

# Advancing Health Rights Through Oversight: SADC-PF's SRHR and HIV Governance Framework

<sup>\*1</sup>Jacob Ntsholeng Segale., <sup>2</sup>Munashe Tofa, <sup>3</sup>Boemo Sekgoma, <sup>4</sup>Krishna Seegobin

<sup>1</sup>M&E Manager SADC PF SRHR Project

<sup>2</sup>Climate Change Manager SADC PF SRHR Project

<sup>3</sup>Policy and Legal Advisor SADC PF SRHR Project

<sup>4</sup>Secretary General SADC PF

**\*Corresponding Author**

DOI: <https://doi.org/10.47772/IJRISS.2026.100400212>

Received: 08 April 2026; Accepted: 14 April 2026; Published: 02 May 2026

## ABSTRACT

This article examines the role of parliamentary oversight in advancing Sexual and Reproductive Health and Rights (SRHR) and HIV governance within the Southern African Development Community (SADC) region. Utilising a qualitative, document-based methodology, the study conducts a descriptive and comparative analysis of programme implementation data from the SADC Parliamentary Forum (SADC-PF) SRHR, HIV, and AIDS Governance Project (October 2024 to November 2025). The analysis, supported by data triangulation and thematic coding in Atlas.ti 24, reveals that regional-level institutional strengthening and capacity-building initiatives anchored on SADC-PF's model laws, peer-learning platforms, and regional norms serve as conduits through which national Parliaments can enhance their legislative, budgetary, and oversight functions. Without this regional catalyst, national-level capacity-building alone is insufficient to drive harmonised, sustained health governance reform. The findings demonstrate significant achievements in legislative reform, increased health budget allocations, and strengthened accountability mechanisms across 13 member parliaments. This Article introduces a conceptual framework derived from the SADC-PF's approach, illustrating the causal pathway from capacity-building inputs to tangible governance outcomes and, ultimately, the advancement of health rights. The study concludes that regional parliamentary forums are critical platforms for harmonising norms, fostering peer learning, and catalysing national-level reforms, thereby creating a more conducive environment for the realisation of universal access to SRHR and HIV services, in alignment with SDG 3. This research provides a replicable model for parliamentary strengthening and offers evidence-based recommendations for enhancing health governance in the Global South.

**Keywords:** Parliamentary Oversight; Health Governance; SRHR; HIV/AIDS; SADC; Legislative Reform; Health Financing; Accountability.

## INTRODUCTION

The pursuit of universal health coverage and the realisation of health as a fundamental human right remain central challenge for many nations, particularly in the Global South. Within the Southern African Development Community (SADC), a region disproportionately affected by the HIV epidemic and persistent challenges in Sexual and Reproductive Health and Rights (SRHR), the role of robust governance structures is increasingly recognised as a critical determinant of health outcomes (SADC-PF, 2025). Whilst health systems strengthening often focuses on service delivery and infrastructure, the political and institutional dimensions of health governance particularly the functions of national parliaments are foundational to creating sustainable, rights-

based health ecosystems. Parliaments, through their legislative, budgetary, and oversight mandates, possess the constitutional authority to shape policy, allocate resources, and ensure accountability for public health commitments (Oronje & Zulu, 2018).

However, the potential of parliaments to drive the health rights agenda is frequently constrained by a lack of technical capacity, limited access to evidence, and the complexities of navigating sensitive political terrain (Rugumamu, 2011). In response to these challenges, the SADC Parliamentary Forum (SADC-PF), with support from the Government of Sweden, has implemented a multi-year project aimed at strengthening the capacity of national parliaments to effectively govern the response to SRHR and HIV. This initiative represents a significant regional effort to institutionalise health as a governance priority and to empower parliamentarians as champions for the rights of their constituents.

The SADC region faces unique and pressing health challenges. The HIV prevalence rate in Southern Africa remains the highest in the world, with countries such as Eswatini, Lesotho, and Botswana experiencing adult prevalence rates exceeding 20% (UNAIDS, 2023). Recent analyses from 2025 and 2026 continue to highlight the urgent need for integrated strategies that link HIV prevention with broader SRHR services to meet the ambitious goal of ending AIDS by 2030 (Chola et al., 2026; WHO, 2025). Concurrently, the region grapples with high maternal mortality rates, limited access to comprehensive sexuality education, and persistent gender-based violence, issues that are exacerbated by socio-economic inequalities and political instability (Baatsen et al., 2025). These health challenges are not merely medical issues but are deeply rooted in social, economic, and political structures that perpetuate inequality and marginalisation. Addressing them requires a multi-sectoral approach that recognises the centrality of governance and the rule of law.

This article analyses the approach and impact of the SADC-PF's SRHR, HIV, and AIDS Governance Project. Specifically, it is centered on providing a comprehensive response to the question on the relevance of a regional inter-parliamentary body in adding unique value beyond what national-level parliamentary strengthening alone could achieve. To that end, the article argues that the value proposition of SADC-PF lies in its strategic positioning as a funnel for translating regional aspirations espoused in SADC Protocols and Model Laws, technical expertise and peer accountability mechanisms into domestic legislation and policy frameworks, budgetary reforms and incisive oversight on the Ministries, Departments and Agencies of the State and Government. The article further argues that bypassing this regional layer would culminate in fragmented national-level implementation which, in most instances, will be at odds with the broader SADC regional integration agenda.

Additionally, it seeks to understand how a regional inter-parliamentary body can catalyse national-level change and contribute to the broader goals of health equity and human rights. To do so effectively, the article examines programme implementation data from October 2024 to November 2025 and provides a contemporary analysis of the mechanisms through which parliamentary oversight can be enhanced and translated into tangible improvements in health governance. The central argument is that strengthening parliamentary functions is a high-yield investment for advancing health rights, and that regional platforms such as the SADC-PF play an indispensable role in this process. The article develops and presents a conceptual framework based on the SADC-PF's multifaceted approach, offering a model for understanding and replicating successful health governance interventions in other contexts.

## **Theoretical Background: Parliaments and Health Governance**

The theoretical foundation for this study draws from the literature on democratic governance, health systems strengthening, and regional integration. Parliaments are, by design, the primary institutions of representative democracy, tasked with translating the will of the people into law and policy. In the context of health, this means that parliaments have a constitutional responsibility to ensure that the health needs and rights of citizens are reflected in national legislation and adequately resourced through the budget process (Oronje & Zulu, 2018). However, the effectiveness of parliaments in fulfilling this responsibility varies widely, influenced by factors such as the political system, the strength of civil society, and the capacity of individual parliamentarians.

Rugumamu (2011) argues that capacity development is particularly critical in fragile or developing contexts, where parliaments may lack the technical expertise and institutional infrastructure to effectively perform their

functions. His research on African parliaments highlights the importance of targeted interventions that build both individual and institutional capacity. These interventions can include training programmes for MPs and parliamentary staff, the provision of research and analytical support, and the strengthening of parliamentary committees. The SADC-PF project embodies this approach, providing a comprehensive package of support designed to enhance the capacity of parliaments to govern the health sector.

Notably, the article seeks to address the theoretical gap extant in the question of vertical subsidiarity versus horizontal diffusion in parliamentary strengthening. As evidenced by analysis of publications by various scholars (Oronje and Zulu, 2018; Rugumamu, 2011), the literature focuses on capacity-building interventions at the national parliamentary level, treating regional bodies as optional add-ons. Therefore, the import of this article is to challenge this notion by highlighting the strategic relevance of regional parliamentary bodies. That is why it is also anchored on the regional integration theory as posited by Godsäter, 2015 and soft-power parliamentary diplomacy (Leibrandt-Loxton, 2022), and further proposes a model of governance that recognizes SADC-PF as an active norm entrepreneur that produce model laws, generates peer-review pressure, and creates collective accountability mechanisms. These regional inputs are then domesticated through national parliaments. Without this regional layer, national parliaments lack the harmonised standards, comparative evidence, and political cover needed to advance SRHR reforms, which in some contexts are contentious.

