring many benefits, but the greater mobility of different groups of people can also contribute to the spread of infectious diseases such as malaria, cholera, tuberculosis and HIV. Close cooperation between Member States is essential to control these diseases and ensure that they do not undermine the beneficial effects of economic integration. At the same time, greater cooperation between Member States will enable them to take advantage of economies of scale in areas such as the bulk purchase of medicines and the sharing of expensive facilities and equipment. Close collaboration will also enable Member States to ensure that SADC health interests are well represented in world fora, and to share expertise and to work together to combat common diseases and other problems including: diabetes; cancers and other non-communicable diseases, and problems such as landmines, violence (especially against women and children) and drug abuse.

At present reliable data needed for rational planning of health services is often not available and data that is available is often not comparable between Member States. Nevertheless, the data that is available shows clearly that the health status for the Region as a whole is unacceptable. There are wide variations in health status between (and often also within) Member States. Infant, Child and Maternal Mortality rates, and rates of preventable diseases are all high, while rates of literacy and of access to safe water and sanitation are low. The regional health profile is also characterised by demographic and epidemiological transitions.

3.2 Goal, Principles and Policies

The **main goal** of the SADC Health Sector is to attain an acceptable standard of health for all citizens by promoting, coordinating and supporting the individual and collective efforts of Member States.

In pursuit of this goal, Member States have accepted a **draft protocol** in which they recognise certain facts and agree to act in accordance with five principles. The main policy implications can be summarised as follows.

3.3 Equality of Member States

The actions of each Member State will be guided by mutual respect for the sovereign equality of States. All Member States will actively advocate this principle as the basis for sound relationships between all States in the region, the continent, and the rest of the world. In the international arena, the Member States will strive for the formulation of health policies based on the principles of equity, solidarity, and consistency with national and regional health policies. To ensure the realisation of the above, the Region will be an active and informed player in policy setting fora and will work closely with all those who seek to advance the interests of developing nations as equals, mindful of the right of peoples to struggle for self-determination. Member States will also strive for equitable regional representation in all international health fora where such representation is considered to be in the interests of health of the people of the Region

3.4 Coordination, Sharing and Support

Reliable and comparable **data** is essential for rational planning. For the SADC Region, the data needed for health and health service planning is often not reliable nor comparable either over time or between Member States. Much of the existing data has been collected at different times by different groups for different purposes. One of the first tasks in the SADC Health Sector will be to agree on a minimum data set that each Member State will collect using agreed definitions, and to analyse the pooled data to identify regional trends and priorities.

The regional health profile is also characterised by both demographic and epidemiological transitions. Member States commit themselves to collaborative **research** in order to better understand the scope and impact of these changes on the health of citizens. Results from joint research activities will be shared and used to promote equity and to identify interventions likely to improve the health of all those who live in the Region. A surveillance centre will be established to continually up-date Member States on progress being made in health and development.

The **promotion of health** involves both health education and the promotion of healthy public policy. Member States will, through the SADC Health Sector, coordinate their health education messages and share resources for the production of appropriate educational materials to help reduce common health risks such as smoking, alcohol and drug abuse, violence and teenage pregnancy. They will also assist each other to promote healthy policies, to assess the likely impact on health of other policies, especially those proposed by donors, multinational companies or powerful trading partners, and where appropriate to present a consensus SADC view in international fora.

Resource mobilisation for health care will be a particular focus for sharing ideas and experiences. Most Member States have seen a steady decline in the public funding of health services, and a rise in private spending on health care. The combined effects of

droughts, wars, AIDS and economic reform programmes threaten the sustainability of public health financing in most countries in the Region. The progressive globalization of economies has encouraged unregulated market approaches to the delivery of health services. In certain cases this has been to the detriment of public health and has limited the ability of developing countries to take appropriate corrective action. Through the SADC Health Sector, Member States will explore ideas and international experiences both on how best to minimise the negative impact of these forces on health, and on how best to harness market forces and economic reforms in support of better health. Ideas and experience will also be shared on building partnerships with NGOs and the private sector to ensure the optimal use of resources on the one hand and that the growth of private medicine does not deplete scarce public sector resources on the other.

The impact of **donor support** for health programmes in the Region has varied. While donors in the health sector have often been coordinated around World Bank and IMF led economic reform programmes, Member States have had no mechanism to coordinate their responses. The SADC Health Sector will address this in line with national strategies for effective management of donor support. In addition, a mechanism will be created to mobilise and use certain resources from Member States and donors on selected, agreed regional programmes in the health sector.

Another area that requires coordination and sharing is **human resource development** and training. Health workers constitute a significant proportion of all persons employed in the Region with, for example, at least 250,000 nurses alone. There are multiple training programmes for health workers, wide variations in remuneration both within and between countries, and increasing movement of health workers out of public services and out of the Region to richer countries. Recognising that some movement of health personnel within the Region will contribute positively to regional integration, efforts will be made to harmonise training and registration requirements of health professionals. At the same time, Member States will coordinate policies to limit the “brain drain” both within the Region and from developing to developed countries. Every effort will be made to ensure the availability of appropriately trained health personnel to each Member State within its available resources, and to build regional capacity through preferential recruiting and supply of Technical Assistants and consultants from within SADC.

The Health Sector will work closely with the Education Sector to promote competence-based training, to strengthen the capacity of middle-level health personnel and to share capacity in different Member States to train health workers at diploma, undergraduate and postgraduate levels. There are particular needs for such training in research and in the fields of health economics, financial management, epidemiology and bio-statistics, policy development and change management. Where one Member State has to pay for its students to train in another Member State, every effort will be made to charge the same fees as are charged to local students.

Finally in the area of coordination, efforts will be made to harmonise, over time, a wide range of health related activities. These activities may include the **legal requirements and technical guidelines** for the registration, procurement and management of drugs,

medical equipment and health care technology, standards for port health, food safety, water supplies and occupational and environmental health, and clinical referral guidelines. Consideration will be given to strengthening regional capacity to regulate pharmaceutical products through establishing a single regional regulatory authority with an adequate enforcement infrastructure. Member States are committed to ensuring that all those in need have access to safe, affordable and good quality drugs and technology. **Increased capacity to produce** generic essential drugs within the Region, and **coordinated procurement** at reasonable prices, particularly of goods that cannot be produced within SADC, will both therefore be priorities for the Health Sector.

3.5 Health for All through PHC

The Primary Health Care approach recognises that the maintenance of good health is a joint responsibility between individuals, households, communitities, and governments. Within this co-operative environment however, individuals have the primary responsibility to remain healthy.

Member States are committed to the Primary Health Care approach and believe that patients should all be treated as close to their homes as possible, and in the facility and by the staff that are most appropriate to the patient's health condition. This makes high quality health care more accessible and more affordable. Referral of patients will take place between all levels of care and all types of facilities, depending on available resources and the patient's condition at the time.

Household food security, jobs, safe water supplies, housing and sanitation are all major determinants of health status that can only be addressed effectively through inter-sectoral collaboration and community participation, but many aspects of efficient health care provision also depend on other sectors such as education, telecommunications, energy and transport. Ensuring that workplaces are safe and healthy also requires inter-sectoral teamwork.

Through the Health Sector, Member States will encourage and assist each other to participate fully in existing strategies such as the Southern Africa TB Control Initiatives (SACTI) and the Mapping Malaria Risk in Africa (MARA), and to attain the World Health Organisation targets set for achieving "Health for All by 2020".

HIV/AIDS is spreading rapidly and Member States will collaborate in a number of interventions aimed at reducing the transmission of HIV and Sexually Transmitted Diseases (STDs). Member States will strive to raise public awareness of the issues, to gain political commitment at all levels for sustained action, and to foster an environment that protects and promotes the rights of all individuals be they free of, living with or vulnerable to HIV/AIDS. Research will continue in order to estimate the likely impact of HIV/AIDS on the employment and living conditions of all citizens, and the likely costs of increases in AIDS related conditions such as TB.

A related priority is the promotion of access for all to appropriate comprehensive **reproductive health services** that are integrated with other PHC services. Specific aims will include reducing maternal and perinatal morbidity and mortality (including reducing the total number of terminations of pregnancy), reducing the incidence of STDs and increasing the proportion of deliveries supervised by trained birth attendants.

Better child health will be promoted through continued attention to immunisation programmes and campaigns, the promotion of breast feeding, appropriate strategies to prevent and treat diarrhoea and acute respiratory infections, social mobilisation to eliminate (as far as possible) the abuse of and violence against children and their mothers, and ratification and implementation of international agreements such as the Convention on the Rights of the Child.

3.6 Health Care for All through better access

Each Member State will be encouraged and assisted to provide as full a range of health care services for its nationals as possible, with appropriate referral between levels of care. In addition, mechanisms will be developed or expanded to facilitate efficient **referral of patients** for tertiary care in other Member States where this is appropriate, within the requirements of port health and immigration laws. Referral back for follow-up care, reports and exchange visits will be used to ensure that capacity is developed in the referring country. Most referrals will be to tertiary care facilities, but referrals must not undermine the capacity of that country to provide care to its own citizens. In time however, Regional Centres of Excellence, funded by SADC, may also be developed in order for Member States to share scarce or highly specialised equipment or personnel.

Other mechanisms to support effective national referral systems may include linking facilities via telecommunication system, computers (telemedicine) and making provision for visiting specialists from the Region to travel within the Region to provide health care and support health workers. Member States will monitor referrals to both public and private sector providers in order to contain the spread of infections, and to ensure compliance with regional and national policies.

