Session Two: Part 2 : Health MDGs

This session will focus on achieving the health MDGs – with a specific focus within this on maternal and child health. It will assess the role and potential of innovative partnerships, innovative financing, and scientific and technological innovation. The background papers include the material circulated for the 13th APF on the impact of the crisis on health.

Issues for Discussion

(i) Are we right in identifying maternal and child mortality as a key concern?
(ii) What action needs to be taken by African governments?
(iii) What action needs to be taken by the G8 and other Development Partners?
(iv) How can we increase the part played by innovative partnerships and innovative financing?

Background Documents	
Health MDGs **GOAL 4: REDUCE CHILD MORTALITY** **Target 1: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate** **GOAL 5: IMPROVE MATERNAL HEALTH** **Target 1: Reduce by three quarters the maternal mortality ratio** **Target 2: Achieve universal access to reproductive health** **GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES** **Target 1: Have halted by 2015 and begun to reverse the spread of HIV/AIDS** **Target 2: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it** **Target 3: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**	1. Impact of global financial crisis on Africa's health system (NEPAD Paper and Powerpoint presented at 13th APF) 2. Key Messages on Science & Technology Innovations for MDGs (NEPAD Office of Science and Technology: to follow 3. Background note prepared for 'Continental Conference On Maternal And Child Health In Africa: The Maputo Plan Of Action On Sexual And Reproductive Health And Rights (SRHR)', 19-21 April 2010, Addis Ababa

Africa Partnership Forum

13th Meeting of the Africa Partnership Forum

Addis Ababa, Ethiopia
25 January, 2010

The Impact of the Financial Crisis on Health

This document has been prepared by the NEPAD Secretariat for discussion during Session 4 on the Impact of The Crisis on Health at the 13th Meeting of the Africa Partnership Forum in Addis Ababa on 25 January 2010. It is available at www.africapartnershipforum.org

APF/ADDIS-2010/06

I. Introduction

Poverty is directly linked to poor health through multiple routes. Thus, the global financial crisis has led to the concern that the economic crisis could bring a health crisis in its wake, which would undermine the important advances made in health care in Africa in the past decade.

The Crisis is not only financial

Understanding the routes of potential impact on health of the reduction of income for individuals and countries, globally and in Africa, as a consequence of the Crisis, provides the framework for action to mitigate against this threat becoming a reality. The pathways through which the recession in rich economies effects Africa are central to overall solutions, but, whatever route they take, the ultimate impact on health is similar, whether it is from a decline in export growth, commodity prices; foreign direct investment, exchange rates, capital or remittances.

- African government revenues decline, reducing expenditure in infrastructure that enhances health, such as improved water supply (to overcome diarrhoea) and electricity (offsets indoor air pollution, a major cause of pneumonia), reduction in informal settlements and support for agriculture;

- Emerging social nets for the poor are damaged leaving more people without the basic necessities, while the chances of the socially excluded and marginalised of moving out of their trap are blocked – indeed, their numbers are increased;

- More households dip below the poverty line from the impact of job losses leading to increases in malnutrition and vulnerability to other diseases, while food security declines;

- Household income declines due to job losses, reduced remittances etc. so that the health of those above the poverty line is also impacted on;

- Fewer health workers are employed and less is spent on health infrastructure, maintenance and running costs. Reducing running costs makes health spending inefficient as health workers lack supplies and other essentials and referrals become more difficult and workers become demoralised and frustrated and leave;

- As staff costs are often fixed by permanent public sector employment, staffing takes an increasing share of the budget, reducing funds for non-staff costs, such as medicines and supplies – yet, already half of Africans do not have regular access to essential medicines;

- Medicines and commodities become more expensive to import if local currencies are devalued;

- Funding pressure leads to a focus on financing for medicines, but as other aspects of the health system are impacted, health system performance is weakened, leading for example to reduced adherence to chronic disease care;

- Health service utilisation is reduced as governments reduce services and households are less able to buy care;

- People delay seeking care to avoid transport and health care costs, leading to more people presenting with more advanced disease, costing more to treat and increasing the need for hospitalisation;

- The contribution to care by non-state non-profit providers is reduced and use of private providers falls, putting pressure on the public system;

- Development assistance for health is reduced or delayed as tax revenues decline in developed countries and savings are sought to counter the effects of the crisis and to fund the counter measures;

The impact of all the various consequences of the crisis will not be felt equally by African countries, nor within countries, with the most vulnerable being hit the hardest. Also, the political economy of disease in Africa is such that the consequences tend to work together to reinforce each other in a vicious cycle of ill health, be it HIV/AIDS, Tuberculosis, Malaria, Malnutrition, Maternal and newborn deaths or locally endemic diseases. Poverty and weakened health services also have a compounding impact.

II. Have the Concerns about the Health Impact of the Financial Crisis Become a Reality?

Thus far there are concerns, but little in the way of strong evidence of health and health service impacts, but that certainly doesn't mean that there are none now, or that we should not be concerned about the future. One of the real difficulties is

that the kind of information needed to assess the effects of the financial crisis lags behind real time – health expenditure and disease and mortality data.

Increased poverty, reduced household income, job losses and reduced remittances have an effect on the social determinants of health and on access to health care and hence on health.

On the positive side we have seen global commitment to health reach unprecedented levels in the last decade, with more African countries starting to increase the proportion of their government expenditure on health and development assistance to health more than doubling and the emergence of The Global Fund and GAVI, the Bill and Melinda Gates Foundation and latterly the International Health Partnership. This has been matched by improvements in child health, AIDS and malaria interventions and care and commitments to universal access to AIDS care for all who need it by 2010.

However, maternal mortality, the best indicator of the performance of health systems and newborn mortality remain a concern. The urgent need for health systems strengthening and dealing with the Human Resources for Health crisis remains, while achievements are at risk and progress needed is jeopardized.

There is still a huge gap in financing to achieve the Health Millennium Development Goals – and this is an important issue: The aim in health and health care had not been to maintain the status quo – a huge burden of preventable disease and death, but to impact on disease burden through increased investments and commitment by both African countries and donors. Therefore, it is reasonable to reflect that staying the same actually constitutes a negative impact for which the financial crisis must be at least a fair share of the responsibility. Flattening of the slope of the trajectory of expenditure is something to watch out for. Absolute expenditures become important because the same per cent of a reduced national budget constitutes a reduction.

Past experience in health of structural adjustment and commitments being made when publicly expedient and then letting them slide still sits raw. But, this is offset by global recognition of investment in health as an investment in economic development. Also, development partners have become more aware of their responsibilities to keep to commitments and about the architecture of development aid. This has come with commitments not to allow the financial crisis to impact on promised development aid for health services and disease, but there have been indications that aid will be cut. Either way, G8 countries are still lagging behind funding their Gleneagles commitments, with the shortfall estimated at US$ 34 billion globally before the crisis. Expenditure in many African countries remains below the critical minimum needed to fund essential basic health care. African countries are not in a position to bridge this gap – they simply do not have the fiscal space.

The High-level Taskforce on Innovative International Financing for Health Systems has highlighted the critical need to raise up to an additional US$10 billion per year to spend on health in poor countries, much of it in Africa. It points out that the cost of not raising this additional funding is dire – 4 million children dying each year, who otherwise would have been saved, and 780,000 avoidable deaths of adults, including 322,000 women dying as a result of giving birth. Experience has shown that the often blamed "lack of absorption capacity" is not the key impediment to use of funds, the architecture of donor funding not uncommonly being an impediment.

It is still early to judge whether public health services and access to health care is being maintained. If medicines purchasing is used as an indicator, then services are being maintained, at least in the short term. But this does not offer room for complacency. We have still not seen if country expenditure on health services will be maintained and grown, likewise for development aid. Similarly, we have not seen whether the shortfalls in the commitment to provide Anti retroviral

treatment for all those who need it by 2010 will be bridged. Nor do we know if support for primary health care system strengthening to achieve adherence with care will be sufficient.

It is important to recognise that continental or regional economic community aggregates may belie stress on individual countries, especially those that have suffered the most as a result of the crisis and potentially those who have a heavy dependence on donor funding.

In sum, we need to recognise the commitments made to protect health in the face of the economic crisis, but not allow any lack of immediate evidence to delay action needed to ensure that impact is offset. Certainly 2010 will be a critical "litmus test" year for government budgets as financial planning for this year will have been done after the crisis and health allocations need to be thoroughly analysed.