The role of regional bodies in facilitating policy diffusion and harmonisation is another key theoretical lens for this study. Godsäter (2015) examines the role of civil society in regional governance within SADC, highlighting how regional platforms can serve as spaces for knowledge production and issue-framing. Similarly, Leibrandt-Loxton (2022) explores the concept of “soft power” in multilateral parliamentary diplomacy, arguing that regional parliamentary forums can influence national policy agendas through agenda-setting and norm-building. The SADC-PF’s use of model laws exemplifies this soft power approach, providing a regional standard that member states can voluntarily adopt and adapt to their national contexts.

Finally, the literature on health governance increasingly emphasises the importance of multi-stakeholder engagement and the integration of evidence into policymaking. Opondo, Maina, and Munyasia (2024) argue for a holistic “ecosystem approach” to SRHR policy, one that brings together government, civil society, academia, and communities in a collaborative effort to advance health rights. This approach recognises that no single actor can address the complex challenges of SRHR alone and that sustainable change requires building broad-based coalitions of support. The SADC-PF project’s emphasis on National Working Groups and tripartite consultative councils reflects this ecosystem approach, creating institutionalised platforms for dialogue and joint action.

## MATERIALS AND METHODS

This study employs a qualitative, document-based research design to conduct an in-depth analysis of the SADC-PF SRHR, HIV, and AIDS Governance Project. The research is centred on a descriptive and comparative analysis of programme implementation data from October 2024 to November 2025. This timeframe provides a rich dataset for assessing progress, challenges, and emerging outcomes from the project’s second year of implementation. While the study primarily relies on the project’s annual report, it incorporates a comparative analytical lens and data triangulation to enhance methodological rigor and broaden the generalisability of the findings.

### Data Sources and Triangulation

The primary data source for this research was the SADC-PF SRHR, HIV & AIDS Governance Project Annual Report for 2024-2025. This comprehensive 68-page report serves as a repository of programmatic data, including performance metrics, country-specific achievements, and financial records from the 13 participating national parliaments. To mitigate the limitations of relying on a single secondary data source, a process of data triangulation was employed. The findings, case studies, and claims within the SADC-PF report were systematically cross-referenced with other publicly available documents. These supplementary sources included national health strategies from member countries, official parliamentary records (Hansards), and global reports from international bodies such as the World Health Organization (WHO) and UNAIDS. This triangulation process served to validate the report’s data and place the project’s achievements within a broader national and international context, thereby strengthening the credibility of the analysis.

---

## Data Analysis

The data analysis process integrated both quantitative and qualitative techniques. The quantitative data within the report, such as performance achievement rates and budget increases, were extracted and re-analysed to create a series of visualisations. These visualisations were developed using advanced image generation tools to ensure a high-quality, professional presentation suitable for publication, and they serve to illustrate key trends and comparative outcomes.

The qualitative data, comprising case studies from (Lesotho, Mauritius, Zambia and Democratic Republic of Congo), narrative descriptions of legislative reforms, and stakeholder accounts, were analysed using a thematic approach. The analysis was conducted using Atlas.ti 24, a leading qualitative data analysis software package. An inductive coding process was employed, allowing themes to emerge directly from the data. The initial open coding of the 68-page report and supplementary triangulated documents (including Hansard records from the parliaments of Angola, DRC, Eswatini, Lesotho, Malawi, Mauritius, Madagascar, Mozambique, and Zambia Zimbabwe) generated 112 initial codes. These codes were then consolidated and categorised through axial coding, resulting in 15 code groups (e.g. 'Budgetary Influence', 'Legislative Amendment', 'Civil Society Partnership'). Finally, these groups were synthesised into 5 overarching themes that form the analytical backbone of the results section:

1. Institutional Mobilisation,
2. Legislative Reform and Harmonisation,
3. Budgetary Oversight and Influence,
4. Multi-Stakeholder Collaboration, and,
5. Adaptive Management in Response to Challenges.

This systematic process, facilitated by Atlas.ti, allowed for a rigorous and transparent analysis of the rich textual data, ensuring that the interpretation was firmly grounded in the source material.

A comparative analysis was then conducted across the country case studies. This involved systematically comparing the strategies, challenges, and outcomes in different national contexts to identify common success factors and context-specific variables. This comparative dimension elevates the analysis beyond a simple description of a single project, allowing for more generalisable conclusions about the mechanisms of parliamentary strengthening in the SADC region.

## Framework Development

A key methodological step was the development of a conceptual framework based on the SADC-PF's approach. This framework was inductively derived from the thematic and comparative analysis of the project's activities and Theory of Change. It aims to provide a clear, visual representation of the project's logic and the causal pathways through which parliamentary oversight contributes to the advancement of health rights. The framework serves as both an analytical tool for this study and a potential model for future health governance interventions.

## Ethical Considerations and Limitations

This study is based entirely on secondary data from publicly available reports and academic literature. No primary data collection involving human subjects was conducted. Therefore, formal ethical approval was not required. The primary limitation of this study is its reliance on secondary data from a single project, which may introduce reporting bias and limit the generalisability of the findings. The use of data triangulation and a comparative analytical approach were deliberate methodological choices to mitigate these limitations. A dedicated limitations section in the discussion further explores these issues and their implications for the interpretation of the results.

## Results

The analysis of the SADC-PF project data from October 2024 to November 2025 reveals significant progress in strengthening parliamentary governance for SRHR and HIV across the region. The results are presented in four main sections: overall regional performance, key institutional achievements, legislative and budgetary outcomes, and detailed country-specific case studies. These findings demonstrate the tangible impact of the project’s interventions on the capacity and effectiveness of national parliaments.

### Overall Regional Performance

The project’s performance framework measures the achievement of seven key outcomes, ranging from institutional management to evidence-based governance. The data indicates a strong overall performance, with a regional uptake of 75-80% across the core governance outcomes (Outcomes 2-7). This suggests that the project has been highly effective in engaging member parliaments and fostering the adoption of its strategic priorities. However, the performance of Outcome 1, which relates to the internal management of the SADC-PF itself, was lower at 56%. Whilst this still falls within the ‘moderate performance’ tier, it indicates a need for continued institutional strengthening within the Forum to ensure it can effectively support its member parliaments.

Figure 1 indicates the performance achievement rates for each of the seven project outcomes. It highlights the strong performance in the core governance areas (Outcomes 2-7), with achievement rates between 75% and 80%, demonstrating widespread adoption of the project’s strategic priorities. In contrast, Outcome 1 (Management) shows a lower but still moderate performance at 56%, suggesting the need for continued institutional capacity building within the SADC-PF itself.