3.7 Promoting equity to achieve better health

Reducing inequalities in health status is both a moral imperative and a practical strategy for promoting rapid economic development. Member States are fully committed to equity, to equitable access to resources and to ensuring equal opportunities for all citizens. While the first responsibility of each Member State is to eliminate significant inequities within its borders, all are also committed to help to improve the health status of the most impoverished communities in the Region and thereby progressively to

reduce inequalities throughout SADC. The Health Sector will therefore support all efforts of Member States to prioritise access to scarce resources according to need.

Member States are cooperating in order to improve access to health care for all throughout the SADC Region. For this reason, policies that could encourage “Health tourism”, where foreigners from developed countries are encouraged to come to a developing country for health care because it is cheaper there, must be implemented with great caution to ensure that inequities are not perpetuated or even exacerbated.

INSTITUTIONAL FRAMEWORK

The following committees will be established to convene Member States and co-ordinate the functions of the Health Sector:

a) Sectoral Committee of Ministers of Health;

b) Sectoral Committee of Senior Health Officials; and

c) Sector Co-ordinating Unit.

4.1 Sectoral Committee of Ministers of Health

The Health Ministers of Member States shall be politically responsible for the development and implementation of health policies that affect the region via the Sectoral Committee of Ministers of Health to which they shall all belong. This Committee shall meet at least twice a year under the chairpersonship of South Africa. The chairperson will also present the Sectoral Annual Report to the Council of Ministers on behalf of the Sector.

The Sectoral Committee of Ministers of Health shall be responsible for:

a) providing guidance and co-ordination of policies, programmes and projects;

b) advising the Council of Ministers on health policies and strategies;

c) liaison with the SADC Secretariat on health matters; and

d) approving the Annual Report.

4.2 Sectoral Committee of Senior Health Officials

This committee shall be comprised of Senior Officials (Accounting/ Controlling Officers or their Delegate) of health in Member States and be responsible for managing the affairs of the Sector. The committee shall meet at least twice a year under Chairpersonship of South Africa before the meeting of the Sectoral Committee of Ministers of Health. One such meeting shall be held annually in March/April and will consider the Annual Report as well as consolidate preparations for the World Health Assembly. Members of this committee shall also serve as Sectoral Contact Points and are responsible for co-ordinating participation in the Sector. Each Sectoral Contact Point shall establish and maintain effective consultation with the Sector Coordinating Unit. This Committee shall be accountable to the Sectoral Committee of Ministers of Health.

The committee shall:

a) examine and approve all reports and documents developed by the Sector Coordinator, the SADC secretariat and technical sub-committees before discussion by the Sectoral Committee of Health Ministers;

b) advise the Sectoral Committee of Health Ministers on issues, proposals and projects to be presented to the Council of Ministers for approval;

c) review the Sectoral Programme of Action in order to ensure consistency with the objectives of the health sector and of SADC;

d) receive all communication from the Sector Coordinator and ensure that relevant stakeholders are informed, as appropriate, on the work of the Sector;

e) establish such Technical Committees as may be necessary and take full responsibility for their work; and

f) formalise links with existing Technical Committees and ensure their co-ordination with mainstream SADC activities both regionally and nationally.

4.3 Sector Coordinating Unit

The Sector Coordinating Unit shall be established in the Department of Health of the Republic of South Africa. The operating expenses of the Unit will be funded by contributions from Member States. The unit shall be accountable to the Sectoral Committee of Officials.

The responsibilities of the Unit include:

a) co-ordination of the Sectoral Programme of Action;

b) initiation of Sectoral Plans and projects;

c) advising Members on matters pertaining to the development of the Sector;

d) organising meetings of the Sector;

e) preparation of the Annual Sector Report;

f) drafting terms of reference for technical experts hired by the sector and managing such projects or consultants;

g) carry out decisions taken by the Sectoral Committees of Senior Officials, Health Ministers and the Council of Ministers;

h) mobilise resources for the Sector; and

i) carry out any other function that promotes the aims and objectives of the Sector.

PROGRAMME PLANS

5.1 HEALTH RESEARCH AND SURVEILLANCE

5.2 HEALTH INFORMATION SYSTEMS

5.3 HEALTH PROMOTION AND HEALTH EDUCATION

5.4 HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES

5.5 COMMUNICABLE DISEASE CONTROL

5.6 MALARIA

5.7 NON-COMMUNICABLE DISEASES AND CANCER

5.8 GERIATRICS

5.9 DISABILITIES

5.10 REPRODUCTIVE HEALTH

5.11 CHILDHOOD AND ADOLESCENT HEALTH

5.12 HUMAN RESOURCE DEVELOPMENT

5.13 NUTRITION AND FOOD SAFETY

5.14 VIOLENCE AND SUBSTANCE ABUSE

5.15 MENTAL HEALTH

5.16 ENVIRONMENTAL AND LIVING CONDITIONS

5.17 OCCUPATIONAL HEALTH

5.18 DISASTER PREPAREDNESS AND MANAGEMENT

5.19 EMERGENCY MEDICAL SERVICES

5.20 HEALTH LABORATORY SERVICES

5.21 HEALTH TECHNOLOGY AND EQUIPMENT

5.22 REFERRAL OF PATIENTS BETWEEN MEMBER STATES

5.23 QUALITY ASSURANCE

5.24 PHARMACEUTICALS

5.25 HEALTH RESOURCE MOBILISATION

5.26 INTERACTION BETWEEN THE SADC HEALTH SECTOR AND OTHER MULTILATERAL INSTITUTIONS

5. PROGRAMME PLANS

Programme 5.1: Health Research and Surveillance

5.1.1 Health Research

The main policy objective is to:

a) provide a regional framework for co-operation, sharing of experiences and collaboration in research aimed at improving health provision, planning and management as well as the control and prevention of diseases.

Priorities

i) strengthen the regional health research strategy in particular;

ii) strengthen capacity for research;

iii) promote health programme-driven research; and

iv) disseminate research findings.

Strategies

1. promote advocacy for research in general and health systems research;

2. build capacity in regional essential health research;

3. harmonise research ethical standards;

4. strengthen regional research training and internship programmes;

5. share regional research expertise;

6. co-ordinate multi-country research;

7. mobilise funding for priority health research in the Region;

8. develop a region-wide database on research undertaken; and

9. encourage and support joint enabling mechanisms to share information between Member States on health research developments.

Indicators

i) Essential Regional Health Committee established;

ii) Regional Ethics Committee established;

iii) Number of research strengthening initiatives eg. capacity development through training, use of research electronic information networks, evidence based research data bases etc. (facilitated through the ERH Committee);

iv) Priority regional research projects conducted (for Health Research and Health Systems Research);

v) Proportion of health systems research projects (identified as necessary for planning, management and programme strengthening) that are conducted in each Member State;

vi) Health Systems Research makes a difference to planning, programme management and policy (as measured by assessments that can be conducted); and

vii) Number of research publications initiated in the Region that are cited in international scientific and peer review journals.

5.1.2 Surveillance

The main policy objective is to:

a) harmonise approaches to disease prevention and control of communicable and non-communicable diseases, including health systems research in support of their control and prevention.

Priorities

i) provide information for disease control, intervention and control of epidemics as well as improved planning and management;

ii) target surveillance of HIV/AIDS, TB and STDs, malaria and other emerging and re-emerging infectious diseases;

iii) strengthen and coordinate surveillance through a Regional Surveillance Forum; and

iv) monitor priority health status indicators key national health policy strategies.

Strategies

1. strengthen national surveillance and control strategies, including plans for priority non-communicable and communicable diseases .

2. develop national strategies for effective surveillance and disease control/ intervention programmes as a basis for co-operation and growth of technical assistance.

3. establish a forum which will develop standard guidelines and policies, and facilitate exchange of surveillance training methods and skills. The forum would ensure that surveillance systems that are proposed, co-ordinated or in any way managed by implementing directorates/units in member countries are clearly integrated, co-ordinated and accessible to surveillance/information units and managers in member countries.

4. promote access to international research and results of disease surveillance, and arrange for international exchanges within the Region.

5. identify and participate in appropriate on-going initiatives e.g. the International Epidemiology Associations Regional meetings, and the Biomedical Research and Training Institute (BRTI) to further the objectives and activities of regional surveillance in both communicable and non-communicable diseases.

5.1.2.1 Surveillance of Specific Diseases and Health Issues

1. HIV/AIDS and STDs

The measurement of the incidence, prevalence and impact of HIV/AIDS and STDs is important to provide information for advocacy, planning of services and monitoring of the effectiveness of interventions. Harmonisation of HIV/AIDS/STD surveillance systems would facilitate collation of regional information, intra-regional comparisons and joint action to halt the spread of the diseases.

2. Regional TB Surveillance

Inter-state transmission of TB is common and expedited by socio-economic developments. The measurement of the incidence, prevalence and impact of TB on health is important to provide information for planning and monitoring of TB control. In line with the desire to establish a common

approach to tuberculosis control in the Region, a common approach to an effective tuberculosis information system is needed to constantly measure the burden of disease and progress being made in its control**.**

3. Communicable Diseases

The main aim of the communicable disease surveillance strategy is for early detection and to serve as a warning system for diseases, which have potential for the spread of major epidemics in the regions.

4. Malaria

The effective control of communicable diseases may include a number of strategies for example, the Mapping of Malaria Risk in Africa (MARA). The MARA project aims to plot the geographical incidence of malaria on a map so that large-scale interventions for the Region can be effectively implemented.

5. Diarrhoeal diseases

Water and food borne disease are a major cause of mortality and morbidity among children under five each year. One of the priorities of the World Health Organisation is to reduce mortality and morbidity due to diarrhoea by 50%, by the turn of the century. Common prevention strategies will be developed to effectively and efficiently deal with this important public health problem. These will interface with initiatives and program from sectors such as Water Affairs and Housing.