III. Actions Needed to Protect Health and Health Care – *Key Action Points*

A wide range of actions need to be taken or reinforced by national, continental and global stakeholders. It is imperative that these are pro-actively implemented, rather than wait and create realities for negative historic analysis.

1. Determinants of Health

- As ongoing global and continental action is taken to address the fallout of the financial crisis, priority should be given to measures that are pro-poor and that create jobs;

- Food security and support for agriculture, especially high health yield foods, must be a priority;

- Infrastructure decisions should give a high priority rating to those developments with the greatest health benefit;

- In all measures – jobs, infrastructure, social nets and health care access – implement measures in a manner to that avoids "the inverse care law" – that those who would benefit most are the least likely to receive it;

2. Health services

- Countries should prepare costed health service plans, including Human Resources plans that clarify the mix and numbers of professional, mid and community health workers. Development partners should prioritise filling the gaps in agreed national health strategies;

- Efforts achieve to strengthen rural services should not be reduced in response to more organised and vocal urban challenges to reductions;

- Health systems should move towards universal coverage and away from payment at the time of needing services and offset the possibility of the poor being faced with catastrophic health expenditure;

- Countries should introduce revolving contract employment in the public service to match cycles of funding – this to overcome the concern of making commitments that may not be able to be sustained;

3. Pharmaceuticals

- Commit to making the concept of Global Public goods a reality;

- Implement financing commitments to encourage the pharmaceutical industry to develop medicines needed by Africa and at an affordable price;

- The African Union Pharmaceutical Manufacturing Plan for Africa should be supported;

4. Financing

- Maintain and grow development aid for health and improve its architecture in line with the Paris Declaration on Aid Effectiveness – reducing the transaction costs and providing long term, predictable aid;

- Implement innovative health financing systems of the kind recommended by the High Level Task Force on Health Financing;

- Partners should fund public health services, but when doing so should seek a commitment from countries that they will not reduce their own funding for health as development aid increases;

- Countries should submit more ambitious proposals to the Global Fund to Fight AIDS, TB and malaria in line with their need and the HS windows of this and other Funds should be expanded and made easier to obtain;

- Balancing rewarding good governance and stewardship and nurturing others forward is a difficult balance, but routes to supporting fragile states and closing national variations between needs and funding are important;

- Greater use should be made of needs based indicative funding for health versus competitive funding;

5. Monitoring and evaluation

- Develop real time monitoring systems on key indicators of potential impact of the global financial crisis on health and health systems;

- Countries should commit to being forthcoming with timely information needed to track the impact of the financial crisis on health;

- Commission research targeted at achieving a better understanding of the Impact of the global financial crisis on Health;

- Early warning systems should be in place, especially for impact on individual countries;

- Countries should share their experience – both positives and problems - on dealing with the health and health service implications of the crisis;

6. Leadership

- Global advocacy by world leaders and organisations to stress the importance of health to development and its need as an intrinsic good and basic right, to sustain global momentum and citizen support;

- The African Union Health Strategy should be supported;

- Strong leadership is needed from Ministries of Finance and of Planning to give effect to the value of health as a productive investment and human right and for pro-health policies;

- Strengthening of Ministries should not be impeded by the crisis, nor should measures to strengthening national and local institutional management capacity;

- Domestic policy formulation and ownership should not be overridden by international technocracy;

- International agreements to create a viable response to the bleeding of Africa's health professionals need to be reached and implemented and there should be a commitment to having no unemployed health professionals;
- All stakeholders, including the private for-profit and not-for profit sectors and global and local civil society should be integral part to the response to the crisis;

IV. Conclusion

African countries and development partners should reaffirm their commitment to or, as they see fit, support / endorse the actions proposed to protect health and health care from the effects of the global financial crisis and the measures taken to address it.

The African side and Development partners, under the auspices of the Africa Partnership Forum (APF), should continue to investigate further the impact that the global financial crisis is having on their efforts to support attainment of the Millennium Development Goals (MDGs) and other globally agrees health and health care goals and the measures being taken to overcome these and African partners should do likewise for the continent.

NEPAD Secretariat
January 2010

THE IMPACT OF THE FINANCIAL CRISIS ON HEALTH

NEPAD Secretariat

13th African Partnership Forum

Addis Ababa

25 January 2010

POVERTY THE ROOT OF IMPACT

< income, > poverty impacts on health, regardless of source of Crisis

- Most vulnerable hit hardest
- Reinforces vicious poverty - ill health cycle
- Disease burden grows

PATHWAYS OF IMPACT

- Social determinants
  - Reduced infrastructure that enhances health
  - Social nets damaged
  - Income declines, more in poverty

- Health systems
  - Expenditure cut, inefficiencies grow
  - Development assistance cut or delayed
  - Fewer staff, less on medicines, infrastructure
  - Utilization drops, care delayed, adherence less
  - Reduced non-state contribution

→ Pathways of impact guide action

HAS THE CRISIS IMPACTED

- Concerns are based on historical experience
  - little immediate evidence as information lags
  - medicines purchasing holding in short term

→ don't wait for evidence to act

- Past decade – scaled up commitments, matched by improvements
  - But not maternal mortality emphasizing HSS, HR needs
  - Huge financing gap remains
  - Architecture of funding key not so much absorption

- Positive commitments made to protect health
  - Threat of absolute reductions a reality

ACTION NEEDED

- **Determinants of Health**
  - Pro poor, pro job and social nets – avoid inverse care
  - Invest in infrastructure that enhances health
  - Infrastructure that advances health prioritized

- **Health services**
  - Costed country plans, universal coverage
  - Revolving employment contracts for term funds

- **Pharmaceuticals**
  - Global Public Good, develop medicines for Africa
  - AU Pharmaceutical Manufacturing Plan

ACTION NEEDED

- **Financing**
  - Grow aid and continue to improve architecture
  - Fund public services against country commitment not to reduce own investment
  - Implement innovative health financing
  - More ambitious Global Fund proposals
  - Fragile states support and needs based funding

- **Monitoring and Evaluation**

- **Leadership**
  - Global advocacy by world leaders and organizations
  - Leadership from Ministers of Finance and Planning
  - Viable response to Africa bleeding its professionals

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**CONTINENTAL CONFERENCE ON MATERNAL,
INFANT AND CHILD HEALTH IN AFRICA:
THE MAPUTO PLAN OF ACTION (MPoA) ON
SEXUAL AND REPRODUCTIVE HEALTH
AND RIGHTS (SRHR)
ADDIS ABABA, ETHIOPIA
19-21 APRIL 2010**

SRHR-MICHA/4 (I)

Theme: "***Achieving the MDGs through Accelerated Reduction of Maternal and Child Mortality in Africa***"

PROGRESS REPORT ON IMPLEMENTATION OF THE MAPUTO PLAN OF ACTION ON THE CONTINENTAL POLICY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (2007-2010)

Revis

31 March 2010
DRAFT

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ACKNOWLEDGEMENTS

The African Union Commission wishes to express its appreciation to Member States for operationalisation and reviewing the status of implementation of the Maputo Plan of Action (MPoA) on the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) and submitting national implementation reports. The AU Conference of Ministers of Health is also commended for coordinating this process as well as reviewing the continental progress report.

The Commission also wishes to express its appreciation to members of the AU/UN Cluster on Human and Social Development and other partners for their technical contributions to review on the status of implementation of the Maputo PoA and other related activities.

The Commission wishes to particularly thank the UN Population Fund (UNFPA) for its technical and financial support, the advisory role it has played before and during the review process, as well as in facilitating the implementation of the Maputo PoA at national and regional levels.

The Commission further extends its appreciation to the International Planned Parenthood Federation (IPPF) for the technical and financial support, as well as in facilitating the implementation of the Maputo PoA at national and regional levels.
Thanks are also due to the Partners in Population and Development (PPD) for technical and financial support for preparatory activities for the review.