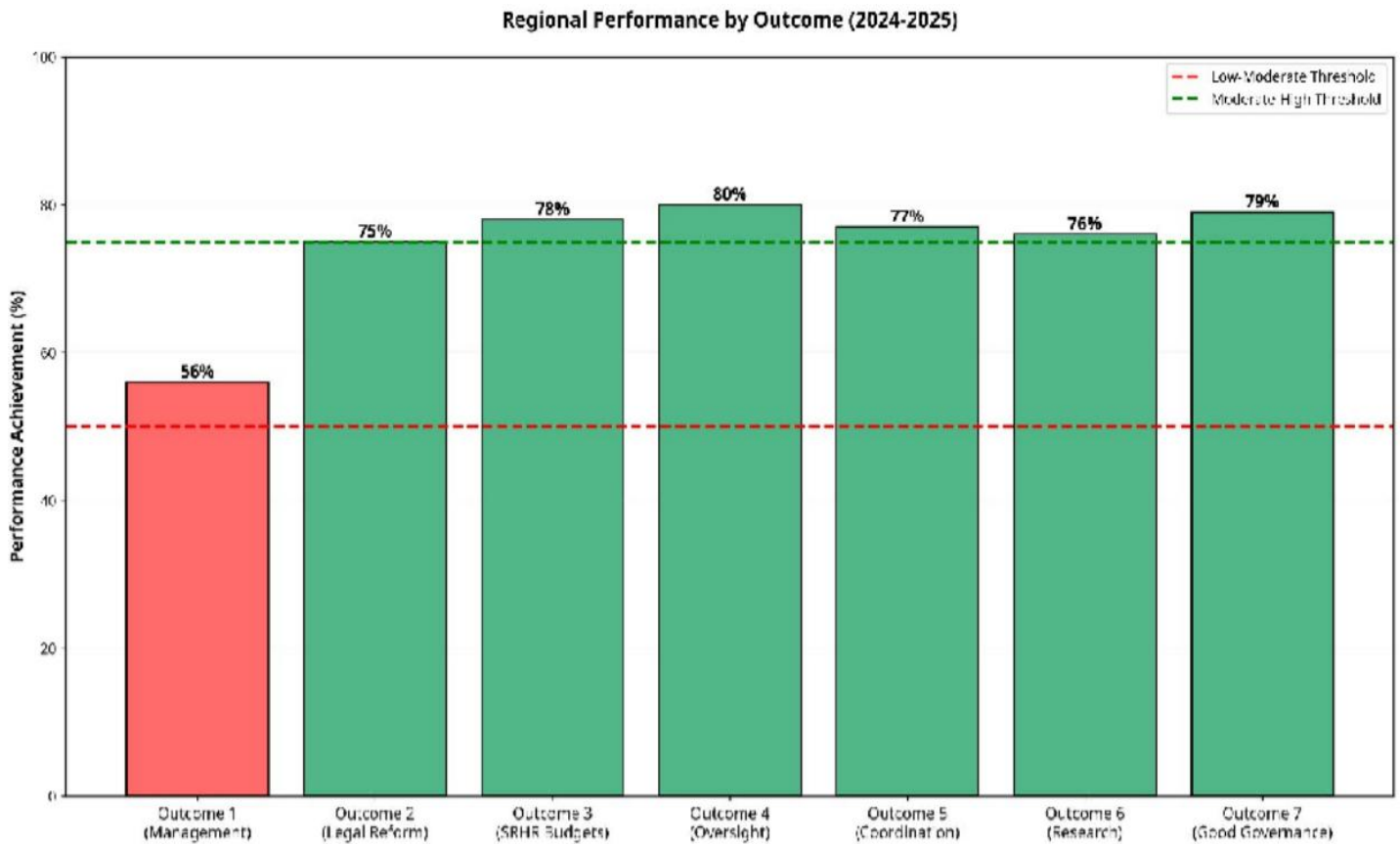


Figure 1: Regional Performance by Outcome (2024-2025)

The distribution of performance across the 13 member parliaments further illustrates the project’s impact. As shown in Figure 2, a significant majority of parliaments (69.2%, or 9 countries) achieved a ‘high performance’ rating, with scores between 75% and 100%. A further 23.1% (3 countries) were rated as ‘moderate performers’, whilst only one country (7.7%) fell into the ‘low performance’ category. This distribution underscores the broad-based success of the project in elevating the performance of parliaments across the region. The high proportion

of high performers is particularly noteworthy given the challenging political context, including a “super election” cycle that saw significant MP turnover in several countries (SADC-PF, 2025).

Figure 2 illustrates the distribution of the 13 participating member parliaments across three performance tiers: high (75-100%), moderate (50-74%), and low (0-49%). The data shows that the majority of parliaments (69.2%) are high performers, demonstrating the widespread effectiveness of the project’s interventions in building parliamentary capacity across diverse national contexts.

### Institutional Mobilisation and Engagement

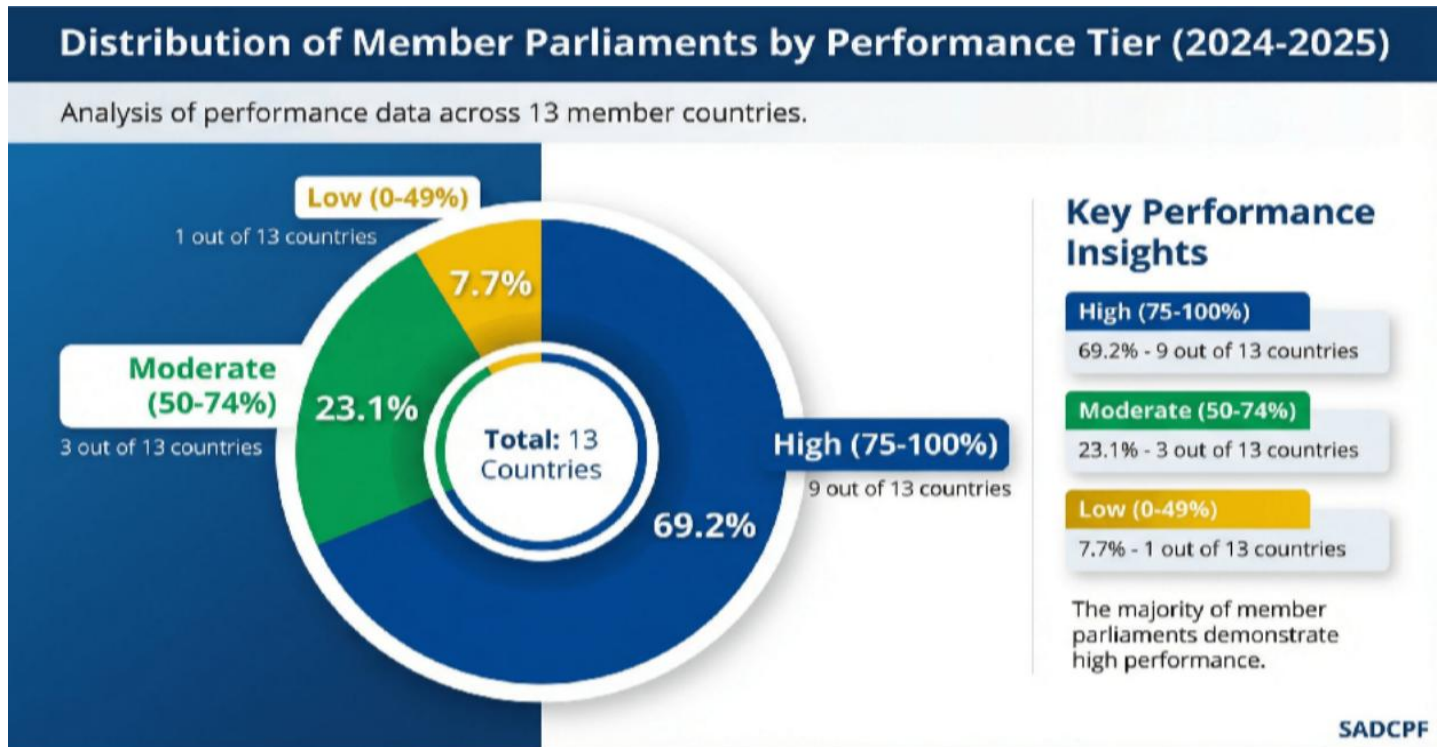


Figure 2: Distribution of Member Parliaments by Performance Tier (2024-2025)

A key driver of the project’s success has been its ability to mobilise and engage parliamentary structures at both the regional and national levels. The SADC-PF convened three Plenary Assemblies during the reporting period, providing a high-level platform for norm-setting, policy dialogue, and the adoption of regional frameworks. These assemblies were supported by the work of eight statutory and standing committees, which coordinated the engagement of 121 committee members from across the 13 member states. The committees held a total of 27 meetings, including three joint sessions, to advance their respective mandates (SADC-PF, 2025).

The committees played a crucial role in translating the project’s objectives into concrete action. The Human and Social Development and Special Programmes (HSDSP) Committee served as the primary vehicle for SRHR advocacy, whilst the Democratisation, Governance and Human Rights (DGHR) Committee focused on anti-corruption and civic participation. The Gender, Women Advancement and Youth Development (GEWAYD) Committee championed gender-responsive budgeting, and the Regional Parliamentary Model Laws Oversight Committee (RPMLOC) monitored the domestication of model laws at the national level. This multi-committee approach ensured that SRHR was mainstreamed across the Forum’s work and not confined to a single thematic area.