6. Epidemic Management

An early warning system for epidemic management will be established. This will ensure co-operation among experts in the management of different conditions and the development of common strategies for managing these epidemics. Common epidemic management protocols will be prepared.

7. Non- Communicable Diseases

Important non-communicable conditions will include amongst others the following areas:

- Nutrition related conditions (child & adult)
- Mental health
- Occupational health

- Maternal & Women's health
- Chronic diseases such as, hypertension, diabetes and cancer
- Disabilities and birth disorders
- Intentional and unintentional injuries
- survivors of landmines
- Environmental Health

8. Nutrition related diseases

There is a need to provide information mainly on child malnutrition and nutritional conditions of lifestyles in adults, e.g. stunting and weight prevalence among children under six and, obesity and diabetes among adults.

9. Substance Abuse

Surveillance on drug and alcohol abuse are relevant given the relationship between drug and alcohol abuse with HIV infection, interpersonal violence and other social problems.

10. Intentional and non intentional injuries

Violence surveillance will provide data on the prevalence and incidence of domestic violence, rape, child abuse and motor vehicle accidents on a national scale.

11. Occupational Health

Surveillance areas might include smoke intoxication, chemical and contact dermatitis and lead poisoning.

Mine accidents are another area for which the Member States need to gather relevant data in order to support interventions aimed at promoting the safety of mine workers and supporting issues related to compensation.

12. Maternal and Women's Health

Maternal and Women's health is a good indicator of the availability and quality of health care services. Surveillance of the main causes of maternal mortality will provide data to strengthen and monitor safe motherhood initiatives. Pregnancy related hypertension, peri-natal haemorrhage and septic abortions are some of the conditions of importance.

13. Chronic Diseases

Member States that are experiencing a “health transition” see changes in the patterns of disease from infectious diseases to conditions such as hypertension, diabetes and cancer. It is important to monitor these health trends as they have important economic implications

Surveillance of cancer of the cervix in women using methods such as pap smears, and lung cancer (associated with tobacco and occupational exposure) are important to monitor. Other cancers such as Kaposi sarcoma, closely associated with HIV infection, should be monitored where resources are available.

Other important chronic disease surveillance systems that should be considered would include establishing effective mechanisms to monitor the epidemiological trends of hypertensive conditions and diabetes. These conditions contribute to high mortality and disability in the SADC region, and a better understanding of their epidemiology would contribute to improved intervention and care strategies.

14. Environmental Health

Particular emphasis will be put to monitor issues related to food, air, water, soil and sanitation.

Indicators

i) Functional Regional Health Surveillance Forum established;

ii) Functional surveillance systems in place for communicable and non-communicable diseases and other priority health conditions of the Member States and Region;

iii) Functional regional early warning system for epidemic management and control;

iv) Comparable morbidity, mortality (and if possible disability) rates for HIV/AIDS, STDs, TB, Malaria, diahorrea and other conditions available in each Member States; and

v) Health status and other health information available.

Programme 5.2: Health Information Systems

The main policy objectives are to:

(a) harmonise the health information systems of the Region;

(b) ensure that data collected is accurate and used for health planning, monitoring and evaluation;

(c) share technical resources with respect to health information systems; and

(d) ensure that the use of appropriate health technologies are maximised to improve health status and health provision.

Priorities

i) strengthen national and regional health information system to serve the needs of the Region;

ii) create efficient mechanisms to share information;

iii) agree on the type of information to be shared;

iv) identify and promote the effective utilisation of telehealth, electronic mail and other technologies in and between Member States;

v) ensure basic data sets on health status and core indicators are available on the national information system networks; and

vi) integrate fragmented data and information systems into national information system which would allow a window for easy access of other information users in SADC.

Strategies

1. establish a regional health information system committee;

2. establish mechanisms for the exchange of resources and information;

3. harmonise the standards for electronic documents and develop a common data dictionary;

4. determine common formats for data exchange and a minimum data set for the measurement of health status of the SADC population;

5. develop and share appropriate, new and evolving technologies like TeleHealth and Distance Learning; and

6. establish a functional regional health information system.

Indicators

i) regional health information system committee set up.

ii) mechanism for the exchange of resources and information developed.

iii) existence of common data dictionary.

iv) mechanism for sharing appropriate, new and evolving technologies established.

v) availability of basic health data accessible from health information systems

Programme 5.3: Health Promotion and Health Education

Policy objectives are to:

a) improve and support the health of all our people through creating a social, political, economic and physical environment which helps to make health choices easy;

b) play an advocacy role for good health as a major resource for social, economic and personal development and as an important dimension of quality of life;

c) promote equity in health by reducing differences in current health status and by ensuring equity in access to opportunities and resources; and

d) promote intersectoral action because the prerequisite and prospects for health cannot be ensured by the health sector alone but requires coordinated action by all stakeholders.

Priorities

i) develop and coordinate health promotion messages in the Region;

ii) exploit the cultural diversity in the Region and use locally acceptable strategies for promoting health and empowering individuals and communities with health information in order to increase their opportunities for making healthy choices;

iii) harmonise public health policies and guidelines such as tobacco control and drug abuse, especially amongst the youth; and

iv) establish a SADC Health Promoting Schools Network.

Strategies

1. building of healthy public policy by promoting and protecting the health of the population, including the reduction of tobacco dumping;

2. creation of supportive environments by mobilising political support and resources to improve living and working conditions through intersectoral action in government, community action in the non-governmental and voluntary sectors and resources from the private sector to improve access to clean water and sanitation, electricity, safe housing, pollution-free environments, etc.

3. strengthening of community action by harnessing our rich heritage and cultural diversity to promote health in culturally acceptable ways which are also sustainable.

4. development of personal skills that empower individuals and communities through ownership and control of their own endeavours and destinies. This will be done by increasing awareness and skills regarding opportunities and choices available to improve health. Every individual must be enabled throughout life to prepare themselves for all of its stages, based on the settings where they are, such as school, home, work and the community.

5. reorientation of health services based on the primary health care approach and the district health system.

Indicators

i) Effective health promotion and education structures and processes developed and strengthened e.g. Health Promoting Schools;

ii) Appropriate health promoting legislation developed and enacted in parliament;

iii) Evidence of community participation in health promotion;

iv) Reduction in unhealthy practices e.g. substance abuse among youth and unprotected sex;

v) Adoption of harmonised regional health control measures for basic health services, safe water, sanitation, safe food and other control such as tobacco control.

Programme 5.4: HIV/AIDS and Sexually Transmitted Diseases

Policy objectives in HIV/AIDS control are to:

a) reduce transmission of HIV and STDs;

b) raise public awareness on the extent and impact of HIV throughout the Region;

c) reduce the personal and social impact of HIV infection by strengthening health and social systems;

d) ensure equitable access to comprehensive care, counselling and support;

e) protect and promote the rights of individuals, in particular those living with or most vulnerable to HIV/AIDS; and

f) mobilise resources from and forge partnerships within and outside of government to mount an effective response to the epidemic.

Priorities

i) mobilisation of societal responses to the HIV/AIDS/STD epidemic within the Region;

ii) increase HIV/AIDS/STDs surveillance, information exchange, communication and resource networks;

iii) promote efficient resource mobilisation to tackle HIV/AIDS/STDs/TB, including bulk purchasing of drugs and improved personnel utilisation; and

iv) co-ordinate regional research to inform policy development.

Strategies

1. promote the use of preventative measures including abstinence and condom use;

2. broaden the mobilisation of responses to the HIV/AIDS/STD epidemic;

3. develop a harmonised regional HIV/AIDS/STDs surveillance system;

4. improve regional advocacy efforts to increase political commitment and mobilise resources for the HIV/AIDS/STDs expanded response;

5. increase HIV/AIDS/STDs information exchange, communication and resource networks;

6. ensure bulk purchasing of HIV/AIDS/STDs/TB-related drugs for regional consumption;

7. increase awareness of the relationship between HIV and development;

8. increase involvement of people living with HIV/AIDS in policy development, planning, advocacy and education;

9. develop a mechanism to provide health services to people who move across borders; including tourists, refugees and all those who travel as part of their work; and

10. co-ordinate regional research to inform policy development.

Indicators

i) Plans from other Ministries that form part of the National HIV/AIDS Plan.

ii) National plans developed by Member States.

iii) Policies developed by Member States as set out in the Protocol.

iv) Existence of regional policies for other sectors, e.g. education, employment, mining, tourism, insurance and other financial institutions.

v) Existence of harmonized surveillance systems developed.

vi) Increased access to appropriate care for persons living with AIDS.

vii) Availability of accurate comparable regional information on HIV/AIDS and STDs.

5.4.1 Policy objectives in STDs control are to:

a) develop and implement national STD control programmes, especially syndromic management of STDs within primary health care programmes by 2000;

b) develop prevention activities targeted at specific groups such as the youth and sex workers and their clients by 2002;

c) institute mechanisms for co-ordination and integration of STD control within and outside the health sector by 2002; and

d) include STDs control in all national Reproductive Health Programmes (RHP) by 2002.

Priorities

i) develop strategic and action plans for the STD control programme.

ii) conduct programme managers' training course.

iii) review, print and distribute national treatment guidelines.

iv) review health workers' training curricula, train trainers in syndromic management of STDs, and develop training plans for the training of clinicians.

v) incorporate training in syndromic management of STDs into undergraduate and post-basic curricula of nurses and doctors.

vi) hold consultations with all service providers (within and outside of the health sector, as well as with RHPs) to identify common areas for co-ordination and integration, develop guidelines and provide appropriate training.

vii) develop strategies for screening all pregnant women for syphilis, determine laboratory support, develop guidelines, distribute test kits and STD drugs.