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immuno-deficiency Syndrome
AU: African Union
CSOs: Civil Society Organisations
DAC: Day of the African Child
DHSs: Demographic and Health Surveys
EmONC: Emergency Obstetric and neonatal care
FP: Family Planning
GBV: Gender based violence
HIV: Human Immuno-deficiency Virus
ICPD: International Conference on Population and Development
IMCI: Integrated Management of Childhood illnesses
IMR: Infant mortality rates
IPPF: International Planned Parenthood Federation
MDGs: Millennium Development Goals
MMR: Maternal mortality rates
NGOs: Non-Governmental Organizations
ODA: Official development assistance
PAC: Post-abortion care
PAT: Progress Assessment Tool
PHC: Primary health care
PoA: Plan/Programme of Action of Action
PPD: Partners for Population and Development
RH: Reproductive Health
SDPs: Service Delivery Points
SRHR: Sexual and Reproductive Health and Rights
TB: Tuberculosis
UNAIDS: UN Joint Programme on AIDS
UNFPA: UN Population Fund
UNICEF: UN Children's Fund
WHO: World Health Organization

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INTRODUCTION

1. The historic 1978 Alma Ata Declaration on health for all through access to Primary Health Care (PHC) reaffirmed that "*health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*"; and that health is a fundamental human right. It addressed strategies to promote health very comprehensively, and covered such issues as the social determinants of health, maternal and child health including family planning; and also emphasized the need to focus on disadvantaged populations.

2. Three decades later, universal access to PHC is still a core concept for promotion of global health, and is a major component of other policy commitments that have been adopted over the years. These include the 1992 Dakar/Ngor Declaration on Population, Family and Sustainable Development which endorsed, among others, the establishment of the African Population Commission (APC) and was Africa's Common Position to the 1994 Cairo International Conference on Population and Development (ICPD). The ICPD Programme of Action (PoA) emphasized universal access to education and health including reproductive health (and family planning), safe motherhood, treatment, prevention of sexually transmitted infections (STIs) and protection from violence. Other relevant forums include the World Summit and UN General Assemblies on Children; World Conferences on Women and Development; International Year of Family; the Copenhagen World Summit on Social Development (1995), and the 2000, 2001, 2006 Abuja Special Summits on HIV/AIDS, TB and Malaria.

3. The Millennium Development Goals (MDGs) adopted at the Millennium Summit comprise conclusions or a culmination of decades of work through the above-mentioned forums that addressed diverse issues, including health and social development, human rights and environment. The 8 MDGs comprise a framework for efforts to alleviate the suffering of poor, vulnerable and marginalized people in developing countries, and are all directly or indirectly linked to maternal and child health, including reproductive health (RH). Empowering women which includes access to reproductive health ensures strong and viable families and communities, able to collectively fight poverty. In particular, it ensures neonatal, infant and child survival and development. It is not surprising therefore that the most important development indicators are maternal, neonatal and infant morbidity and mortality rates.

4. Although a lot has been accomplished during the last decade towards universal access to health services, Africa still carries the heaviest burden of largely preventable diseases and conditions closely associated with poverty. Women and children bear the brunt of these diseases and remain the most vulnerable groups to causes of high morbidity and mortality rates in Africa. The continent consequently lags behind others as concerns progress towards the achievement of the Millennium Development Goals (MDGs), particularly MDG4 (Reduce Child Mortality), MDG5 (Improve Maternal Health) and MDG1 (Eradicate Extreme Poverty and Hunger). To attain the MDG targets, Africa has to invest more for people's health, that is, strong health systems. This is in line with the recommendations of the 2000 WHO Commission on 'Macro-Economics and Health: Investing in Health for Economic Development'.

5. The Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) was, thus, adopted at the 2nd Session of the AU Conference of Ministers of Health which was held in Gaborone, Botswana in 2005, as a call for reduction of reduction of maternal and infant mortality in Africa (MDG 4 & 5). In 2006 the Maputo plan of action (2007-2010) for the implementation of the continental policy framework was adopted. These are closely linked to the Declaration and Plan of Action (PoA) on Africa Fit for Children (2001) which also comprised Africa's Common Position to the UN General Assembly Special Session on Children (2002).

BACKGROUND

6. The Continental Policy Framework on Sexual Reproductive Health and Rights (SRHR) was adopted with the aim of accelerating the improvement of sexual and reproductive health and rights in Africa which is vital to the achievement of the goals of the ICPD, and the MDGs, particularly MDG 4 & 5. The Continental Framework focuses on the following priority areas:

i. Sexual and Reproductive Health Legislation into Primary Health Care;
ii. Integration of Sexual and Reproductive Health Services;
iii. Sexual and Reproductive Health Communication ;
iv. Budgeting of Sexual and Reproductive Health Activities;
v. Mainstreaming Gender in Development Programmes ;
vi. Youth Sexual and Reproductive Health;
vii. Mid-life Concerns of both Men and Women;
viii. The Fight against the HIV/AIDS Pandemic and Other Infectious Diseases;
ix. Strengthening of Sexual and Reproductive Health Programme of the AU.

7. At the 2006 Special Session of AU Health Ministers, the Maputo Plan of Action for operationalisation of the Continental Policy Framework on SRHR was adopted, with a goal for all stakeholders and partners "*to join forces and re-double efforts, so that together, the effective implementation of the Continental Policy framework including universal access to sexual and reproductive health by 2015 in all countries in Africa can be achieved*". The Maputo PoA key strategies include the following:

i. Integrating STI/HIV/AIDS, and SRHR programmes and services, including reproductive cancers, to maximize the effectiveness of resource utilization and to attain a synergetic complementary of the two strategies;

ii. Repositioning family planning as an essential part of the attainment of health MDGs;

iii. Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component;

iv. Addressing unsafe abortion;

v. Delivering quality and affordable services in order to promote safe motherhood, child survival, maternal, newborn and child health.

vi. African and south-south co-operation for the attainment of ICPD and MDG goals in Africa.

8. The Maputo PoA also addressed the following cross-cutting issues:

i. Increase domestic resources for sexual and reproductive health and rights including addressing the human resource crisis;
ii. Include males as an essential partner of SRHR programmes;
iii. Adopt a multisectoral approach to SRHR;
iv. Foster community involvement and participation;
v. Strengthen SRH commodity security with emphasis on family planning and emergency obstetric care and referral;
vi. Put in place operational research for evidence based action and effective monitoring tools to track progress made on the implementation of the Plan of Action;
vii. Integration of nutrition in STI/HIV/AIDS, and SRHR especially for pregnant women, and children by incorporating nutrition in the school curriculum, fortification of food institutionalisation.
viii. Involvement of families and communities;
ix. Involvement of the Ministries of Health in conflict resolution;
x. Rural-urban service delivery equity.

MANDATE

9. In the Maputo PoA, *“the African Union Commission was mandated to play advocacy role, resource mobilization, monitoring and evaluation, dissemination of best practices and harmonization of policies and strategies”.*

10. Furthermore the Commission has been mandated by:

i. Executive Council Decision on the Special Session of the AU Conference of Ministers of Health on Sexual and Reproductive Health and Rights of 2006 (EX.CL/Dec.327 (X) rev.1): “*Requests the Commission, in collaboration with relevant United Nations Agencies and other development partners to, advocate for implementation of the Maputo Plan of Action for operationalisation of the continental Framework on Sexual and Reproductive Health and Rights in Africa, and report periodically on progress of implementation ”;*

ii. Executive Council Decision on the theme of the July 2010 Session of the AU Assembly - 2009 (Assembly/AU/Dec.2329XII) - “*Fourteenth Ordinary Session of the Assembly: “Promotion of Maternal, Infant and Child Health and Development”;*

iii. Summit Decision on Accelerating Action for Child Survival and Development in Africa to Meet the MDGs -2005 (Assembly/AU/Dec.75(V);

iv. Africa Health Strategy (2007-2015).

11. Other relevant AU and International Policy Documents on: Reproductive Health, Maternal and Child Health; Child Survival, Growth and Development; and Women, Gender and Development.

PURPOSE OF THE REPORT

12. The purpose of this report is to assess the progress made in the implementation of the Maputo PoA on SRHR. Specifically, the report intends to identify the challenges encountered by Member States in the process of implementation, identify best practices that can be shared among stakeholders, and propose recommendations for the next steps in the promotion of sexual and reproductive health and rights in Africa.

LITERATURE REVIEW

13. The literature review utilizes data available from reliable sources to look at the state of sexual and reproductive health and rights (SRHR), with focus on maternal and and child health, and in the overall framework of health, population and development. In some instances, Africa is compared with other continents to indicate where performance has been satisfactory, and if not, identify gaps that need to be addressed to achieve the MDGs by 2015, particularly no. 4 & 5. Note should, however, be made of inter- and intra-country variations which cannot be addressed or taken account of in most reports.

FACTORS AFFECTING SRHR IN AFRICA

SOCIO-DEMOGRAPHIC FACTORS

14. The most recent population estimates for Africa was 987 million in 2008, showing an average annual population growth rate of 2.3 percent from 2005 to 2010 (UNFPA, 2008). During the 1990 – 2000 decade, Africa's population increased from 622.4 million to 795.7 million, an addition of 173.3 million (28.4 percent) in 10 years. According to the projections, Africa's total population will more-than double in the next four decades, increasing to nearly 2 billion by 2050. The challenge is that population growth is not moving hand in hand with socio-economic development, but is instead associated with increasing poverty and hunger in Africa.