Figure 3 provides a quantitative overview of the project’s institutional mobilisation efforts. It highlights the significant scale of engagement, with three plenary assemblies, eight standing committees, 121 coordinated committee members, 24 committee meetings, and three joint sessions. This intensive level of activity indicates a high degree of institutional buy-in and demonstrates the project’s success in creating a vibrant regional platform for parliamentary action on SRHR and HIV.

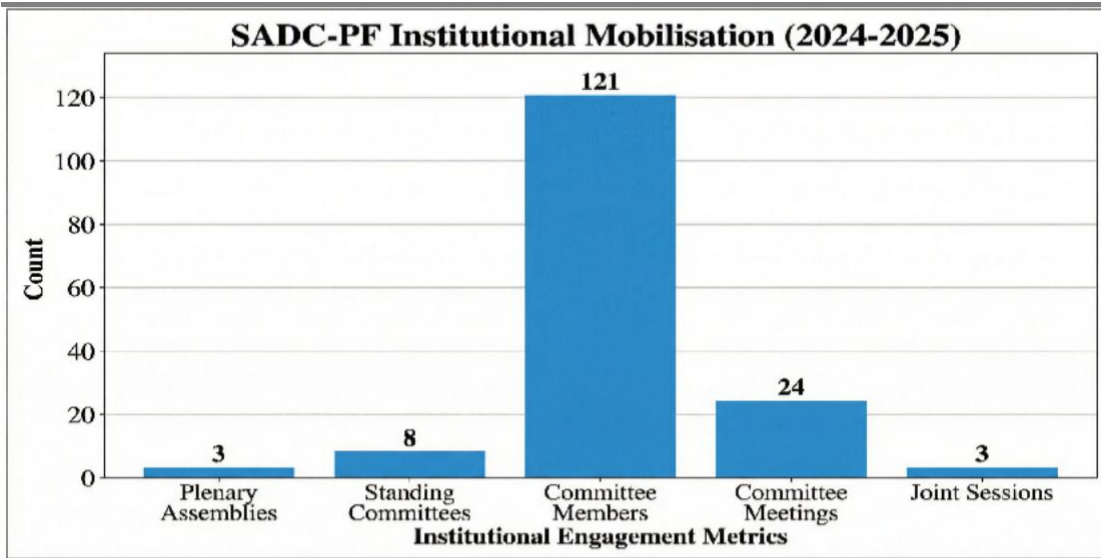


Figure 3: SADC-PF Institutional Mobilisation (2024-2025)

This intensive engagement has been instrumental in building capacity and fostering a sense of collective ownership over the SRHR and HIV agenda. The project’s capacity-building activities have reached a wide range of stakeholders, including over 60 MPs and 30 parliamentary staff who received specialised training in SRHR advocacy in Malawi alone. When aggregated across the region, the project has trained hundreds of parliamentarians and staff, creating a critical mass of champions for health rights within national legislatures. This investment in human capital is a critical component of the project’s strategy for ensuring the long-term sustainability of its impact.

### Legislative and Budgetary Outcomes

The ultimate measure of the project’s success lies in its ability to translate regional norms and capacity-building efforts into tangible national-level reforms. The data from 2024-2025 provides compelling evidence of this translation in practice. Several countries have made significant strides in legislative reform and budgetary allocation for health.

Table 1: Summary of Key Country-Specific Legislative and Budgetary Outcomes (2024-2025)

Country	Key Legislative/Policy Achievement	Key Budgetary Achievement
<b>Democratic Republic of Congo</b>	Advancement of SRHR-related bills	11% increase in national health budget
<b>Zimbabwe</b>	Modernisation of Prisons and Correctional Service Act	5% increase in budget for youth-friendly services
<b>Malawi</b>	Passage of Marriage Bill, Mental Health Bill, and Prisons Bill	Health Budget increased from 8.7% to 12.2% and saw family planning budgets rise by 23%
<b>Mauritius</b>	Enactment of two acts strengthening protections against GBV	Total health budget increased from Rupees 18.5 billion, Rupees 1,2 billion
<b>Lesotho</b>	Adoption of Public Participation Bill	N/A
<b>Zambia</b>	Resolution of legal inconsistencies for adolescent SRHR access	N/A

Source: Adapted from SADC-PF SRHR, HIV & AIDS Governance Project Annual Report 2024-2025.

In the Democratic Republic of Congo (DRC), parliamentary advocacy directly contributed to an 11% increase in the national health budget, with specific allocations for maternal health, reproductive supplies, and cancer screening. This achievement is particularly significant given the DRC’s challenging fiscal environment and competing demands on the national budget. The GEWAYD Committee worked closely with the budget

committee to ensure that the increased allocation was accompanied by transparent mechanisms for tracking expenditure, addressing longstanding concerns about corruption and mismanagement in the health sector (SADC-PF, 2025).

In Zimbabwe, parliamentary debates on adolescent SRHR, catalysed by the project, led to increased budget allocations for youth-friendly health services. The Parliament also modernised the Prisons and Correctional Service Act to include health rights and parliamentary provisions, inspired by the SADC Model Law on Prison Oversight. This reform is a significant step towards ensuring that the rights of incarcerated individuals, including their right to health, are protected and that parliaments have the tools to hold prison authorities accountable.

Malawi Health Budget increased from 8.7% to 12.2% and saw family planning budgets rise by 23%, On the legislative front the country passed three significant bills during the reporting period: the Marriage Bill, the Mental Health Bill, and the Prisons Bill. These reforms address critical gaps in the country’s legal framework and demonstrate the Parliament’s commitment to a comprehensive approach to health and human rights. The Marriage Bill, in particular, is a landmark achievement, as it raises the minimum age of marriage and provides stronger protection against child marriage, a practice that has significant negative consequences for the health and well-being of girls.

Mauritius health budget increased from Rupees 18.5 billion, Rupees 1,2 billion and enacted two acts that strengthen protections against gender-based violence (GBV) and align its laws with the SADC Model Law on GBV. The repeal of Section 242 of the Criminal Code, which had been identified as discriminatory, and the enactment of the Bail (Amendment) Act 2025, which makes it more difficult for alleged perpetrators of domestic violence to be released on bail, are concrete examples of how regional standards can inform and guide national legal reform. Mauritius also established a 27-member National Working Group comprising MPs, civil society organisations, and representatives from line ministries, creating a permanent and influential body for coordinating action on SRHR.

Lesotho’s adoption of the Public Participation Bill represents a landmark achievement in institutionalising civic engagement in the legislative process. Championed by the DGHR Committee, this legislation creates a legal framework for citizens to participate in policymaking, ensuring that the voices of ordinary people, particularly women and young people, are heard in the corridors of power. This is not merely a procedural reform but a fundamental shift towards a more inclusive and responsive model of governance.

Figure 4 presents a comparative snapshot of key achievements in selected countries, highlighting the diverse impacts of the project. The DRC achieved a significant 11% increase in the national health budget, whilst Zimbabwe secured a 5% increase for youth-friendly services. Malawi stands out for its intensive capacity-building efforts, with 60 MPs trained (represented as 6 on the scaled axis). Multiple countries passed important bills and acts, with Malawi leading with three legislative reforms, followed by Mauritius with two, and Lesotho, Zimbabwe, and Zambia each with one. This diversity demonstrates the tailored nature of the project’s support, responding to the specific needs and contexts of each member state.



Figure 4: Selected Country-Specific Achievements (2024-2025)

The legislative reforms were not confined to a single issue but addressed a range of thematic areas critical to SRHR and HIV governance. The most widespread reforms were in the area of SRHR access, with five countries taking action to address legal and policy barriers. This was followed by reforms related to GBV (four countries) and child protection (three countries), indicating a strong focus on protecting the rights of women and children. Two countries undertook prison reforms, and one country focused on civic participation.