Strategies:

1. assess the current situation in relation to STD's;

2. build consensus and advocacy on syndromic management;

3. promote the use of preventative measures such as condom use and abstinence;

4. encourage Member States to develop and implement national STD control programmes;

5. identify steps for the implementation of targeted interventions;

6. identify mechanisms for co-ordination and integration of STD control within the Region;

7. identify mechanisms for co-ordination and integration of STD control activities within reproductive health programmes;

8. coordinate information dissemination; and

9. strengthen STDs treatment in user friendly environment.

Indicators.

i) Extent of use of preventive methods e.g. use of condoms.

ii) STD’s incidence.

Programme 5.5: Communicable Disease Control

Policy Objectives are to:

a) co-ordinate regional efforts for the control and prevention of communicable diseases of public health importance; and

b) co-ordinate regional disaster and epidemic preparedness and response.

Priorities

Overall

i) harmonisation of goals, policies, guidelines, interventions and treatment.

ii) improved communication between countries at senior and middle management level to achieve agreed goal.

iii) timely dissemination of surveillance information across borders.

Strategies

Overall

1. strengthen the capacity of programme management through training in planning, budgeting, organisation, personnel and resource utilisation;

2. devise appropriate disease surveillance strategies through the expanded routine monitoring of interventions and outcomes;

3. ensure compatibility between programmes and harmonised disease control tactics goals, policies, interventions and treatment; and

4. improve communication between countries at senior and middle management levels and then adjust priorities to reflect changing needs and circumstances.

5.5.1 Tuberculosis

Priorities

i) ensure that all TB cases are identified and effectively managed using available strategies e.g. DOTS;

ii) establishment of sufficient laboratory services with quality control to ensure accurate and rapid results;

iii) regular reliable supply of quality drugs; and

iv) improve capacity to manage HIV/TB and co-infections.

Strategies

1. harmonise the approaches to TB control via the Southern African Tuberculosis Control Initiative (SATCI) by:
   - developing and promoting common approaches in the use of guidelines for measuring the burden of disease and progress being made in TB control as well as in joint training programmes;
   - developing common methods and standards for diagnosis and quality assurance in the Region; and
   - improving communication between programme managers within Member States.

Indicator

i) Cure rate of 85% in new smear positive patients by the year 2000

5.5.2 Immunisation programme

Priorities

i) improvement of coverage for the existing EPI vaccines (BCG, OPV, DTP and measles);

ii) establishment of active surveillance structures for acute flaccid paralysis (AFP), measles and neonatal tetanus;

iii) progressive introduction of appropriate new vaccines e.g. Hepatitis B;

iv) progressive self-sufficiency in vaccines budgets; and

v) polio and measles eradication.

Strategies

1. Strengthen routine coverage by determining the catchment populations and providing friendly services, outreach programmes, and campaigns

2. Eradicate polio through collaboration in sharing technical expertise and attaining high vaccination rates through:
   - mass immunization campaigns;
   - active surveillance for cases of suspected polio (acute flaccid paralysis: AFP);
   - collaboration between laboratories; and
   - information exchange between WHO and Member State.

3. Member States with high routine immunisation coverage (>80%) for measles and a low measles case fatality rate (< 0.5%) will adopt the unified measles elimination goal of “interrupting the indigenous transmission of measles in the Region by the end of 2002” through:
   - collaboration between laboratories for diagnosis.
   - building a Southern African measles virus strain bank to identify sources of outbreaks.
   - establishing a mechanism for data sharing.
   - coordinating periodic surveillance and measles immunisation campaigns to avoid sub-regional epidemics.

4. In Member States with intermediate routine measles coverage (60 - 80%) and case fatality ratios of between 0.5 and 2 %, measles control will be accelerated through:
   - increased routine immunisation coverage by removing barriers to immunisation;
   - mass immunisation campaigns of under fives in low coverage areas; and
   - improved case management for acute measles, including Vitamin A supplementation.

5. Improve vaccine self-sufficiency as a step to ensure the full sustainability of the EPI programme.

6. Advocacy and budgeting for new vaccines (e.g. Hepatitis B and Hib).

Indicators

i) 80% of children fully immunised by 1 year of age and 90% coverage for children under 2 years.

ii) Declare polio free after finding at least one AFP case per 150 000 population and proving that they were not due to polio virus.

5.5.3 Other diseases

Priorities

i) standardization of diagnostic and reporting techniques for communicable diseases;

ii) strengthening appropriate disease control programmes in Member States; and

iii) development of rapid co-ordinated outbreak response.

Strategies

These will be tackled through:

- improved communication, consensus and harmonisation of case definitions, diagnostic techniques and reporting mechanisms, including the use of e-mail;

- ongoing joint training courses and the development of common resource material; and

- setting up a regional surveillance network which can provide updated epidemiological information on a daily basis.

Indicator

i) Member States participating in a regional surveillance network.

Programme 5.6: Malaria

The main policy objectives are to:

a) co-ordinate regional efforts for the control and prevention of communicable diseases of public health importance;

b) co-ordinate regional disaster and epidemic preparedness and response;

c) develop a regional epidemic forecasting system in collaboration with national meteorological services;

d) encourage capacity building with regards to malaria control; and

e) promote surveillance and research.

Priorities

i) At an Inter- country Level

a) harmonisation of goals, policies, guidelines, interventions and treatment;

b) improved communication between Member States at senior and middle management level to achieve agreed goals; and

c) timely dissemination of information across borders.

ii) At a National Programme Level

At a programme level, the priorities of the malaria control strategy should include the following basic elements:

a) providing early diagnosis and prompt treatment;

b) planning and implementing selective and sustainable preventive measures including appropriate and targeted vector control programmes;

c) improved use of additional preventative measures (eg bednets);

d) increased use of new technology such as GIS and remote sensing;

e) preventing, detecting or containing epidemics early; and

f) strengthening local capacities in basic and applied research that will permit and promote the regular assessment of a country's malaria situation, in particular the epidemiological, ecological, social and economic determinants of the disease

iii) At a Community Level

Components of a malaria control programme that should be concentrated at the community level include:

a) case management;

b) vector control;

c) epidemic prevention and control; and

d) integration with Primary Health Care.

Strategies

Overall

1. The capacity in programme management will need to be strengthened through training in management skills including planning, budgeting, organisation, personnel and resource management;

1.1 Appropriate disease surveillance and monitoring strategies will be devised or expanded to measure the size of the problem and monitor the outcome of interventions;

1.2 To ensure compatibility between programmes and harmonised disease control strategies, policies, interventions and treatment; and

1.3 Improved communication between Member States at senior and middle management levels is essential to monitor the priority areas and to adjust to changing needs and circumstances.

2. Malaria control and prevention will be facilitated by:

2.1 Proper case management

2.1.1 case management practices will be standardised and monitored through the development of health facility survey protocols;

2.2.2 causes of high CFR will be clearly identified;

2.2.3 therapeutic efficacy protocols will be made available to all Member States;

2.2.4 supervision at health facilities will be intensified;

2.2.5 Member States will set up a drug efficacy database and the data will be used to review and update policies;

2.2.6 standard case definitions (ranging from malaria case definitions to epidemics) will be established

3. Sharing of information

3.1 exchange of information across international borders to facilitate early detection of cases;

3.2 drug sensitivity studies will be conducted in the subregion and the results should be used in policy formulation;

3.3 use of electronic communication will be developed between the programme managers at country level; and

3.4 annual reports will be developed by the programme managers and disseminated throughout the Southern African Region.

4. Policies

4.1 standardising treatment and drug efficacy protocols to ensure comparability of results between countries;

4.2 control strategies ad procedures will be standardised in the subregion; and

4.3 the integration of the malaria control with Primary Health Care is a component of the malaria control programme that will be strengthened.

5. Training

5.1 specific training courses will be tailored for Southern African conditions;

5.2 training for vector control will be encouraged to ensure that indoor residual spraying is applied timeously and correctly resulting in it being effective;

5.3 training of field entomologists will be a priority to overcome the current shortage in capacity;

5.4 capacity and skills in mapping and GIS will be developed and field support should be given; and

5.5 training will be held for programme managers and malaria data managers

6. Operational research

6.1 drug sensitivity studies will be conducted in the subregion to determine the extent of drug resistant malaria parasites; and

6.2 field biossays and insecticide resistance studies will be conducted to monitor the susceptibility status of vectors to the currently used insecticides.

7. Advocacy

7.1 common strategies for sensitising the public to the malaria problem will be developed;

7.2 greater use of all forms of media will be encouraged and Member States will establish malaria libraries through procuring materials from WHO and other sources.

8. Personal Protective Measures

8.1 improved use of additional protective measures will be encouraged;

8.2 the feasibility of using insecticide impregnated materials will be assessed;

8.3 people at risk will be encouraged to change their behaviour to minimise exposure to mosquitoes; and

8.4 environmental management will be encouraged at a community level.

Indicators

i) The malaria mortality rate (number of deaths / total number of cases) will not be higher than 0.5%.

ii) Targets for the incidence of malaria infection will be Member State specific.

iii) Malaria specific mortality will be reduced by 50% by the year 2010.

Programme 5.7: Non-Communicable Diseases and Cancer

5.7.1 Chronic Diseases

Policy Objectives are to:

a) share scientific knowledge and technological developments;

b) assess and monitor all processes that strengthen decision making;

c) strengthen research and ensure quality health care;

d) protect the health rights of the chronically ill; and

e) encourage active involvement of patient, families and communities.