15. The Report of the 15-year review of the implementation of the ICPD in Africa 1994-2009 (ICPD+15, 2009) indicates that life expectancy at birth in Africa, in general, has shown a slow but steady increase from 39 years in the 1950-1955 period to 54 years in 2005-2010. The Northern African countries have a higher average life expectancy, rising from 43 years to 68 years. However, in Southern Africa where the impact of AIDS-related mortality was most severe the average life expectancy rose to 61 years during 1990-1995, but subsequently declined to 51.6 years from the 2005-2010. This represents a significant reversal of gains in health, including RH.

16. Another challenge is that the population of most African countries continues to be young, with children and adolescents below age 15 constituting about 40 percent of the total population. The most recent estimates show that children under age 15 constitute 41.2 percent of the population. When children and youth aged 30 and below are taken together, they constitute over 70 percent of the continent's total population (UN, World Population Prospects – 2008 Revision). This has impact on SRHR including high fertility rates, high rates of teenage pregnancies, a tendency to have large but poor and under-nourished families, high rates of new HIV infections including maternal to child transmission (MTCT).

SOCIO-ECONOMIC FACTORS

17. Also according to the Report of the 15-year review of the implementation of the ICPD in Africa 1994-2009, compared with other regions of the world, Africa suffers disproportionately from poverty and deprivation. Worldwide, about 20 percent of the population survives on less than $1 a day. Half the population of Africa lives in extreme poverty and one third in hunger, while about one sixth of children also die before age five – the same as a decade ago. In the previously war-torn countries, the levels of poverty and hunger have stagnated and even worsened in some. Food security has worsened in Africa since 1970. The proportion of the malnourished population has remained within the 33 to 35 percent range in sub-Saharan Africa, with over 70 percent of the food insecure population in the continent living in rural areas. Poverty reduces access to adequate and balanced nutrition, an important factor for improving maternal and child health and survival. Such a picture is not conducive to health and development.

18. It will also be recalled that developed countries committed to providing 0.7% of their GNP to developing countries of which between 0.15 and 0.2 was to be allocated to the least developed countries (LDCs). Nevertheless, net official development assistance (ODA) flows to these countries remain generally far lower than expected. Consequently, the social sector in general and the health sector in particular, receive limited support, whereas all MDGs all hinge on social development. This situation has a negative impact on maternal and child health in Africa.

WEAK HEALTH SYSTEMS

19. Most African countries continue to have poor, inadequate or non-functioning health systems, indicative of the low priority given to the well-being of people and to the fundamental right to health. Health facilities are ill-equipped and poorly staffed; basic supplies are often unavailable, salaries are low, working hours are long, all of which contribute to low staff morale which, in turn, affects the quality of services. In addition, distances between referral points are long and the roads are often bad and inaccessible, resulting in under-utilisation of the available services. Service providers usually do not have adequate training, and are not versatile in issues of sexual and reproductive health and rights. Further, they are unable to provide specialized and well informed services. The few skilled medical personnel often work outside the continent, which aggravates the lives of women and children. Furthermore, the available services tend to neglect or overlook the special needs of adolescents and youths, who as mentioned above, comprise a large percentage of the populations.

20. According to the UNFPA Arab State Regional Office (Sven Torfin/Panos/UNFPA), Northern African Member States have made significant but variable improvements in maternal and child health. These improvements are reflected in the reductions in infant and child mortality to about 20 or less deaths per 1000 live births between 1990 and 2008. However, both maternal and child mortality are still high by international standards. These indicators drop quickly when mothers have access to medical care and emergency obstetric services during childbirth. Some countries for example, dramatically lowered a woman's lifetime risk of dying from pregnancy or childbirth during the 1990s and some even earlier, and are now considered successful models. This was managed through adaption of a comprehensive and coordinated approach to improving the health of expectant mothers. This followed the analysis of the specific factors contributing to poor

maternal health in communities and took effective steps to address those causes. The countries are also seeking to increase the use of contraception to help bolster child and maternal health as well as lower fertility and slow population growth.

21. In 27 Countries in Africa, annual health expenditures (including foreign aid and loans), is less than US$ 30 per person (WHO Regional Committee for Africa, 2008). This is far below the minimum 'survival kit' for essential health, and a large percentage of this comes from external funding. While local health financing has generally increased over the years, this has mainly been due to external funding. Only about 10 AU Member States have attained the 15% target pledged by African Leaders in 2001, and a few others 10% and above. According to World Bank Statistics, 41% of people in Sub-Saharan Africa live on <1US$ per day, although a small percentage lives on much higher amounts, comparable to developed countries. This cannot ensure family and community health and development (WHO Regional Committee for Africa, 2008)

GENDER INEQUALITIES

22. Gender inequality is one of the social determinants at the heart of inequity in health. Inequality along gender lines and roles means that women do not have the same levels of information, choices, rights and powers to take and act on decisions concerning their sexual and reproductive health. This is demonstrated by high prevalence of young girls in sexual relationships with much older men, high fertility as a result of the number of years in sexual relationships, their limited ability to negotiate for safe sex. Sexual rights are further compromised through cultural values and practices that limit women's understanding of their sexuality and thus reduce their ability to take informed decisions. Examples of such practices include female genital mutilation and early marriages resulting in maternal morbidity and mortality. Gender-based violence, armed conflict and other related harmful traditional practices remains high in some countries in Africa, and also impacts negatively on the health of women and girls. Whereas Africa is 11% of the world's population, has 49% of the world's burden of maternal deaths, 67% of AIDS cases and 26% of underweight children (UNAIDS 2007, INICEF, www.childinfor.org, Lancet nutrition series).

OTHER FACTORS AFFECTING MATERNAL HEALTH AND SRHR

23. Other factors which aggravate maternal ill and mortality health in Africa include HIV and AIDS, Malaria, other infectious diseases, malnutrition and anemia which affect many women and children in Africa. Underlying these diseases and conditions are the same factors previously mentioned which include inequality, lack of respect for people's rights, poverty and lack of social protection which limits access to health services.

24. In view of the foregoing, AU Member States and Africa as a continent have a lot of challenges and gaps to overcome urgently if the MDG targets are to be attained by 2015. These include the same issues that the PAT and analysis of country reports should address:

i. Strengthening of health systems in the broad sense for universal, integrated and comprehensive service delivery at all levels. This requires good supervision and coordination, among others. Adolescent and school health plans should be part of general health and development plans;

ii. Related to strengthening of health systems is the need to address the burden of other diseases and conditions that aggravate SRH;

iii. Development of the health workforce, not only training but also creating incentives to motivate health workers to deliver quality service and reduce turnover. Emphasis should be laid on skilled midwives and health workers for rural settings;

iv. Predictable health financing, local supplemented by external funding should be a priority of national development planning and budgeting, as well as poverty reduction strategies. This should also take account the promotion of social protection for all, particularly for vulnerable groups, and of course good planning and rational use of the resources;

v. For good follow-up, monitoring and evaluation, developing health information systems;

vi. Educating communities by giving them correct information and involving them in both planning and implementation of programmes;

vii. Intensifying and sustaining advocacy to fight harmful traditional practices that negatively impact on SRHR should be intensified, involving communities, both men and women;

viii. Coordination and harmonization of partnerships with stakeholders at different levels.

SCOPE OF THE REPORT, METHODOLOGY AND LIMITATIONS

SCOPE OF THE REPORT AND METHODOLOGY

25. Several techniques form the methodology adopted to synthesize information for this report from secondary sources, literature review and consultation with a number of stakeholders. A progress assessment tool was designed by a group of experts during a meeting held in Kampala, Uganda from the 11th to 12th July 2009.These included experts from PPD Africa, UNFPA, WHO-AFRO, IPPF-AFRO, Marie Stopes International and AUC. Thirty seven (37) key indicators were selected from the more than 100 indicators mainly based on reporting requirements of the AU. The tool was also intended to collect information on challenges, lessons learned during the implementation process, and recommendations.

26. The PAT was sent to all AU Member States through their respective Embassies in Ethiopia, and electronically to the Ministries of health and also posted on the AU website. Country reports were forwarded to the commission through the embassies, by email and through the UNFPA.