Figure 5 illustrates the thematic focus of the legislative reforms undertaken by member parliaments during the reporting period. It shows that the project has catalysed action across a broad range of SRHR-related issues, with a particular concentration on improving access to services (5 countries) and combating gender-based violence (4 countries). The diversity of thematic areas addressed demonstrates the project’s comprehensive approach to health rights and its success in empowering parliaments to tackle multiple dimensions of the SRHR agenda simultaneously.

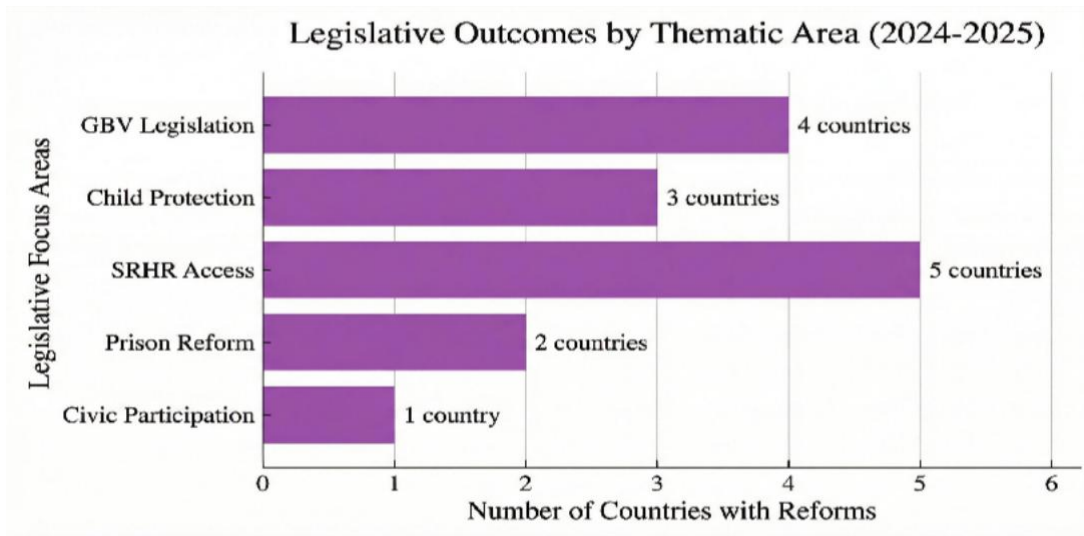


Figure 5: Legislative Outcomes by Thematic Area (2024-2025) Detailed Country Case Studies

Whilst the aggregate data provides a regional overview, a closer examination of individual country experiences reveals the nuanced ways in which the project has supported parliamentary action. This section presents detailed case studies from four countries that exemplify different aspects of the project’s impact.

### Case Study 1: Lesotho - Institutionalising Participation and Protecting Children

Lesotho’s experience highlights the project’s success in promoting both democratic governance and child protection. The adoption of the Public Participation Bill is a transformative achievement that goes beyond SRHR to fundamentally reshape the relationship between the state and its citizens. By creating a legal obligation for government to consult with the public on policy matters, the Bill empowers citizens to hold their representatives accountable and ensures that policies are informed by the lived experiences of those they affect. This is particularly important for marginalised groups, such as women and young people, who have historically been excluded from decision-making processes.

In addition to this governance reform, Lesotho made significant strides in child protection. The advancement of the Children’s Protection and Welfare Bill and the approval of Comprehensive Sexuality Education (CSE) Regulations demonstrate a holistic approach to safeguarding the rights and well-being of young people. The CSE Regulations, in particular, are a critical step towards ensuring that adolescents have access to accurate, age-appropriate information about their bodies, relationships, and rights. This is essential for enabling young people to make informed decisions and to protect themselves from HIV, unintended pregnancies, and sexual violence.

### Case Study 2: Mauritius - Building Multi-Stakeholder Alliances Against GBV

Mauritius provides a compelling example of how the project has facilitated multi-stakeholder collaboration to address gender-based violence. The establishment of a 27-member National Working Group, comprising MPs,

CSOs, and representatives from line ministries, has created a permanent and influential platform for coordinating action. This collaborative structure has been key to the country's success in advancing a comprehensive GBV agenda, from legal reform to service provision to public awareness campaigns.

The legal reforms enacted in Mauritius, including the repeal of Section 242 of the Criminal Code and the enactment of the Bail (Amendment) Act 2025, were the result of sustained advocacy by the National Working Group and the strategic use of the SADC Model Law on GBV as a blueprint for reform. These reforms send a strong message that GBV will not be tolerated and that survivors will be protected and supported. The alignment of national laws with regional standards also facilitates cross-border cooperation and the sharing of best practices, creating a more cohesive regional response to GBV.

### **Case Study 3: Democratic Republic of Congo - Championing Health Financing**

The DRC's achievement in securing an 11% increase in the national health budget is a testament to the power of parliamentary advocacy. In a context of limited fiscal resources and competing priorities, this increase represents a significant political victory for the GEWAYD Committee and its allies. The Committee's strategy was not simply to lobby for more money but to build a compelling case for investment in health, grounded in evidence about the health needs of the population and the potential return on investment.

Crucially, the advocacy did not stop at securing a larger budget. The Committee worked closely with the budget committee to ensure that the increased allocation was accompanied by specific provisions for maternal health, reproductive supplies, and cancer screening. This demonstrates a sophisticated understanding of the budget process and a commitment to ensuring that resources are directed to where they are most needed. The establishment of more transparent allocation mechanisms is also a significant step towards addressing corruption and ensuring that health funds reach the intended beneficiaries.

### **Case Study 4: Zambia - Enhancing Access and Strengthening Justice**

Zambia's experience highlights the project's impact on both improving access to SRHR services and strengthening the justice system's response to SRHR violations. The resolution of legal inconsistencies that were hindering adolescents' access to SRHR services is a critical achievement. In many African countries, contradictory laws create confusion and barriers to access, with some laws setting a minimum age for consent to sexual activity that is higher than the age at which young people can access health services. By addressing these inconsistencies, the Zambian Parliament has opened the door for more young people to access the information and care they need.

Zambia has also taken a strong stance against child defilement through its advocacy for stiffer punishments for perpetrators. This demonstrates a commitment to not only preventing violence but also ensuring that those who commit these crimes are held accountable. The establishment of tripartite consultative councils has created a valuable platform for ongoing dialogue between parliament, the executive, and civil society, fostering a more collaborative approach to tackling the country's pressing SRHR challenges.

These case studies, whilst not exhaustive, illustrate the profound and varied impact of the SADCPF project. They show that by providing a combination of technical support, capacity building, and a platform for regional collaboration, the project has empowered national parliaments to become more effective champions for health and human rights. The successes in these countries provide a source of inspiration and a set of transferable lessons for other nations in the region and across the continent.

## **DISCUSSION**

The findings from the SADC-PF SRHR, HIV, and AIDS Governance Project offer a compelling affirmation of the critical role that parliamentary oversight plays in the advancement of health rights. The descriptive analysis of the 2024-2025 programme data not only highlights the project's significant achievements but also provides the basis for a conceptual framework that can guide future health governance interventions. This section discusses the key implications of the findings, introduces the SADC-PF Governance Framework as a model for understanding

the process of parliamentary strengthening, and situates the results within the broader academic literature on health governance and regional integration.

### The SADC-PF SRHR and HIV Governance Framework

Based on the analysis of the project’s activities and its Theory of Change, the article proposes the SADC-PF SRHR and HIV Governance Framework (Figure 6). This framework conceptualises the process of parliamentary strengthening as a four-level causal pathway, moving from inputs to impact. It provides a structured way to understand how interventions aimed at building parliamentary capacity can lead to improved health governance and, ultimately, the realisation of health rights.