Priorities

i) Hypertension.

ii) Diabetes mellitus.

iii) Chronic respiratory disease.

iv) Cardiovascular diseases

v) Eye diseases/conditions.

vi) Epilepsy.

Strategies

1. The Primary Prevention Strategy is supportive of efforts to increase public knowledge and the ability of individuals to make healthy lifestyle choices as well as to create environments to assist individuals in making healthy choices;

2. Train health care providers in early detection and management of people with non-communicable diseases;

3. Strengthen community based rehabilitation services; and

4. Harmonise prevention strategies on non-communicable diseases focussing on diet, alcohol, tobacco control, etc.

Indicators

i) Prevalence , incidence and morbidity rates of non-communicable diseases established.

ii) Number of health personnel trained in the management of non-communicable patients.

iii) Number of community based rehabilitation programme implemented.

5.7.2 Cancer Control

Policy objectives are to:

a) increase public knowledge about cancer, e.g. lung and oesophagus cancer;

b) prevent cancer from developing;

c) diagnose cancer early;

d) provide appropriate treatment;

e) control pain and other symptoms and prevent suffering;

f) protect the health rights of the dying patient;

g) encourage active involvement of patients, families and communities; and

h) share scientific knowledge and technological developments.

Strategies

1. Train health care providers in early detection and care of women with cancer.

2. Develop sustainable programme for population-based screening, treatment and rehabilitation, and palliative and supportive care.

3. Promote health education programmes through community based organisations.

4. The Palliation Strategy is to provide access to patients at all stages of all illness at institutions and at home to allow them to have a good quality of life through symptom and pain control and to die with dignity if death is inevitable.

Indicators

a) Existence of cancer screening programmes and appropriate treatment management guidelines.

b) Prevalence and incidence rates of cancers as well as morbidity rates.

c) Number health personnel trained in cancer management.

Programme 5.8 Geriatrics (Diseases of older persons)

The main policy objectives are to:

a) share scientific knowledge and technological developments in relation to diseases/conditions of older persons;

b) assess and monitor all processes that strengthen decision making;

c) strengthen research and ensure quality health care;

d) promote health of older persons through appropriate health promotion strategies;

e) elimination of risk exposure, management and control of diseases;

f) protect the health rights of older persons ; and

g) encourage active involvement of patients, families and communities.

Priorities

(i) Arthritis/rheumatism.

(ii) Abuse.

(iii) Foot health.

(iv) Falls.

(v) Menopause/osteoporosis.

(vii) Psychogeriatric disorders.

Strategies

1. Develop prevention, management and control guidelines on diseases of older persons;

2. Strengthen community based care programmes to empower older persons as well as to provide care;

3. Prevent age related disabilities e.g. cataract blindness and deafness through curative and rehabilitative programmes.

Indicators

i) Prevalence rates of diseases of older persons.

ii) Number of personnel trained in geriatrics.

Programme 5.9 Disabilities

The main policy objectives are to:

(a) initiate or strengthen comprehensive national disability prevention and rehabilitation policies/programmes;

(b) promote the integration of community - based rehabilitation programmes into National Health Systems based on Primary Health Care;

(c) promote the training of rehabilitation personnel particularly at the community and district level;

(d) involve people with disabilities in the development and implementation of programmes on disability and rehabilitation;

(e) protect and promote the rights of people with disabilities; and

(f) equalisation of opportunities through a barrier free environment.

Priority groups

i) Children.

ii) Women.

iii) People in rural areas.

iv) Older persons.

Strategies

1. Develop more effective strategies to integrate community-based rehabilitation programmes into primary health care (PHC);

2. Develop and implement guidelines for early identification, intervention, and rehabilitation;

3. Develop human resource training strategies for all rehabilitation workers to enable them to understand the implications of the social model of disability for rehabilitation services;

4. Integration and development of appropriate rehabilitation technology and assistive devices

5. Enable people with disabilities to access communication, information and the built environment

Indicators

(i) Prevalence rates of disabilities per age group/gender.

(ii) Legislation to protect the rights of people with disabilities.

Programme 5.10: Reproductive Health

Policy objectives are to:

a) introduce and strengthen reproductive health services, including contraception services and Safe Motherhood initiatives;

b) reduce maternal morbidity and mortality due to pregnancy and childbirth;

c) decrease morbidity and mortality due to termination of pregnancy;

d) reduce perinatal morbidity and mortality;

e) increase the percentage of deliveries supervised by trained birth attendants; and

f) promote awareness of and prevent harmful effects of genital mutilation in both females and males.

Priorities

i) harmonise maternal and women's health protocols

Strategies

1. establish a Regional Reproductive Health Committee to coordinate activities in reproductive health;

2. adopt and endorse the WHO/AFRO Strategy for the African Region 1998-2007;

3. implement exchange programmes for the training of health workers in reproductive health;

4. review, reform and formulate laws to ensure that they promote the human and reproductive rights of women;

5. promote community mobilisation and advocacy for women's rights and maternal health; and

6. undertake cultural sensitive research in each Member State to determine the prevalence of genital mutilation.

Indicators:

a) prevalence of anaemia among pregnant women.

b) maternal mortality ratios.

c) contraceptive prevalence rates.

d) morbidity/mortality due to termination of pregnancy (legal/illegal).

e) adolescent fertility rates.

5.10.1 Genetic Disorders

Policy objectives are to:

a) develop and introduce a basic comprehensive genetic service for all individuals to reduce morbidity and mortality resulting from birth defects, genetic conditions and disabilities; and

b) improve the quality of life of at risk or affected individuals to enable them to live and reproduce as normally as possible.

Priorities

i) utilise population based surveys to determine the prevalence of birth defects in the Region.

ii) develop and implement birth defects surveillance.

ii) implement educational programmes and awareness campaigns.

Strategies

1. develop policy guidelines and protocols for counselling, prevention and management of birth defects, inherited disorders and disabilities;

2. develop awareness programmes using educational strategies on birth defects, inherited disorders and disabilities;

3. train health workers within a primary health care setting to provide comprehensive genetic services;

4. review and develop curricula of health workers for the inclusion of training on counselling, prevention and management of birth defects, inherited disorders and disabilities;

6. promote inter-sectoral collaboration and integration of programmes to benefit affected individuals and their families; and

7. evaluate and monitor genetic service provision through data collection and birth defects surveillance.

Indicators

i) prevalence of congenital/genetic disorders; and

ii) staff trained in genetics and rendering a basic genetic services as part of the comprehensive PHC service.

5.10.2 Cancer[6]

Policy objective is to:

a) develop and implement programmes for the early detection and management and palliative treatment of common female cancers, especially cancers of the cervix and breast;

b) develop awareness campaigns that are culturally sensitive, involving CBOs and NGOs, and women's groups; and

c) make services affordable and sustainable.

Priorities

i) screen for cervical cancer;

ii) mobilise communities for prevention of cancer of the cervix of the cervix;

iv) develop referral systems for the treatment of breast ,cervix and prostrate cancers.

[6] Cancer of the prostate inclusion in the policy document needs to be clarified.

Strategies

1. train health care providers in early detection and care of women and men with cancer.

2. develop sustainable programme for population-based screening, treatment and rehabilitation, and palliative and supportive care.

3. promote health education programmes through community based organisations.

Indicators

d) cervical cancer screening programmes and appropriate treatment management guidelines;

e) women with early stage cervical cancer (up to Stage 1); and

f) prevalence and incidence of cervical and other cancers as well as morbidity rates.

Programme 5.11: Childhood and Adolescent Health

Policy Objectives are to:

a) strengthen National Programmes in accordance with the United Nations Convention on the Rights of the Child;

b) reduce neonatal, infant, and under-5 child mortality from diarrhoeal and acute respiratory diseases;

c) reduce and prevent intentional and unintentional injuries;

d) reduce child abuse, including sexual abuse;

e) decrease and prevent commercial sexual exploitation of children;

f) curtail the prevalence of high risk sexual behaviour among adolescents; and

g) promote reproductive health awareness for young children.

Priorities

i) reduce the number of deaths due to priority childhood illnesses (diarrhoea, acute respiratory infection, malnutrition, malaria / fever, HIV/AIDS, anaemia);

ii) develop and implement a Regional Action Plan for Children as set out in the Convention on the Rights of the Child; and

iv) reduce the number of deaths caused by intentional and unintentional injuries amongst children, including such injuries as may result from child abuse and commercial sexual exploitation.

Strategies

1. harmonise and develop regional protocols to address infant and child mortality and morbidity;

2. develop and implement SADC Regional Programme of Action (RPA)

3. harmonise and develop regional policies to address child abuse and/or commercial sexual exploitation of children;

4. develop and harmonise policies on the intentional and unintentional injuries amongst children, including road safety;

5. develop a strategy for inter-country training on the Integrated Management of Childhood Illnesses (IMCI); and

6. build capacity relating to the Regional Programme of Action for Children (RPA).

Indicators

i) Number of countries that have functional integrated management of childhood illness programme.

ii) Number of countries that have expanded IMCI as a country strategy.

iii) Country specific prevalence of child abuse; and

iv) Morbidity and mortality rates for diarrhoea, acute respiratory infection, malnutrition, maternal pyrexia and anaemias among HIV/AIDS children.

5.11.1 Teenage Pregnancy

Policy objectives are to:

a) reduce teenage pregnancy rates; and

b) eliminate discrimination against teenage mothers.

Priorities

i) review of IEC materials.

ii) develop programmes for healthy lifestyle among young people.

iii) reduction by 10% of teenage pregnancy rate by year 2003.

iv) increase access to contraception services to 50% of all teenagers by year 2003.