27. A total of thirty four (34) countries responded to the PAT. These are: Angola, Benin, Botswana, Burkina Faso, Cameroon, Chad, Congo, Comoro Islands, Cote d'Ivoire, Djibouti, DRC, Ethiopia, Equatorial Guinea, Gabon, The Gambia, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Sudan, Tanzania, Togo, Uganda, Zambia and Zimbabwe. This represents 60.3% of all AU Member States. A list of AU Member States indicating those that reported is annexed to the Report. Reports from a few countries were received after the Report was completed: Egypt, Ghana, Swaziland …. Therefore, findings from these reports will be incorporated later.

28. According to the PAT there is qualitative and quantitative data. The data collected was analyzed both qualitatively and quantitatively. For qualitative analysis, Thematic analysis was used to extract key messages and Content Analysis was used to extract the commonly mentioned themes.

29. For quantitative analysis, Epi Info 3. 5.1 with a univariate analysis of variables to generate data (frequencies) were used.

30. Additional information to enrich the report was taken from reports by relevant partners.

LIMITATIONS

31. These were the limitations to the analysis and discussion to the report:

i. Some Member States did not fully respond to the questionnaire therefore data on particular indicators with their challenges and recommendations were not captured.

ii. Timeframe allocated for the completion of the report was short due to delay in response from Member States. The initial deadline for submission was 31st December 2009.

iii. Out of the more than 100 indicators, thirty seven (37) key indicators were selected for the PAT.

MAJOR FINDINGS

INTEGRATION OF HIV/STI, MALARIA AND SRH SERVICES INTO PRIMARY HEALTH CARE

32. Integration of HIV/STI, Malaria and SRH Services into PHC: many countries have plans in place and some are already implementing them. This is difficult because some well-funded programmes are vertical and not ready to take on other programmes (Table 1).

Table 1: Integration of HIV/STI, Malaria and SRH Services into PHC

Indicators	Done	In Progress	Not Done
Integrated SRHR/STI/HIV/AIDS & Malaria policy documents and/or national plans	27 (79.4%)	5(14.7%)	2 (5.9%)
Multisectoral Plans supporting SRHR	20(60.6%)	7(21.2%)	6 (18.2%)
Laws /legal instruments dealing with gender based violence (GBV) in place	25 (73.5%)	5 (14.7%)	4 (11.8%)
Strategies dealing with GBV developed and implemented	18 (52.9%)	14 (41.2%)	2 (5.9%)
Policies and programmes Against harmful traditional practices	21 (61.8%)	8 (23.5%)	5 (14.7%)
Training institutions integrating STI/HIV/AIDS, nutrition with SRHR in their curricula	24 (70.6%)	6 (17.6%)	4 (11.8%)

33. Only 17 (50%) countries responded to this indicator. Two (11.8%) countries reported offering integrated SRHR/STI/HIV/AIDS and malaria Services in 2-40% of their service delivery points. Five (29.4%) of countries offered the services in 50-80%. Nine (52.9%) countries offered integrated SRHR/STI/HIV/AIDS and malaria Services in all their service delivery points. One country (5.9%) did not offer the services in any of its service delivery points (indicator 7).

STRENGTHENING OF COMMUNITY-BASED STI/HIV/AIDS AND SRHR SERVICES

34. Eighteen (54.5%) countries reported that Strategies for community based STI/HIV/AIDS and SRHR Services are in place, 11 (33.3%) have initiated action while 4 (12.1%) had not done so (indicator 8).

35. Many countries have plans in place and some are already implementing them. Communities should be involved in all levels of planning and implementation for better results.

FAMILY PLANNING REPOSITIONING AS KEY STRATEGY FOR ATTAINMENT OF MDGs

36. Only 13 (40.6%) countries reported on this indicator. Three (23.1%) countries did not allocate a specific budget to Family Planning, as support to this area is derived from the global health budget. Five (38.5%) countries indicated that they allocated 1-2% of the health budget to Family Planning commodities, while 5 (38.5%) other countries allocated between 10-15%. Only one (7.7%) country allocated 16% of their budget to Family Planning (Indicator 9).

37. Many countries have supportive FP protocols and guidelines, but need to implement them more effectively and to reach all communities in need. This requires skilled human resources, IEC and regular supplies of commodities.

38. Supportive protocols and guidelines for family planning are in place in 29 (87.9%) countries, the process is underway in 3 (9.1%) countries; and in 1 (3%) no action has been taken (indicator 10).

39. Policies and strategies are in place in most countries, but effective operationalisation in still a challenge. Education institutions, youth organizations and other and Community Based Organizations are important partners in this regard.

YOUTH-FRIENDLY SRHR SERVICES POSITIONED AS KEY STRATEGY FOR YOUTH EMPOWERMENT, DEVELOPMENT AND WELL-BEING

40. Twenty (60.6%) countries have policies/strategies supporting SRHR services for young people in place, 10 (30.3%) are in progress whilst 3 (9.1%) have nothing in place (indicator 11).

41. Youth-friendly SRHR services have been integrated in the training curricula in 16 (50%) countries, action has been initiated in 8 (25%) and nothing has been done in 8 (25%) countries (indicator 12).

42. Policies and strategies are in place in most countries, but effective operationalisation in still a challenge. Education institutions, youth organizations and other and Community Based Organizations are important partners in this regard.

INCIDENCE OF UNSAFE ABORTION

43. In 18 (52.9%) countries Legislative/policy frameworks on abortion are in place for many years, 7 (20.6%) are developing them and 9 (26.5%) have not started yet (indicator 13).

44. Twenty-three (67.6%) countries have Programmes, strategies and action plans to reduce unwanted pregnancies and unsafe abortion in place, for 6 (17.6%) the process is underway and for 5 (14.7%) no action has been taken (indicator 14).

45. Nine (45%) countries have 8-50% of their service delivery point providing PAC Services while 11 (55%) countries have more than 50% of their service delivery point providing PAC Services (Indicator 15).

46. Many countries have strategies in place or are developing them, although laws and legal frameworks need review, because abortion is generally criminalized, back-street abortion prevails, and post-abortion care is still unsatisfactory. A strategy for advocacy and education to improve the attitude of health workers, teachers and the community at large to abortion should be adopted.

ACCESS TO SAFE MOTHERHOOD AND CHILD SURVIVAL SERVICES

47. Roadmaps for the reduction of maternal and newborn morbidity and mortality have been developed by most countries and are under implementation. However, providing and accessing services for emergency obstetric care country-wide still poses a challenge (Table 2).

Table 2: Access to safe motherhood and child survival services

Indicators	Done	In Progress	Note Done
Roadmap for the reduction of maternal and newborn morbidity and mortality	32 (94.1%)	1 (2.9%)	1 (2.9%)
National action plan to operationalise the roadmaps	27(79.4%)	5 (14.7%)	2(5.9%)
Pre-service curricula incorporating Emergency Obstetric and neonatal care for all appropriate cadres	25 (73.5%)	6 (17.6%)	3 (8.8%)
Functional referral system from community to health facility	11 (32.4%)	16 (47%)	7 (20.6%)
Availability of Integrated Management of Childhood illnesses (IMCI) protocols	28 (82.4%)	1 (2.9%)	5 (14.7%)

48. Seven (30.4%) countries reported to be offering 100% of EmONC sites with access to adequate supply of safe blood, 11(47.6%) countries reported to offer 50-80%, while 5 (22%) countries reported to offer less than 50% of the service (Indicator 21).

49. Twenty-six (76.5%) countries have programmes and strategies to scale up PMTCT, 5 (14.7%) countries are developing them and 3 (8.8%) have nothing in place (Indicator 22).

50. One (4.8%) country had 100% coverage of HIV positive mothers who have delivered and are receiving ARVs, 11 (52.3%) had 50-91% coverage, 9 (42.9%) had below 50% coverage (Indicator 23).

RESOURCES FOR SRHR

51. The available resources are mainly within the general health budget which is limited in some countries. A few countries are allocating limited but specific budget lines for RH including FP. Many programs are donor dependent which is not a healthy approach. Local resources should be mobilized, and supplemented by external funds (Table 3).

Table 3: Resources allocated to Health and to SRHR

Indicators	Done	In Progress	Not Done
National budget allocated to Health	3(8.8%)	10(29.4%)	21(61.8%)
SRHR integrated in national PRSPs & other Development Plans	26(78.8%)	3(9.1%)	4(12.1%)

52. Four (44.4%) countries out of the nine countries that responded to this indicator, allocated between 10-15% of the health budget to SRHR, 2 (22.2%) countries allocated between 1-2%, 1(11.1%) country allocated 6%. Two countries had no specific budget allocated to SRHR (Indicator 25).