Figure 6 presents a conceptual framework derived from the SADC-PF project’s approach. It illustrates a four-level pathway, from capacity-building inputs (Level 1) through parliamentary processes (Level 2) to governance outcomes (Level 3) and ultimately to health rights impact (Level 4). The framework highlights the central role of parliamentary functions legislative reform, budget scrutiny, oversight mechanisms, and multi-stakeholder engagement in translating capacity into tangible results. The framework is supported by an enabling environment (depicted on the left) and a continuous cycle of monitoring and evaluation (depicted on the right), both of which are essential for the success and sustainability of parliamentary strengthening efforts.

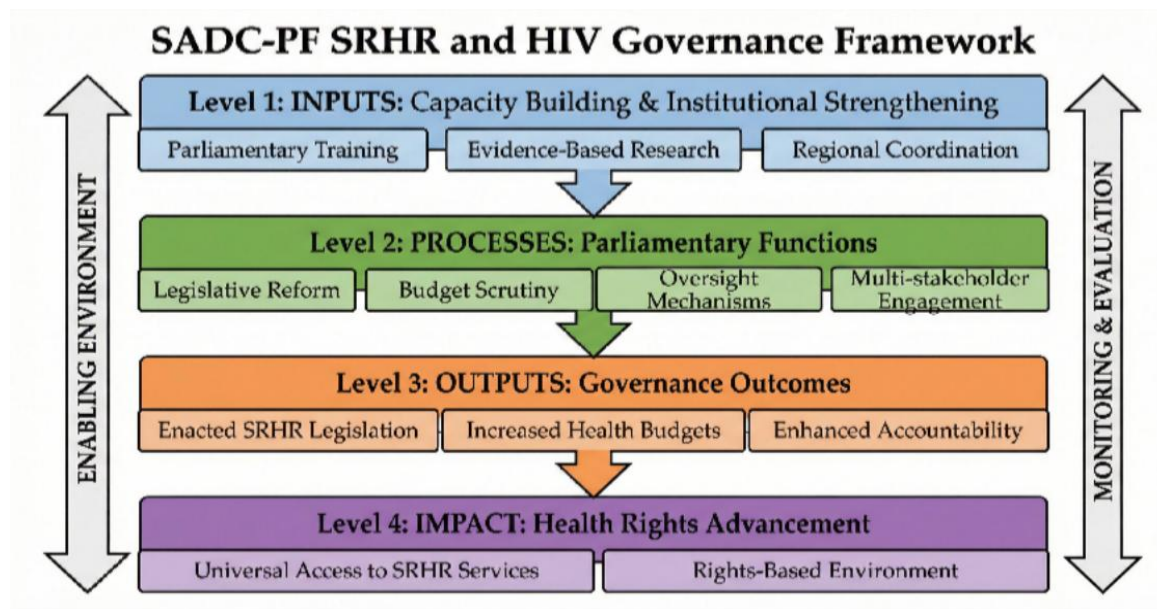


Figure 6: SADC-PF SRHR and HIV Governance Framework

#### Level 1: Inputs - Capacity Building & Institutional Strengthening.

The framework’s foundation lies in the strategic inputs provided by the project. These are not merely financial resources but targeted investments in human and institutional capacity. The data shows that activities such as parliamentary training, the provision of evidence-based research, and regional coordination are the essential raw materials for building more effective parliamentary institutions. The training of over 60 MPs in Malawi, for example, is a direct input that enhances the knowledge and skills of individual parliamentarians. Similarly, the provision of research support and the facilitation of regional exchanges enable parliamentarians to access the evidence and peer learning opportunities they need to make informed decisions.

#### Level 2: Processes - Parliamentary Functions.

The inputs from Level 1 are designed to enhance the core functions of parliament. This is the process through which capacity is translated into action. The framework identifies four key parliamentary functions that are central to the project’s success: legislative reform, budget scrutiny, oversight mechanisms, and multi-stakeholder engagement. The 11% increase in the DRC’s health budget is a clear example of the budget scrutiny process in action, where parliamentarians used their enhanced capacity to influence national resource allocation.

The passage of the Public Participation Bill in Lesotho demonstrates the legislative reform function, whilst the establishment of National Working Groups in Mauritius exemplifies the multi-stakeholder engagement function.

### **Level 3: Outputs - Governance Outcomes.**

The effective execution of parliamentary functions leads to tangible governance outcomes. These are the measurable results of parliamentary action. The framework highlights three critical outputs: enacted SRHR legislation, increased health budgets, and enhanced accountability. The passage of the Public Participation Bill in Lesotho is a concrete governance output that resulted from the legislative reform process. The budget increases in the DRC and Zimbabwe are outputs of the budget scrutiny process. Enhanced accountability, whilst more difficult to quantify, is evidenced by the increased number of oversight visits, parliamentary questions, and the establishment of mechanisms for citizen participation.

### **Level 4: Impact - Health Rights Advancement.**

The goal of the framework is the advancement of health rights. The governance outputs from Level 3 creates the conditions for achieving this long-term impact. By enacting progressive legislation, securing adequate funding, and holding governments accountable, parliaments contribute to the vision of universal access to SRHR services and the creation of a rights-based environment for all citizens. Whilst the full impact on health outcomes may take years to materialise, the governance reforms documented in this study represent critical steps on the pathway to that impact.

The framework is bounded by two cross-cutting elements: the Enabling Environment and Monitoring & Evaluation. The results of this study map directly onto this framework. The Inputs (Level 1) are represented by the project's capacity-building activities, such as the training of over 60 MPs in Malawi. The Processes (Level 2) are demonstrated by the core parliamentary functions, such as the budget scrutiny that led to the 11% health budget increase in the DRC (a key Output- Level 3). The passage of the Public Participation Bill in Lesotho is another clear Output (Level 3) resulting from the legislative reform Process (Level 2). Ultimately, these outputs contribute to the long-term Impact (Level 4) of advancing health rights by creating a more enabling legal and financial environment for SRHR services. The enabling environment, which includes factors such as political will, the strength of civil society, and the broader socio-economic context, can either facilitate or constrain the process of parliamentary strengthening. The project's success in navigating a challenging electoral cycle demonstrates the importance of adaptive strategies to manage the enabling environment. The project employed several mitigation strategies, including onboarding new MPs, establishing National Working Groups to provide continuity, and fostering regional solidarity to create peer pressure for continued engagement (SADC-PF, 2025).

Monitoring and evaluation, in turn, provides the feedback loop that allows for continuous learning and adaptation, ensuring that the project remains responsive to the evolving needs of the region. The project's performance framework, which measures achievement across seven outcomes, is a key tool for monitoring progress and identifying areas that require additional support. The data generated through this monitoring process has been invaluable for this study and provides a model for evidence-based project management.

### **Implications for Health Governance Theory and Practice**

The results of the SADC-PF project, when viewed through the lens of the proposed framework, offer significant contributions to both theory and practice of health governance. The findings do not merely describe a successful project but provide empirical grounding for key theoretical concepts and offer transferable lessons for practitioners.

From a theoretical standpoint, this study provides a powerful illustration of policy diffusion and norm subsidiarity within a regional governance context. The SADC-PF acts as a regional norm-setter, creating model laws that are then domesticated at the national level. This process, as described by Leibrandt-Loxton (2022) in the context of parliamentary diplomacy, is not one of coercion but of 'soft power' and persuasion. The 'snowball effect' of the model laws (SADC-PF, 2025) is a clear manifestation of policy diffusion, where innovations spread from a central node (the SADC-PF) to other actors within the network (the national parliaments). The framework presented in this Article models this diffusion process, showing how regional inputs are translated into national-

level outputs. This provides an empirical case study that enriches the theoretical literature on regional integration and policy transfer.

Furthermore, the project's emphasis on multi-stakeholder engagement provides a practical application of the 'ecosystem approach' to health policy, as advocated by Opondo, Maina, and Munyasia (2024). The National Working Groups in Mauritius and the tripartite councils in Zambia are not ad-hoc committees but institutionalised ecosystems for policy dialogue. They bring together the legislative, executive, and civil society actors who are often seen as operating in separate, and sometimes adversarial, spheres. The success of these platforms in driving legislative reform and enhancing accountability demonstrates the synergistic potential of such collaborative governance models. This study, therefore, contributes to the growing body of evidence that challenges traditional, state-centric models of governance and highlights the importance of networked and participatory approaches.