Strategies

1. ensure life skills programmes are included in school curricula and that teachers are appropriately trained;

2. implement life skills (and particularly sexuality) education in all schools and in institutions of higher learning;

3. promote appropriate and sensitive sexuality education through Community Based Organisations (CBOs) and religious institutions; and

4. promote appropriate and user-friendly environment for teenagers seeking advice on contraception and pregnancy.

Indicators

a) teenage pregnancy rates.

b) access to contraception services.

c) prevalence/incidence of teenage pregnancy by age, geographic area, educational level and parity.

Programme 5.12: Human Resource Development

Policy Objectives are to:

a) ensure availability of appropriately trained health personnel to each Member State within available resources;

b) promote the harmonisation of education and training of health personnel by inter alia, review of curricula and the accreditation of health professionals and academic programmes;

c) establish mechanisms for student exchange programmes; and

d) strengthen undergraduate and post-graduate training.

Priorities

i) conduct Human Resources audits in Member States;

ii) strengthen and harmonise SADC Human Resources Planning Policy;

iii) promote the use of participatory learning methods in education and training health institutions;

iv) conduct an inventory of training institutions;

v) promote a caring and compassionate environment for the development of every individual within the work force; and

vi) define the roles of traditional and complimentary healers in health service delivery.

Strategies

1. improve the productivity and the quality of output of the available human resource;

2. decentralise management at all levels and improve accountability;

3. use skill mix to ensure greater flexibility of roles and functions to strive for greater efficiency and effectiveness;

4. introduce more flexible remuneration and employment packages to accommodate health personnel needs and improve staff performance;

5. strengthen staff development programmes to improve quality of performance, including career structures;

6. greater use of modern technology (TeleHealth) to ensure maximum use of regional expertise for the benefit of all Member States; and

7. develop new roles for all levels of management linked to ongoing capacity-development for acquisition of relevant knowledge, skills and values.

Indicators

i) Number of countries which have a full audit indicating the proportion of posts filled in relation to establishment targets;

ii) A harmonised human resource policy in place;

iii) Number of countries with human resource policies; and

iv) Statistics on achievements in relation to decentralisation target achievements, training against targets, etc.

Programme 5.13: Nutrition and Food Safety

Policy Objectives are to:

a) improve conditions of household food security and nutrition by supporting appropriate food systems and practices;

b) protect, promote and support breastfeeding for four to six months;

c) promote regional programmes in human nutrition and incorporate competence-based training in the curricula;

d) strengthen the capacity of middle level nutrition cadres in the Region to plan, manage and implement nutrition programmes;

e) develop a nutrition data base and provide regular updates on nutrition in the Region;

f) promote research and technical support for traditional plant and animal foods to reflect seasonal availability and use;

g) ensure collaboration in the field of food safety control; and

h) develop and implement efficient national food control systems.

Priorities

i) Develop a integrated Plan of Action for household food security and nutrition.

ii) Conduct baseline survey of national breastfeeding practices and support.

iii) Tackling protein energy malnutrition and micro-nutrient deficiencies.

iv) Capacity building through training, research, and advocacy and build national and international political commitment to food and nutrition.

v) Promote programme-driven training and research for cadres involved in food and nutrition programmes.

vi) Mobilise indigenous resources (human and material) for improved nutrition in the Region.

vii) Establish and support Nutrition Units in relevant government ministries in the Region.

viii) Promote healthy eating habits through programmes within institutions of learning;

ix) Harmonise and strengthen food-related disease investigation, surveillance and reporting systems.

x) Implement principles of Risk Analysis as well as of Hazard Analysis and Critical Control Point (HACCP) system by the relevant authorities as well as the food industry.

xi) Develop and produce appropriate material for information and training of food-handlers, particularly street-vendors, domestic kitchen workers and consumers, aimed at improving food safety and hygiene.

xii) Harmonise regional food regulations with the work of the Codex Alimentarius Commission.

Strategies

1. Develop local capacity to monitor and respond to food insecurity;

2. Strengthen community based nutrition education;

3. Formulate and implement inter-regional human resources development plans in food and nutrition.

4. Develop appropriate training materials and methods, and implement them in collaboration with relevant sectors.

5. Develop research for use in surveillance and policy development.

6. Strengthen advocacy work to and from Ministries, NGOs, private sector, and others.

7. Develop a Regional Food Safety Programme, including:

   - Assess food safety infrastructures and problems within SADC and prepare a Member State profile.

   - Formulate a Regional Food Safety Policy and Plan of Action.

   - Develop and update food safety legislation.

   - Strengthen food control systems.

- Promote Voluntary Management Systems for food safety assurance in the food sector.

Indicators

i) Existence of household food security reporting system.

ii) Existence of a national food and nutrition data base.

iii) Prevalence and incidence of stunting and wasting of children under 5 years.

iv) Existence of a regulatory framework for food and nutrition.

v) Food and nutrition control systems established.

Programme 5.14: Violence and Substance Abuse

The main policy objectives are to:

a) understand the magnitude of violence and its implications for public health;

b) set up a surveillance system for violence;

c) share training, expertise and experiences from successful programmes;

e) provide assistance following disasters or in emergencies;

f) promote qualitative and ethnographic research; and

g) co-ordinate campaigns and programmes to reduce violence.

Priorities

i) Develop suitable surveillance instruments for fatal and non-fatal injuries.

ii) Co-ordinate programmes to reduce violence against women.

iii) Prevent injuries due to landmines and provide services to victims.

iv) Develop community-based prevention programmes.

vii) Work closely with other sectors to reduce the impact of MVA's and wars.

viii) Monitor health outcomes of political violence.

Strategies

1. establish a Regional Centre for Violence Surveillance to collect and disseminate information, and undertake relevant training;

2. harmonise campaigns, legislation, and inter-sectoral actions aimed at eliminating violence against women;

3. develop strategies to remove land mines, and harmonise regulations and rehabilitation programmes for survivors of landmines;

4. develop programmes for the prevention of violence:
   - promote violence prevention in schools;

- include prosocial alternatives to violence and human rights education as part of Life-Skills training at various education levels;
- initiate WHO programme for the Enrichment of Interactions between Mother and Child;
- work with groups to develop safe communities through various community psychology and social interventions;
- run programmes with youth that are at risk for becoming violent members of society.

5. establish and support user-friendly services for the victims of abuse and violence.

Indicators

i) incidence of rape, child abuse, domestic violence.

ii) mortality and disability statistics on land mine survivors.

5.14.1 Substance abuse

The main policy objectives are to:

a) assess existing levels of psycho-active substance abuse;

b) identify primary preventive activities and share positively evaluated experiences; and

c) train staff from government and NGOs to implement primary prevention activities.

Priorities

i) Assess extent of substance abuse in the Region.

ii) Develop strategies to deal with the problem of substance abuse.

Strategies

1. transfer knowledge with regard to prevention of substance abuse among young people.

2. mobilize communities to participate and sustain project activities.

3. create networks for co-operation and communication.

4. set up regional substance abuse surveillance.

5. establish appropriate links with existing Regional initiatives such as the law enforcement agencies.

Indicator

i) trends in levels of substance abuse.

Programme 5.15 Mental Health

The main objectives are to:

a) reduce levels of stress in the Region through prevention programmes aimed at the environmental causes, as well as equip people in highly stressful situations to deal more effectively with the stressors;

b) promote the rights and conditions of people with mental illness;

c) coordinate information systems appropriate to the Region;

d) facilitate integration of mental health into primary care and encourage community level interventions through combined efforts; and

e) develop culture specific and cost effective interventions to improve mental health status of communities in the Region.

Priorities

i) Understand the underlying causes of stress in the Region and work towards the alleviation of these stressors.

ii) Develop decentralised services, including greater integration of mental health within primary health care services, to deal with stress related problems. Special emphasis should be paid to individuals and groups who have been exposed to particularly stressful situations or whose traditional support structures have been removed.

iii) Develop mutually supportive community oriented mental health services for acute and chronic psychiatric care.

iv) Co-ordinate the collection of relevant data to assist in the planning of appropriate services.

Strategies

1. Manuals and training courses developed for the specific needs of countries in the Region must be developed and shared.

2. Member States should form a Mental Health Forum to promote mental health in the Region and co-ordinate strategies to improve mental health.

3. The search for cost effective and culturally appropriate interventions must be encouraged through research.

4. The prevalence of mental health in the Region should be established through standardized epidemiological studies.

Indicators

i) Incidence and prevalence of mental illness of various types.

ii) Effective Mental Health Forum established.

iii) Number of manuals having courses developed and started.

iv) Number of cost effective and culturally appropriate interventions produced by research.

Programme 5.16: Environmental and Living Conditions

The main policy objectives which are in line with The Africa 2000 Initiatives, the Pretoria Declaration, Agenda 21, Basel and Bamako Conventions, are to:

a) improve accessibility to safe water and good sanitation through a participatory approach;

b) develop common indicators for monitoring environmental health and living conditions;

c) harmonise the management of waste including biological waste through the use of appropriate technology;

d) improve air quality through efficient use of energy;

e) improve the hygiene and safety of street vended food through the application of appropriate approaches involving the target group;

f) ensure appropriate and adequate delivery of environmental health services through better inter-departmental co-ordination;

g) harmonise legislation, use of technology and practices including the use of environmental impact assessments.

Priorities

i) adopt integrated waste management strategies, in particular hazardous waste;

ii) assess emissions and reduce Ozone Depleting Substances(ODS);

iii) human resource development in environmental and occupational health; and

iv) increase accessibility to safe water and sanitation.