53. One country recorded 41 midwives per 10,000 population, another country recorded 30 midwives per 10,000, 3 countries recorded 11 midwives per 10,000 populations, another 3 countries recorded 5 midwives per 10,000, 5 countries recorded 2 to 4 midwives per 10,000 population, and 7 counties recorded less than 2 midwives per 10,000 population. One country reported to have 1 midwife per 3833, another reported 1 midwife per 5957 and another country reported having 1 midwife per 14,000 population (Indicator 27).

SRHR COMMODITY SECURITY STRATEGIES

54. Strategies and action plans in place; but operationalisation is still a challenge. This results in stock-outs especially in rural areas. Many countries feel that RH commodities should be included in the essential medicines list. Moreover, local or regional production should also be promoted in the framework of the Pharmaceutical Manufacturing Plan for Africa (Table 4).

Table 4: Commodity security for SRH

Indicators	Done	In Progress	Not Done
Nation RH commodity security strategy & action plans in place	25(75.8%)	6(18.2%)	2(6.1%)
RH commodities in essential medicines list	30(90.9%)	2(6.1%)	1(3%)
National budget line for SRH commodity security	14(42.4%)	3(9.1%)	16(48.5%)

55. Experiencing RH commodities stock-outs – Five (15.2%) countries experience prolonged stock-outs of RH commodities, 7(21.2%) had occasional stock-outs and 21 (63.6%) did not experienced stock-outs (Indicator 31).

MONITORING, EVALUATION AND COORDINATION MECHANISMS

56. Many countries have institutionalized M&E systems or are in the process of doing so. Heath Information systems in Africa should be developed and managed properly for effective M&E and information sharing (Table 5).

Table 5: Monitoring, evaluation and coordination mechanism

Indicator	Done	In Progress	Note Done
Regularly conduct censuses, DHSs & maternal and neonatal death reviews	23 (69.7%)	5 (15.2%)	5 (15.2%)
A monitoring and evaluation system institutionalized	22 (66.7%)	9 (27.3%)	2 (6.1%)
Operational research findings utilized	14 (42.4%)	14 (42.4%)	5 (15.2)
Resources allocation and utilization regularly monitored	17 (51.5%)	8 (24.2%)	8 (24.2%)
Best practices documented	14 (42.4%)	12 (36.4%)	7 (21.2%)
Functional coordination and harmonization	18 (54.5%)	10 (30.3%)	5 (15.2%)

PROPORTION OF RESPONSES BY REGION

Table 6: Responses from 4 African regions

Region	No. of Countries	Percentage	Cumulative%
Central Africa	6	17.6	17.6
East Africa	10	29.4	47.1
Southern Africa	9	26.5	73.5
West Africa	9	26.5	100
Northern	1	16.67	100
Total	34	100	100

ACTION UNDERTAKEN BY AU AND PARTNERS 2007-2010

57. Following its adoption, the Maputo PoA was disseminated to Member States. They were urged to operationalise it at national level, working in close collaboration with all relevant stakeholders and partners. The UNFPA, IPPF and other partners facilitated Regional Workshops to scale up and monitor progress towards this end.

58. As a follow-up to the Maputo PoA, the African Continental Workshop to "*Harmonize/Develop, and Institutionalize the Maternal, Newborn and Child Mortality Reviews and Accelerate the Implementation of Recommendations - Towards Meeting MDG 4 and 5*" was organized by the Government of South Africa, in collaboration with the AUC, WHO, UNFPA and UNICEF in April 2008. This was deemed very important because if deaths are not registered, the underlying causes cannot be addressed. Among others, it was recommended that an AU Goodwill Ambassador and Champion for "Africa's Movement to Improve Maternal Health and Promote Child Survival and Development beyond 2015" be appointed. This recommendation was duly endorsed by the 2008 Special Session of the AU Conference of Ministers of Health.

59. The deliberations of the 4th Session of the AU Conference of Ministers of Health focused on the theme: "***Universal Access to Quality Health Services: Improve Maternal Neonatal and Child Health***". Recommendations for promoting universal access to health services and improving maternal neonatal and child health were made. In this regard, the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) was launched in Addis Ababa, Ethiopia, May 2009 with a slogan: "***No Woman Should Die While Giving Life!".*** The goal of CARMMA is "contribute to further advancement of social development in the continent through proactive support to national efforts aimed at reducing maternal mortality in Africa". The CARMMA was welcomed as an important advocacy tool, and is supported by the international community.

60. In line with the AU Gender Policy, the African Women Decade was extended to 2010-2020. One of objectives is to continue raising awareness and mobilizing support and political will in implementing the agreed international, regional and sub-regional and national commitments on gender. Implementation is focusing on the following priorities, among others: Education; Health and Maternal Mortality; Gender-based Violence including Harmful Practices which covers early marriage, female genital mutilation (FGM).

61. Action at national level is supported by the UN Agencies, bilateral and multi-lateral partners and foundations. The immense support is commended, but should coordinated and harmonized, and in line with national priorities and programmes.

62. It will be recall that the Roadmap for Accelerating the Attainment of MDGs related to Maternal and Newborn health was adopted in 2004 by the WHO Regional Committee for Africa. Its key intervention for reversing maternal and newborn mortality is to give special attention to emergency obstetric and newborn care, and to skilled attendance. Its implementation is linked to that of Maputo PoA.

63. In line with the Continental Policy Framework, the WHO Regional Committee for Africa launched the **'Women's Health Day'** in the Africa Region on September 2009. It has been proposed that a Commission on Women's Health be set up to coordinate and follow up on recommended action. The whole continent should join hands and support this important initiative.

64. Progress report on MDGs indicated that Africa has made forward strides on some MDGs, but unfortunately, the worst performance is still on MDG5: Improve Maternal Health.

65. The AU, specifically the Commissioner for Social Affairs is a partner in the Global Leadership Group on Maternal Mortality particularly the White Ribbon Alliance, led by the Spouse of the British Prime Minister.

66. In the framework of the increasing partnerships between Africa and other continents and sub-continents as well as with specific developed countries and their development Agencies, a lot is being undertaken both at the AU and in Member States: Africa-EU Cooperation, Africa-USA Cooperation and Africa-G8 Parliamentarians.

67. In the framework of the Regional Coordination Mechanism (RCM) of UN Agencies and Organizations Working in Africa in support of the AU, the AU and partners should avoid duplication through joint planning, implementation and coordination of strategies.

CHALLENGES

68. The main challenges highlighted by almost all countries under each priority area are similar to those underscored by the WHO Regional report on MDGs: *"inadequate resources, weak health systems, inequities in access, weak multisectoral response, low priority accorded to health in national development plans, and inadequate data*"; as well as the 2008/9 UNFPA Report. The implementation of the Maputo Plan of Action encountered the following challenges:

Human Resources

i. Inadequate health workforce due to limited training, quick turn-over and migration;

ii. Shortage of skilled health workforce especially midwives.

Weak Health Systems

i. Weak general infrastructure;

ii. Weak intersectoral cooperation;

iii. Inadequate involvement of communities;

iv. Limited centers offering comprehensive services;

v. Low integration and decentralization;

vi. Weak and inadequate health information systems;

vii. Conflicting priorities with other health programs;

viii. Difficulty in controlling standards and barriers such as user fees in the private sector;

ix. Weak management and coordination;

x. Limited operational research;

xi. Inadequate implementation of recommendations on mortality reviews.

Poor service delivery and under-utilization

i. Under utilization of contraceptives other than condoms;

ii. Low access to health services including infrastructures and communication;

iii. Low utilization of available services;

iv. Problems related to procurement and distributions leading to stock-outs especially at district level;

v. Poor health outcomes due to underlying diseases like HIV especially among pregnant women.

Inadequate Health Financing

i. Limited financial resources;

ii. Limited national budget with donor dependency;

iii. Shortage of funds due to global financial crisis.

Poor Coordination of interventions

i. Existence of vertical programmes;

ii. Weak political leadership;

iii. Inadequate community mobilization;

iv. Difficulty to coordinate partnerships.

Unfavorable legislations

i. Limited implementation of legal instruments;

ii. Lack of commitment by policy makers;

iii. Safe abortion not supported by laws.

Traditional Harmful Practices

i. Existence of gender-based violence;

ii. Negative socio-cultural attitudes towards SRHR;

iii. Low male support and participation in SRHR issues.