The findings also speak directly to the literature on parliamentary strengthening and capacity development. Rugumamu (2011) argued that capacity building in fragile environments must be context-specific and institutionally embedded. The SADC-PF project exemplifies this principle.

Rather than a one-size-fits-all training programme, the project provided tailored support that responded to the specific needs and political realities of each member parliament. The combination of regional-level training with in-country technical assistance and peer-to-peer learning created a multi-layered capacity-building strategy that was both flexible and robust. The high performance of the majority of parliaments, despite the challenges of high MP turnover, suggests that this approach has been successful in building institutional, rather than merely individual, capacity.

The results of the SADC-PF project, when viewed through the lens of this framework, have several important implications for the field of health governance. First, they provide strong empirical support for the argument that investing in parliamentary capacity is a highly effective strategy for improving health outcomes. The high performance of the majority of member parliaments demonstrates that with the right support, parliaments can become powerful agents of change. This finding aligns with the work of Rugumamu (2011), who argues that targeted capacity development is essential for enhancing the effectiveness of parliaments, particularly in fragile or developing contexts.

Second, the findings underscore the importance of a holistic approach that integrates legislative, budgetary, and oversight functions. The project's success lies in its recognition that these functions are mutually reinforcing. A new law is of little value if it is not funded, and a budget allocation is meaningless if there is no oversight to ensure it is spent effectively. The SADC-PF's model of integrated support is a key lesson for other development partners working in this space. This integrated approach is consistent with the call from scholars like Ansah et al. (2024) for a greater emphasis on bridging the gap between evidence and policy in African health systems.

Third, the project highlights the unique and valuable role of regional parliamentary forums. The SADC-PF has served as a catalyst for change, providing a platform for norm-setting, peer learning, and collective action. The SADC Model Laws, for instance, have created a "snowball effect," inspiring and guiding national-level reforms in a way that respects national sovereignty whilst promoting regional harmonisation (SADC-PF, 2025). This model of regional catalysis is a powerful tool for policy diffusion and deserves greater attention from researchers and practitioners. Godsäter (2015) has highlighted the role of civil society in regional governance within SADC, and this study extends that analysis to show how inter-parliamentary cooperation can similarly drive regional integration and policy convergence.

Fourth, the study's findings reveal the critical importance of multi-stakeholder engagement. The establishment of National Working Groups and tripartite consultative councils, as seen in Mauritius and Zambia, has created institutionalised platforms for dialogue between parliament, the executive, and civil society. This collaborative approach is essential for building broad-based consensus, ensuring the relevance of parliamentary work, and fostering a sense of shared ownership over the health rights agenda. The success of these platforms provides a strong counter-narrative to the often-adversarial models of governance and highlights the potential of a more inclusive and participatory approach to policymaking. This finding resonates with the work of Opondo, Maina,

and Munyasia (2024), who argue for a holistic “ecosystem approach” to SRHR policy that brings together diverse stakeholders in a collaborative effort.

Finally, the project’s emphasis on evidence-based policymaking is a crucial thread that runs through all of its activities. By promoting the use of empirical research and data in parliamentary work, the project has helped to elevate the quality and credibility of the debate on SRHR. This is a vital step in moving beyond the ideological and political polarisation that so often characterises discussions of these issues. As parliaments become more adept at using evidence to inform their decisions, they are better positioned to craft policies that are effective, equitable, and responsive to the actual health needs of their populations.

### **Challenges, Adaptive Strategies, and Limitations of the Study**

Whilst the project has achieved significant success, it has also faced considerable challenges. The “super election” cycle that coincided with the reporting period resulted in high MP turnover in several countries, threatening the continuity of the project’s work. The loss of trained and committed MPs can undermine the institutional memory and momentum that the project had built. To mitigate this risk, the SADC-PF employed several adaptive strategies, including the rapid onboarding of new MPs through orientation sessions, the establishment of National Working Groups to provide continuity beyond individual MPs, and the fostering of regional solidarity to create peer pressure for continued engagement.

Another significant challenge has been the growing influence of anti-rights movements, which have sought to undermine progress on SRHR through misinformation campaigns and political lobbying. The project has responded to this threat by building a broad coalition of support for SRHR, including community and religious leaders, and by investing in strategic communications to counter misinformation. The project’s success in this area provides a valuable case study in how to defend health rights in the face of organised opposition. Opondo, Maina, and Munyasia (2024) have documented similar challenges in Kenya and have called for a more proactive and coordinated strategy to counter the influence of anti-rights movements. The SADC-PF’s experience offers practical lessons for implementing such a strategy.

The uneven pace of domestication of regional model laws is another challenge that the project continues to grapple with. Whilst some countries have moved quickly to align their national laws with regional standards, others have been slower to act. This variation reflects differences in political will, institutional capacity, and the complexity of the legislative process. The project has sought to address this challenge by providing tailored technical assistance for legislative drafting and by establishing a peer-review mechanism to track progress and share best practices.

It is crucial to acknowledge the limitations inherent in this study’s design. Firstly, the primary reliance on a single project’s annual report as the main data source, while mitigated by triangulation, presents a risk of reporting bias. The report is authored by the implementing organisation and may naturally focus on successes. Secondly, the descriptive and document-based nature of the study limits the depth of causal inference that can be drawn. While the analysis identifies strong correlations between project activities and governance outcomes, it cannot definitively establish causality without primary data from interviews or direct observation. Thirdly, the generalisability of the findings may be constrained. While the comparative analysis across 13 countries provides a degree of breadth, the findings are specific to the SADC region and the unique context of a Swedish-funded parliamentary strengthening project. The framework and lessons learned should therefore be adapted with caution to other regions or contexts with different political systems and donor landscapes. Future mixed-methods research, incorporating primary data collection, would be valuable for validating and expanding upon the findings of this study.

### **Recommendations for Future Research**

The findings of this study point to several important areas for future research. To maximise impact, the following three priority areas are recommended:

- 1. Mixed-Methods Longitudinal Impact Assessments:** Future research should move beyond descriptive analysis to employ mixed-methods longitudinal designs. This would involve tracking a cohort of parliaments

over a 5–10-year period, combining quantitative analysis of health and budgetary data with qualitative interviews with MPs, staff, and civil society actors. This approach would allow for a more robust assessment of the causal impact of parliamentary strengthening on health outcomes and provide deeper insights into the sustainability of interventions.

- 2. Comparative Politics of SRHR Governance:** There is a need for rigorous comparative research that examines why some parliaments are more effective than others in advancing SRHR. This could involve a comparative case study of 2-3 high-performing and low-performing countries from the SADC region, analysing the interplay of political systems, institutional rules, civil society mobilisation, and the influence of anti-rights movements. Such research would contribute significantly to the literature on comparative health policy and provide nuanced, context-specific lessons for practitioners.
- 3. Economics of Parliamentary Oversight:** The economic dimension of parliamentary oversight remains under-researched. Future studies should focus on the return on investment (ROI) of parliamentary strengthening initiatives. This could involve cost-effectiveness analyses of different capacity-building models and studies on the economic impact of improved health budget accountability. Providing a clear economic case for investing in parliamentary health governance would be a powerful advocacy tool for securing greater domestic and international funding for this critical area.