Strategies

1. Implementation of Water and Sanitation Initiatives

Member States will:

- identify under-and unserved communities and take corrective action;
- harmonise legislation, use of technology and selected practices; and
- harmonise standards, procedures and monitoring practices.

2. Improved Information Systems and Expertise

Member States will:

- monitor and share data on selected environmental and living conditions; and
- harmonise port health requirements in line with International Health Regulations.

3. Rationalise Management of Waste

Member States will:

- harmonise norms and standards for Integrated Waste Management;
- pool and rationalise use of resources through adoption of an appropriate management system to deal with hazardous and biological waste; and
- ratify applicable continental and international instruments and translate these into harmonise national legislation.

4. Managing Pollution : Air, Water and Soil

Member states will:

- ensure the use of processes, activities, equipment and/or products that will reduce environmental pollution; and

- will search for and adopt appropriate, non-polluting energy sources.

5. Improve Street Vended Food

- Member States will establish mechanisms to ensure safe and hygienic preparation and sale of street vended foods.

6. Improving Skills and Expertise

Member States will:

- share scarce occupational health and safety resources as appropriate;

- conduct an audit of all occupational and environmental health resources that may have regional use and share the results of such audits with all Member States; and

- share training facilities and material by agreement.

Indicators

i) Percentage of the population with access to safe water and good sanitation.

ii) Common strategies adopted in the management of various forms of waste.

iii) Participation by communities in initiatives aimed at improving health and environment conditions established.

iv) Data on causes of mortality and morbidity in children associated with respiratory and intestinal conditions.

v) Existence of a co-ordinating mechanism in each Member States where multiple authorities are responsible for Environmental Health.

i) Mechanism for sharing expertise, research, and resources established.

Programme 5.17: Occupational Health

The main objectives are to:

a) protect the health and safety of workers through reduction of occupational injuries and diseases;

b) deliver appropriate and adequate occupational health services through better co-ordination of inter-departmental responsibilities;

d) harmonise and establish a culture of creating safe and healthy
e) workplaces;

d) develop capacity for the appropriate delivery of occupational health services; and

e) mobilise and target resources at priority problem areas in collaboration with social partners.

Priorities

i) reduction of occupational diseases and injuries.

ii) the development of coordinated occupational health services.

iii) the harmonisation of occupational health standards in the Region.

iv) the development of occupational health capacity in the Region.

v) targeting resources at prioritised areas.

Strategies

1. Reduction of occupational injuries and diseases

a) Member States will ensure that employers provide safe and healthy workplaces.

b) Ensure the safety of anybody outside the workplace who may be affected by the hazards from that workplace.

c) Ensure that employees cooperate with employers in complying with occupational health standards.

d) Harmonisation of data gathering systems for occupational diseases and injuries.

e) Ensure that penalties for non-compliance with legislative standards are having a deterrent effect.

f) Member States will ensure that employers consult with employee representatives on health and safety issues and that employees are supplied with protective clothing and equipment where appropriate.

g) Ensure continuity of care for affected employees.

h) Member States will establish mechanisms to facilitate cooperation in developing occupational health research programmes and share the results of the research.

2. Co-ordinated Occupational Health Service delivery

A coordinating mechanism will be established in each Member State, where needed, to facilitate the co-ordination of occupational health services.

3. Standard setting

a) Member States will collaborate to ensure the harmonisation of occupational health standards.

b) Develop systems for the identification and monitoring of Occupational diseases

c) A Standards Committee will be established to ensure harmonisation of standards.

4. Capacity development

a) Member States will share scarce occupational health resources as required.

b) An audit of all resources will be conducted and shared with all Member States.

c) Member States will share training facilities and material by agreement.

5. Targetting resources at prioritised problem areas

a) Member States will cooperate in the development and implementation of special programmes to target prioritised problems of the Region.

Indicators

i) Worker occupational public health services established.

ii) The existence of a programme on occupational health.

iii) Existence of administrative system for occupational diseases and injuries compensation.

Programme 5.18: Disaster Preparedness and Management

Disaster Management

The main policy objectives in line with WHO Guidelines are to:

a) ensure that disaster awareness and preparedness plans are developed in order to be able to deal efficiently and effectively with the impact of disasters when they occur;

b) develop emergency medical services which will assist in the immediate management, containment and cost effective overall management of disasters;

c) develop counselling and support services and organisations which can assist those who survive disasters, particularly where the disaster is long term and communities are prevented from normalizing their lives;

d) assist with programmes to deal with the effects of a disaster; and

e) establish a coordinating structure to produce plans for stand-by disaster assistance and management in the Region.

Priorities

i) Ensure disaster preparedness and response plans are developed by appropriate agencies.

ii) Promote public awareness programmes.

iii) Define a mechanism for inter-country rendering of assistance, including access to emergency medical services.

Strategies

1. develop policies, plans, and legislation for disaster prevention, mitigation, preparedness, response, relief and rehabilitation;

2. establish a forum of multi-sectoral officials to maintain inter-country liaison and to facilitate the development of coordinated disaster management plans;

3. develop a local and regional early warning system encompassing risk analyses and monitoring trends;

4. develop public awareness, preparedness and response programs, especially to reach the most vulnerable people;

5. produce operational procedures for effective mobilisation of resources for inter-country assistance in times of a disaster.

6. strengthen emergency medical services so that they can deal with mass casualties, and then rescue, treat, stabilize and transport patients to health facilities.

Indicators

i) A regional disaster management strategy in place.

ii) Availability of legislation and regulatory procedures for disaster management.

Programme 5.19 Emergency Medical Services (EMS)

The main policy objectives are to:-

a) develop accessible and equitable emergency medical services that can deal with day to day medical emergencies particularly, obstetric and paediatric emergencies, land mines, and road traffic accidents;

b) harmonise definitions, norms and standards on the sustainable delivery of emergency medical services; and

c) develop within SADC patient referral systems linked with the needs of the tourist industry.

Priorities.

Produce norms and operational procedures.

Strategies

1. develop appropriate policy, legislation, scope of practice, personnel norms, service level norms, training curricula and operational procedures relevant to emergency medical services;

2. harmonise procedures for equipment, vehicles, and the training of staff used in emergency medical services;

3. establish communication centres for the control and coordination of emergency medical services – including toll free, medical emergency telephone numbers, emergency call boxes, and others;

4. develop bilateral agreements on cross-border assistance in the event of a disaster; and

5. establish an emergency fund to provide for preparedness, resources and relief.

Indicators

i) The existence of service level norms and operational procedures on emergency medical services.

ii) Functioning dedicated EMS vehicles with appropriate staff trained.

iii) Training centres and programmes for EMS personnel established.

iv) Existence of communication centres for the control and co-ordination of EMS.

Programme 5.20: Health Laboratory Services

The main policy objectives are to:

a) develop regional strategies for communicable and non- communicable disease laboratory services;

b) establish a network of reference laboratory services for the Region (e.g., polio, measles, etc);

c) develop a regional policy for laboratory accreditation including blood transfusion services;

d) develop a policy on the supply and quality control of blood and blood products; and

e) harmonize technical laboratory personnel competencies and accreditation of personnel and training institutions.

Priorities

i) Situation analysis of laboratory health services.

ii) Harmonise guidelines for good laboratory practice.

Strategies

1. harmonise methodology, technology and quality assurance on laboratory service;

2. evaluate policies and programmes and agree on minimum standards for implementation;

3. develop a regional policy on blood transfusion services and standards for practice;

4. develop appropriate curricula with minimum standards on training of personnel; and

5. establish a regional database for priority diseases.

Indicators

i) Regional policy and guidelines on blood transfusion services available.

ii) Regional guidelines on laboratory safety, quality control and good laboratory practice established.

iii) Each Member State has protocols for laboratory safety and procedures.

iv) Harmonised competencies required for laboratory personnel.

Programme 5.21: Health Technology and Equipment

The main policy objectives are to:

a) develop and implement harmonised health care technology policies; and

b) co-operate on the acquisition, management and utilisation of health technology and equipment.

Priorities

i) Essential Equipment Lists for Primary Health Care Facilities;

ii) Harmonise training in the utilisation and maintenance of health technology and equipment;

iii) Regulate registration of medical devices and radiation control.

Strategies

1. develop, in line with WHO guidelines, non-prescriptive, essential equipment lists for different levels of care and preparation of programmes for their application;

2. ensure the existence of highly specialised services in the Region consistent with requirements for self sufficiency and recognising the variable availability of trained human resources, avoid unnecessary duplication in the provision of sophisticated and expensive health technology and equipment.

3. strengthen national capacity for evidence based health care technology assessment and improve regional capacity for health care technology management by developing training programmes for health professionals in the utilisation and maintenance of health technology and equipment.

4. harmonise regulations for the registration of medical devices and for radiation control.

Indicators

i) Essential Equipment Lists for Primary Health Care Facilities.

ii) Utilisation of selected highly specialised services determined.

iii) Number of personnel trained in the use and maintenance of health technology and equipment.

iv) Existence of regulations for the registration of medical devices and for radiation control.

Programme 5.22: Referral of Patients between Member States

The main policy objectives

a) Member States are committed to the PHC approach and believe that patients should all be treated as close to their homes as possible, and in the facility and by the staff that are most appropriate to the patient's health condition. Referral of patients must take place in both directions between all levels of care and all types of facilities, depending on the available resources and the patient's condition at the time.

b) Notwithstanding the need and desire to develop Centres of Excellence for the SADC Region in different fields in different countries, and the need to avoid unnecessary and costly duplication of highly specialised services, all Members are committed to developing services in their own countries, including a range of primary, secondary and at least some tertiary health care services and to assisting each other to do so.

c) Monitor all referrals between Member States to both the public and the private sectors in order to identify contacts and to prevent the spread of infections.

d) "Health tourism" policies whereby foreigners are treated in a developing country because it is cheaper would be implemented with great caution to ensure that inequities are not perpetuated.

e) Self-referral for non-emergency health care in another Member State will be discouraged where this tends to overload public services or can lead to an imbalance between public and private sectors.