Behavioral change communication

i. High rates of teenage pregnancies and unplanned pregnancies;

ii. Limited programmes for both in school and out of school youth;

iii. Inadequate community mobilization (men and women) including IEC.

LESSONS LEARNT

69. It was noted that lessons learnt were either those that facilitated or impeded progress towards to the implementation of the Maputo Plan of Action on SRHR.

FACILITATING FACTORS

70. Factors facilitating implementation include the following:

i. Increased partnerships with coordination, supervision and harmonization through working groups acting towards one roadmap are important for scale-up and rational use of resources.

ii. Promotion of integration with comprehensive coverage of all SRH services (including FP) at all levels insures implementation of one Plan.

iii. The community is receptive if provided with good IEC on SRH, empowerment and also involved.

iv. Leveraging resources from different programmes that are better funded has helped promote SRHR; and SWAP provides predictable funding for services.

v. Developing and implementing the roadmap for accelerate reduction of maternal, neonatal and child mortality (including maternal death reviews) provides information to use as a resource mobilization tool.

vi. Resources alone are not enough. In addition there should be a plan for rational use, and demand also should be enhanced as proven by the unmet need of FP.

vii. Communities are ready and willing to accept and institute behavior change, and be involved in promoting their own health. All they need is a peaceful environment, facilitation. Actions should be geared towards both men and women.

viii. The fight against violence and harmful traditional practices is slowly but surely taking off in many countries, some of which are revising or developing related laws/ instruments.

IMPEDING FACTORS

71. Implementation is impeded by following:

i. Top-down (vertical) approach negatively affects community participation;

ii. Inadequate legislation on safe abortion or criminalization of abortion.

RECOMMENDATIONS

72. In line with the identified challenges, the following recommendations towards further implementation of SRHR strategies were made:

Human Resources

i. Ensure availability of skilled human resources;

ii. Health workers should be motivated and retention incentives put in place.

Health Systems

i. Adequate, integrated and comprehensive health systems should be promoted;

ii. Strengthen Health Information with emphasis on M&E offices/ committees;

iii. Promotion of research is essential.

iv. Emergency preparedness and response Plans for undertaking activities upon demand should be in place always.

Service delivery

i. There is need to strengthen emergency obstetric care;

ii. Adequate budget should be made available for reducing unsafe abortion;

iii. There is need to improve logistics and commodity management and integrate HIV/STI and other disease programmes into RH;

iv. The community should be mobilized to participate and utilize available services;

v. It is important to include SRH products and commodities in the list of essential medicines.

Health Financing

i. There is a need to strengthen financial systems with resource mobilization;

ii. The percentage of national budget resources allocated to health care should be increased to at least 15%.

Coordination of interventions

i. Government should ensure ownership of the RH programme, including regulating the health sector;

ii. Coordination should be promoted through establishment of intersectoral committees;

iii. Coordination and supervision should be improved.

Legislation

i. Advocacy to be undertaken towards adoption and implementation of more tolerant laws and instruments;

ii. Abortion should be decriminalized in order to promote SRHR.

Harmful Traditional Practices

i. Appropriate legislation should be put in place or revised as might be required in certain instances such as cases of harmful traditional practices including gender violence, abortion and inheritance

ii. Scale up campaigns against gender-based violence including harmful traditional practices.

Behavioral change communication and education

i. The development of strong school health programmes should be promoted;

ii. There should be increased focus and empowerment on youth and adolescent on SRHR education;

iii. Communication among health care providers including peer educators at various levels should be promoted;

iv. There is need to promote community mobilization and participation including income-generation.

WAY FORWARD

73. The following proposals are made for the way forward concerning the Maputo PoA on SRHR:

i. The Maputo PoA should be extended for the period 2010 to 2015 to coincide with the target of the MDGs;

ii. After adoption by the AU Conference of Ministers of Health, the Report will be submitted to the Executive Council and Assembly of Heads of State and Government for endorsement.

iii. It will then be disseminated for implementation by stakeholders and partners at all levels. In this regard, the AU Commission should establish the Inter-Agency Steering Committee by October 2010, and develop the revised indicators to guide continued implementation by December 2010.

iv. Updates will be made at ordinary Sessions of the AU Conference of Ministers of Health, and the Assembly of the African Population Commission and other relevant forums.

v. Progress Reports on implementation will be submitted in late 2014 by Member States and to the AU organs in 2015.

vi. NGOs and CSOs should sustain and improve on the commendable work being done, and continue to provide support but under the guidance and coordination of the Governments.

vii. RECs and RHOs should promote inter-country cooperation in the region including sharing of useful experiences.

viii. The International Community should provide support to Member States based on the respective mandates and in line with national programmes.

ix. In line with the RCM the AU and partners should improve coordination through joint planning, implementation and coordination of the Maputo PoA.

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ANNEX I

DRAFT DECISION ON THE PROGRESS REPORT ON IMPLEMENTATION OF THE MAPUTO PLAN OF ACTION ON THE CONTINENTAL POLICY FRAMEWORK ON SEXUAL AND REPREDUCTIVE HEALTH AND RIGHTS (SRHR)

The Executive Council:

1. **TAKES NOTE** of the Report of the Special Session of the AU Conference of Ministers of Health (Geneva, Switzerland, 15 May 2010), on the Progress Report on Implementation of the Maputo Plan of Action (MPoA) on the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR);

2. **RECALLING** the various global and continental commitments aimed at universal access to sexual and reproductive health and rights, including maternal, neonatal, infant and child health and development in Africa;

3. **DEEPLY CONCERNED** that Africa will not achieve the Millennium Development Goals (MDGs) unless more effective and visible action is taken to accelerate and ensure that maternal, neonatal, infant and child health indicators improve in all Member States;

4. **ALSO CONCERNED** that Progress Reports on the implementation of MDGs persistently indicate that MDG 5 (Improve Maternal Health) has made the least progress, especially in Africa;

5. **COMMENDS** Member States for action taken to implement policies and strategies aimed at universal access to sexual and reproductive health and rights in Africa, in collaboration with other stakeholders and partners;

6. **REAFFIRMS** all previous commitments towards universal access to sexual and reproductive health and rights, including maternal, neonatal, infant and child health and development in Africa;

7. **ENDORSES** the decision by the AU Conference of Ministers of Health to extend the duration of the Maputo Plan of Action on Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) for the period 2010-2015 with a final Review in 2015;

8. **URGES** Member States, as a 'final push for action' to achieve the MDGs, to review and/or implement comprehensive national policies and strategies on Sexual and Reproductive Health and Rights through an integrated approach, in line with the revised guidelines in the Maputo PoA on SRHR, in collaboration with stakeholders and partners;

9. **CALLS UPON** UN Agencies, Other International Organizations and Development Partners to continue providing financial, technical and material support to Member states, in the implementation of the strategies and programmes to promote sexual and reproductive health and rights and development in Africa; and to support and collaborate with the AU, RECs and RHOs in facilitating their respective roles in this regard;

10. **REQUESTS** the Regional Economic Communities (RECs) and Regional health Organizations/Communities (RHOs) to lead, harmonize and coordinate efforts towards the promotion of sexual and reproductive health and rights in their regions, in collaboration with the AU and development partners;

11. **REQUESTS** the Commission, in collaboration with other relevant AU Organs and partners to:

    i. Coordinate the follow up and reporting on the implementation of the MPoA on SRHR as in line with the recommendations of the Progress Report referred to above;

    ii. Regularly update the AU Conference of Ministers of Health and the Assembly of the African Population Commission on progress towards this end;

    iii. Conduct review and submit a Mid-Term Report on the status of implementation on 2015.

ANNEX II

OAU/AU REGIONS

The Council of Ministers meeting in its Twenty-sixth Ordinary Session in Addis Ababa, Ethiopia, from 23 February to 1 March, 1976 adopted resolution **CM/Res.464 (XXVI)** stipulating that "*there shall be five (5) regions of the OAU, namely, Northern, Western, Central, Eastern, and Southern*".