### Recommendations for Future Practice

Based on the findings, three priority recommendations for practice are proposed to consolidate and expand upon the project's successes:

- 1. Institutionalise and Scale Multi-Stakeholder Governance Platforms:** Development partners and governments should prioritise the institutionalisation of multi-stakeholder platforms, such as the National Working Groups in Mauritius. This involves moving beyond ad-hoc consultations to create legally recognised, resourced, and permanent bodies for joint planning, monitoring, and accountability in the health sector. This approach directly supports SDG 16 (Peace, Justice and Strong Institutions) and SDG 17 (Partnerships for the Goals).
- 2. Develop a Regional Peer-Review Mechanism for Budget Oversight:** The SADC-PF, in partnership with civil society organisations specialising in budget analysis, should establish a formal peer-review mechanism for health budget oversight. This would involve parliamentary committees from different countries reviewing each other's budget scrutiny processes, sharing best practices in gender-responsive budgeting, and developing common standards for financial accountability. This would enhance the technical capacity of parliaments and create a regional accountability loop.
- 3. Launch a Coordinated Regional Counter-Narrative Initiative:** Recognising the growing threat of anti-rights movements, the SADC-PF and its partners should launch a coordinated, multi-country initiative to develop and disseminate evidence-based counter-narratives. This would involve investing in strategic communications, training parliamentarians and journalists in effective messaging, and building alliances with progressive faith leaders and community influencers to reclaim the public discourse on SRHR.

### CONCLUSION

This study provides a methodologically strengthened analysis of the SADC-PF's pivotal role in advancing health rights through parliamentary oversight. By triangulating project data and employing a comparative analytical lens, the research confirms that targeted support for parliaments yields significant improvements in health governance, including legislative reform and increased health budgets. The SADC-PF Governance Framework, introduced and validated through this analysis, offers a replicable model for understanding and implementing effective health governance interventions at national level. The project's success, achieved amidst political transitions and the rise of anti-rights movements, underscores the resilience and adaptability of regional parliamentary platforms.

Moving forward, two actionable calls to action are paramount. First, national governments and international donors must commit to long-term, flexible funding for parliamentary strengthening at regional level, recognising it as a cornerstone for achieving Sustainable Development Goal 3 (Good Health and Well-being) and SDG 16 (Peace, Justice and Strong Institutions). Second, regional bodies like the SADC-PF must institutionalise the multi-stakeholder, evidence-based approaches that have proven effective, creating permanent ecosystems of accountability that can sustain progress beyond the lifespan of individual projects. By embracing these actions, the lessons from the SADC region can be translated into a global blueprint for building more just, equitable, and healthy societies.

## ACKNOWLEDGEMENT

This research was made possible by the comprehensive data provided in the SADC-PF SRHR, HIV & AIDS Governance Project Annual Report 2024/2025. The author acknowledges the dedication and hard work of the SADC-PF Secretariat, The Parliamentarians states, and the Researchers from the 13 member states who tirelessly supported implementation of the programme activities and compiling monthly reports.

## Author Contributions

Jaco Segale, conceptualisation of the study, design, data collection, analysis, interpretation, results, and manuscript draft preparation t, Boemo Sekgoma, Munashe Tofa and Krishna Seegobin, contributed with edits to the original draft and final article.

## Funding

The SADCPF SRHR Project was supported with funding from the Government of Sweden. special thanks go to them for their support of this critical initiative.

## Conflict of interest

The authors declare no conflicts of interest.

## Data Sharing

The data from this article is available upon request and the approval from the Office of the Secretary General Southern African Development Communities Parliamentary Forum (SADCPF)

## REFERENCES

1. Ansah, E. W., Agyepong, I. A., Mirzoev, T., Akua-Sakyiwah, B., Awini, E., Adjei, T., & Atinga, R. (2024). Politics–evidence conflict in national health policy making in Africa: A qualitative comparative analysis of maternal health policy processes in Ghana, Kenya and Senegal. *Health Research Policy and Systems*, 22(1), 47. <https://doi.org/10.1186/s12961-024-01127-3>
2. Asunka, J. (2025). Africans strongly support women’s autonomy in marriage and reproductive decisions, but are divided on contraceptive access. *Afrobarometer*.
3. Baatsen, P., Widdig, H., Gerth, E. M., Zulu, J., & Cumbe, Z. A. (2025). Mid-term review (MTR) of the Netherlands’ regional sexual and reproductive health and rights and HIV/AIDS program in Southern Africa. Government of the Netherlands.
4. Chola, M., et al. (2026). Future directions: Ending HIV in Africa A call to action. *The Lancet Global Health*, 14(2), e234-e245. [https://doi.org/10.1016/S2214-109X\(25\)00408-5](https://doi.org/10.1016/S2214-109X(25)00408-5)
5. Cooper, D., Mantell, J. E., Moodley, J., & Mall, S. (2015). The HIV epidemic and sexual and reproductive health policy integration: Views of South African policymakers. *BMC Public Health*, 15, 1577. <https://doi.org/10.1186/s12889-015-1577-9>
6. El Mimouni, O. (2025). Trending budget cuts: Impact on SRHR in LMICs. *Health Action International*.
7. Godsäter, A. (2015). Civil society and regional governance: Knowledge production and issue-framing around SADC. *Journal of Civil Society*, 11(2), 137-153. <https://doi.org/10.1080/17448689.2015.1024948>

8. Gray, A., & Vawda, Y. (2017). Health policy and legislation. *South African Health Review*, 2017(1), 25-34.
9. Jones, P. S. (2005). "A Test of Governance": rights-based struggles and the politics of HIV/AIDS policy in South Africa. *Political Geography*, 24(4), 437-457. <https://doi.org/10.1016/j.polgeo.2004.10.005>
10. Lee, M., & Nam, Y. (2024). The role of governance in mitigating an epidemic disease: evidence from HIV prevalence in 45 Sub-Saharan African countries, 1996–2019. *International Journal of Health Governance*, 29(2), 169-184. <https://doi.org/10.1108/IJHG-10-2023-0099>
11. Leibbrandt-Loxton, N. (2022). Agenda-setting as a tool of soft power in multilateral parliamentary diplomacy: Experiences of the South African Parliament. *South African Journal of International Affairs*, 29(1), 103-123. <https://doi.org/10.1080/10220461.2022.2046149>
12. Lynch, I., Macleod, C. I., & Chiweshe, M. T. (2025). Vulnerable youth or vulnerabilising contexts? A critical review of youth Sexual and Reproductive Health and Rights (SRHR) policies in Eastern and Southern Africa. *Sexuality Research and Social Policy*, 22, 1-18. <https://doi.org/10.1007/s13178-024-01018-y>
13. Mbete, L. (2016). An evaluation of oversight and accountability by the fourth Parliament of the Republic of South Africa. [Unpublished doctoral dissertation]. University of the Witwatersrand.
14. Opondo, E., Maina, J., & Munyasia, N. (2024). Lessons from Kenya on sexual reproductive health and rights policy-making: The need to centre voices from Africa in global discourses. *Sexual and Reproductive Health Matters*, 32(1), 2409548. <https://doi.org/10.1080/26410397.2024.2409548>
15. Oronje, R. N., & Zulu, E. M. (2018). Contribution of a network of parliamentary committees of health to the ecosystem of evidence use in African parliaments. *Evidence & Policy*, 14(3), 523-531. <https://doi.org/10.1332/174426418X15333019232329>
16. Rugumamu, S. M. (2011). Capacity development in fragile environments: Insights from parliaments in Africa. *International Journal of Public Sector Management*, 24(7), 646-660. <https://doi.org/10.1108/09513551111172179>
17. SADC Parliamentary Forum. (2025). SADC-PF SRHR, HIV & AIDS Governance Project: Annual Report 2024/2025. SADC-PF.
18. Searle, A. (2011). African legislatures and HIV/AIDS: an exploratory analysis. [Unpublished master's thesis]. University of Cape Town.
19. Southern African Development Community. (2024). SADC regional strategy for HIV and SRHR among key populations 2024-2030. SADC.
20. UNAIDS. (2023). Global AIDS Update 2023. Joint United Nations Programme on HIV/AIDS. <https://www.unaids.org/en/resources/documents/2023/global-aids-update-2023>
21. World Health Organization. (2022). Sexual and reproductive health and rights: An essential element of universal health coverage. WHO. <https://www.who.int/publications/i/item/9789240052697>
22. World Health Organization. (2025). Integrated drug resistance action framework for HIV, hepatitis B and C and sexually transmitted infections, 2026–2030. WHO.