Priorities

i) Agree on a common set of definitions related to specialist and tertiary care.

ii) Conduct an audit of current capacity to provide specialist and tertiary care;

iii) Develop clinical guidelines, criteria and pathways for appropriate referral to specialist and tertiary care services;

iv) Develop strategic plans for the establishment of good general specialist services and, where appropriate, tertiary care services.

v) Discuss strategic plans and explore ways of assisting each other to realise these plans.

Strategies

1. develop a rational network of facilities with clear lines of referral between different levels of care;

2. develop clinical protocols or guidelines, and procedures, for the referral of patients within that country, and from other Member States;

3. designate one or two offices (offices of the medical superintendent of their main hospital) to act as the authorised referring offices for that country. Recipient countries will, in the same way, authorise certain persons to accept referrals and to ensure that correct procedures are followed;

4. Patients referred from other countries can be accepted provided:
   - the numbers are not so large that they begin to limit the availability of any services to citizens of the host country;
   - there is a clear system for authorising referral, for accepting a patient and for arranging visas if necessary;
   - the government of the referring country accepts responsibility for ensuring that full payment is made for any patient for whom it requests referral and treatment; and
   - the appropriate letter, clinical notes and the results of investigations accompany each patient who is referred, in both directions;

5. develop strategies to monitor and regulate the numbers of non-SADC patients especially from developed countries consulting private providers or using private facilities, and to ensure that these patients are not depriving citizens of access to services; and

6. develop strategies to monitor the use of public health facilities by tourists in order to ensure that tourists are not abusing access to local health services.

Indicators

i) Maps for the whole Region developed showing clear lines of referral between health facilities.

ii) Guidelines for the referral of patients with selected clinical conditions developed.

iii) Number of patients in different diagnostic categories referred to and from other Member States in the previous 12 months.

iv) Numbers of person's a) from other SADC countries and b) from non SADC countries, using public and private health care facilities each year.

Programme 5.23: Quality Assurance

The main policy objectives are to:

a) facilitate a uniform quality assurance system.

b) develop a standard monitoring system for quality assurance.

c) facilitate and define mechanisms for standard referral systems between Member States.

d) adopt quality assurance as a basic feature in the training for, and rendering of, health care services.

Priorities

i) Define quality assurance parameters for the Region.

ii) Harmonise protocols for the attainment of regional quality assurance.

Strategies

1. develop a critical mass of expertise in quality assurance for the Region;

2. develop uniform standards to ensure quality health care;

3. develop common indicators to measure compliance to a quality assurance system, and to monitor progress made;

4. establish mechanisms to identify obstacles to quality assurance implementation as well as indicate corrective action;

5. harmonise all quality assurance interventions that have the highest potential of influencing the health of the population;

6. facilitate the exchange of students and health professionals for skills transfer;

7. institutionalise and recognise specialization in quality assurance in Ministries and in academic and health care institutions; and

8. facilitate the sharing of experiences between and among Member States.

Indicators

i) Quality assurance unit/individual in each Member State established.

ii) Member States have a functional monitoring system in place.

iii) Common regional indicators (core set) and standards in place.

Programme 5.24: Pharmaceuticals

The main policy objectives are to:

a) ensure adequate supply of affordable drugs by rationalising and maximising the production capacity of the local and regional pharmaceutical industry of generic, essential drugs;

b) promote joint procurement of therapeutically beneficial medicines of acceptable safety, proven efficacy and quality to the people who need them most at affordable prices;

c) promote the adoption of regional standard treatment guidelines;

d) strengthen the regulatory capacity, supply and distribution of basic pharmaceutical products through ensuring a fully functional regulatory authority with an adequate enforcement infrastructure;

e) develop a competent pharmaceutical support personnel through training in Drug Supply Management; and

f) respond to the pharmaceutical needs of regional health programmes.

Priorities

i) Urge all Member States to develop appropriate national drug policy in line with WHO guidelines.

ii) Promote a regional essential medicines and supplies service and technical and administrative support for the procurement, supply and distribution services.

iii) Establish a regional drug procurement unit for carefully selected, high priority essential drugs and coordinate regional procurement and distribution activities so as to bulk purchase and achieve economies of scale.

iv) Promote the harmonisation of regional drug regulatory authorities.

v) Strengthen regional registration and quality control processes of pharmaceutical products.

Strategies

1. harmonise pharmaceutical market intelligence within the region and improve access to pricing information of raw materials, basic intermediaries and packaging materials for the production of essential medicines;

2. rationalise and maximise the production capacity of the local and regional pharmaceutical industry and identify the production types that are economically and financially feasible;

3. adopt regional guidelines and management protocols that promote best medical and clinical practice;

4. promote economic evaluation to ensure the best optimal therapy at the best possible price for the Region;

5. develop strategies for the reduction of inter- and intra-regional pilferage and wastage of medicines;

6. harmonise operating procedures and guidelines on good manufacturing practices, laboratory practices and clinical practices and

7. develop technical support and capacity to control illicit and counterfeit medicines.

Indicators

i) Regional drug procurement unit established.

ii) Regional guidelines and protocols for GCP (Good Clinical Practice), GLP (Good Laboratory Practice) etc, developed.

iii) System to monitor in collaboration with Law Enforcement Agencies, inter and intra regional pilfering of medicine established.

iv) Mechanism established to monitor and control production, use and distribution of counterfeit medicines.

Programme 5.25: Health Resource Mobilization

The main policy objectives are to:

a) mobilise resources from governments in the region, multi-lateral and bi-lateral donors to fund regional priority programmes;

b) ensure availability of adequate and sustainable resources to finance the health systems;

c) reallocate resources to enhance efficiency and cost-effectiveness of public health spending;

d) create partnership with the private and NGO sectors to ensure that resources are optimally used; and

e) create mechanisms that ensure financial accountability within regional programmes.

Priorities

i) Harmonise approaches to donor financing of health services including facilities, equipment and supplies.

ii) Integrate and mobilise regional health resources in line with SADC economic and commercial policies.

Strategies

1. introduce appropriate mechanism for public sector funding ;

2. demonstrate to Finance Ministries that investing in health promotes positive development within Member States, hence health budgetary allocation should be increased.

3. work with the private sector to identify and develop tools for appropriate public-private mix including beds, personnel, equipment etc;

4. generate revenue, where appropriate, to improve the financial sustainability and performance of the health care system;

3. improve cost efficiency of health systems by:
   - improved training and financial management;

- eliminating waste and duplication; and
- eliminating corruption

6. develop regional plans that may be funded by donors; and

7. convene an annual meeting of donors to review existing plans and identify future activities to be funded.

Indicators

i) Amount of revenue generated over and above the current yield.

ii) Amount of funds donated for health services such as personnel, clinics, hospitals, equipment.

iii) Amount saved by using resources in the public and private sector.

iv) Proportion of Health Departments with audited financial statements.

Programme 5.26: Interaction between the SADC Health Sector and Other Multilateral Institutions

The main policy objectives are to:

a) influence the formulation of international health policies based on the principles of equity, solidarity, and consistent with national and regional health policies;

b) coordinate and maximise multilateral and bilateral donor responses to regional health priorities, and in so doing, reap the benefits accruing through the economies of scale and the sharing of information and experiences;

c) mobilise the appropriate human and technical resources in support of the rendering of health services and regional training institutions; and

d) harmonise regional and international research agendas in the pursuit of affordable solutions to regional health priorities.

Priorities

i) Assess the availability of resources to support the development of regional health policies and programmes.

ii) Develop strategies for the effective mobilisation and use of resources for health development in the Region.

Strategies

1. equip SADC representatives to sit in appropriate international committees and to ensure that the concerns of Member States are adequately represented;

2. representatives of Member States should meet prior to international meetings and prepare a common informed and well articulated position of SADC;

3. the policy position taken by SADC health representatives should be based on agreed upon policies and protocols;

4. engage with appropriate national representatives and international organisations to ensure that trade liberalization does not affect the health services in the region;

5. advocate and develop mechanisms to minimise the negative impact of unregulated market approaches to health;

6. establish effective systems for the dissemination of information;

7. facilitate a regional approach to multilateral or bilateral donors in pursuit of solutions to Member States needs; and

8. promote the use of local suppliers, institutions and consultants in meeting the Regions health needs where appropriate.

Indicators.

i) Existence of mechanisms for information dissemination.

ii) Number of regional positions presented to Afro/NAM/WHA.

iii) Existence of a regional approach to multilateral/ bilateral donors.

GLOSSARY

Disaster
A disaster is an unplanned event, which causes disruption of such a nature that local resources are inadequate to manage the effects of the disaster. Disasters take many forms and can include drought, floods, earth quakes, epidemics, major accidents, mass poisonings and civil unrest. If any disaster is so great that the resources of that country are inadequate to manage the effects, then that country must be able to call on other countries for assistance.

Health Promotion
Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well being.

Risk Analysis
A process aimed at promoting consistency and transparency, and which consists of three components, namely: risk assessment, risk management and risk communication.

Hazard Analysis and Critical Control Point (HACCP)
A system which identifies, evaluates and controls hazards which are significant for food and safety.