The geographical distribution of the five (5) regions is currently (March 2004) as follows:

1. West Africa, Fifteen (15) Member States:

	Country	Reported	Not Reported
1.	Benin	√	
2.	Burkina Faso	√	
3.	Cape Verde		**X**
4.	Cote d'Ivoire	√	
5.	Gambia	√	
6.	Ghana	√	~~**X**~~
7.	Guinea		**X**
8.	Guinea Bissau		**X**
9.	Liberia	√	
10.	Mali	√	
11.	Niger		**X**
12.	Nigeria	√	
13.	Senegal	√	
14.	Sierra Leone		**X**
15.	Togo	√	

2. East Africa, Thirteen (13) Member States:

	Country	Reported	Not Reported
16.	Comoros	√	
17.	Djibouti	√	
18.	Eritrea		**X**
19.	Ethiopia	√	
20.	Kenya	√	
21.	Madagascar	√	
22.	Mauritius	√	
23.	Rwanda	√	
24.	Seychelles		**X**
25.	Somalia		**X**
26.	Sudan	√	
27.	Tanzania	√	
28.	Uganda	√	

3. Southern Africa, Ten (10) Member States:

	Country	Reported	Not Reported
29.	Angola	√	
30.	Botswana	√	
31.	Lesotho	√	
32.	Malawi	√	
33.	Mozambique	√	
34.	Namibia	√	
35.	South Africa	√	
36.	Swaziland	√	~~X~~
37.	Zambia	√	
38.	Zimbabwe	√	

4. Central Africa, Nine (9) Member States:

	Country	Reported	Not Reported
39.	Burundi		X
40.	Cameroon	√	
41.	Central African Republic		X
42.	Chad	√	
43.	Congo	√	
44.	Democratic Republic of Congo	√	
45.	Equatorial Guinea	√	
46.	Gabon	√	
47.	Sao Tome & Principe		X

5. Northern Africa, Six (6) Member States:

	Country	Reported	Not Reported
48.	Algeria		X
49.	Egypt	√	~~X~~
50.	Libya		X
51.	Mauritania		X
52.	Tunisia		X
53.	Saharawi Arab Democratic Republic		X

ANNEX III (Already translated in all languages)

AFRICAN UNION

الاتحاد الأفريقي

UNION AFRICAINE

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AFRICAN UNION COMMISSION
Department of Social Affairs
July 2009

Universal Access to Comprehensive Sexual and
Reproductive Health Services in Africa

Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (2007-2010)

Progress Assessment Tool (PAT)

IDENTIFICATION

Name of Country: ______________________________

Date of compilation of Report: ______________________________

DETAILS OF PERSONNEL WHO COMPILED THE REPORT:

Name: ____

Position: ____

Contact Address:
Institution: ____

Street: ____

Telephone: ____

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1. INTRODUCTION

The 2nd Ordinary Session of the African Union Conference of Ministers of Health which took place in Gaborone, Botswana from October 10-14, 2005, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights which was subsequently endorsed by the AU Heads of States and Government in January 2006.The framework seeks to take the continent forward towards the achievement of universal access to comprehensive sexual and reproductive health services by 2015. African Union Ministers of Health held a special session in Maputo Mozambique in September 2006 under the theme: “Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa” and adopted the Maputo Plan of Action for Operationalisation of the Continental Framework for Sexual and Reproductive Health and Rights (2007-2010). The AUC in collaboration with relevant partners have developed a tool to assess progress made by Member States on implementation of the Maputo PoA. It is composed of three sections: A) Data on specific indicators according to the 8 priority areas of the Maputo Plan of Action, B) Challenges encountered in the implementation of the PoA and C) Recommendations for the way forward. Member States are requested to prepare country reports and submit them to the AU Commission using the guidelines below:

2. PROGRESS ASSESSMENT TOOL FOR MAPUTO PLAN OF ACTION ON THE OPERATIONALISATION OF THE POLICY FRAMEWORK ON SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (2007-2010)

The AU Commission would like to kindly request your institution/agency to prepare a country report on the progress of implementation of the Maputo Plan of Action for the operationalisation of the Continental Framework for Sexual and Reproductive Health and Rights (2007-2010). The country report should include the following key information:

Country:	**Done**	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
1. Integration of HIV/STI, Malaria and SRH Services into PHC				
Indicator 1 Integrated SRHR/STI/HIV/AIDS and Malaria policy documents and / or national plans				
Indicator 2 multi-sectoral plans supporting SRHR				
Indicator 3 Laws /legal instruments dealing with GBV in place				
Indicator 4 Strategies dealing with GBV developed and implemented.				
Indicator 5				

Policies and programmes that address harmful traditional practices				
Indicator 6 Training institutions integrating STI/HIV/AIDS, nutrition with SRHR in their curricula				
Indicator 7 **%** SDPs (health facilities) offering integrated SRHR/STI/HIV/AIDS and Malaria services	**Indicate figure**			
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
2. Strengthening of Community based STI/HIV/AIDS and SRHR Services				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 8 Strategy for community based STI/HIV/AIDS and SRHR Services				
3. Family Planning repositioning as key strategy for attainment of MDGs				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 9 Proportion of health budget allocated to family planning commodities	**Indicate %**			
Indicator 10 Supportive protocols and guidelines for family planning				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 11 Policies/strategies supporting				

SRHR services for young people				
Indicator 12 Youth-friendly SRHR services integrated in the training curricula				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
5. Incidence of unsafe abortion reduced				
Indicator 13 Legislative/policy framework on abortion				
Indicator 14 Programmes, strategies and action plans to reduce unwanted pregnancies and unsafe abortion				
Indicator 15 Proportion of SDPs providing PAC Services	**Indicate %**			
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
6. Access to safe motherhood and child survival services increased				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 16 Roadmap for the reduction of maternal and newborn morbidity and mortality				
Indicator 17 National action plan to operationalise the roadmaps				
Indicator 18 Pre-service curricula incorporating EmONC for all appropriate cadres				
Indicator 19 Functional referral system from community to health facility.				

Indicator 20 Availability of IMCI protocols				
Indicator 21 Proportion of EmONC sites with access to adequate supply of safe blood.	**Indicate %**			
Indicator 22 Programmes and strategies to scale up PMTCT				
Indicator 23 Proportion of HIV positive mothers who have delivered and are receiving ARVs	**Indicate %**			
Challenges(mention up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(Suggest up to 3 recommendations): **a.**				
b.				
c.				
7. Resources for SRHR increased				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 24 15% of national budget allocated to health				
Indicator 25 Proportion of health budget allocated for SRHR	**Indicate %**			
Indicator 26 SRHR integrated in national PRSPs, or other development plans				
Indicator 27 No. of midwives per population	**Indicate %**			
Challenges(mention up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
8. SRH Commodity security strategies for all SRH components achieved				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 28 National RH commodity security				

strategy and action plan(s) in place				
Indicator 29 RH commodities in essential medicines list				
Indicator 30 National budget line for SRH commodity security				
Indicator 31 Experiencing RH commodities stock-outs				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				
9. Monitoring, evaluation and coordination mechanism				
	Done	**In progress**	**Not Done**	**Remark(s) – reasons for success or failure**
Indicator 32 Regularly conduct censuses, DHSs & maternal and neonatal death reviews				
Indicator 33 A monitoring and evaluation system institutionalized				
Indicator 34 Operational research findings utilized				
Indicator 35 Resources allocation and utilization regularly monitored				
Indicator 36 Best practices documented				
Indicator 37 Functional coordination and harmonization mechanism in place				
Challenges(up to 3 main challenges): **a.**				
b.				
c.				
Recommendations/way forward(up to 3 recommendations): **a.**				
b.				
c.				

Lessons learned

Mention up to 5 lessons learned:

a.
b.
c.
d.
e.

THE COMPLETED PAT/REPORTS SHOULD BE SENT TO:

The Director of Social Affairs, African Union Commission, P.O Box 3243, Addis-Ababa, Ethiopia. Fax: + 251 115517 844. E-mail: CisseM@africa-union.org or kassak@africa-union.org by December, 2009.

Annex 1

Country Profile

Indicator	value
Total population	
% Population of women aged 15-49 years	
Prevalence of HIV/AIDS	
Under-five mortality rate	
Infant Mortality Rate	
Neonatal Mortality rate	
Maternal Mortality Ratio	
Proportion of births attended by skilled health personnel	
Antenatal care coverage - one visit - four visits	

Total fertility rate - Adolescent fertility rate as a proportion of total fertility	
Contraceptive prevalence rate - Any method - Modern	
Couple Years Protection	
Unmet need for family planning	
Teenage pregnancy rate	
Age of sexual debut	
Prevalence of anemia in pregnancy	
Prevalence of underweight by age group	
Immunization Rate Insecticide Treated bed-Nets(ITN) coverage - Under five - Pregnant women	
Intermittent Presumptive Treatment (IPT) of malaria in pregnancy coverage	