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INTRODUCTION

Reaffirming that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", the historic 1978 Alma Ata Declaration on "Health for All" through access to primary health care (PHC) proclaimed that health is a fundamental human right. The declaration addressed comprehensive strategies to promote health, and covered such issues as the social determinants of health, maternal and child health, and family planning. It also emphasized the need to focus on disadvantaged populations.

Three decades later, universal access to PHC is still a core concept for the promotion of global health, and has been a major component of other policy commitments that have been adopted over the years. These include the 1992 Dakar/Ngoro 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 for the 1994 Cairo International Conference on Population and Development (ICPD). The ICPD Programme of Action (POA) emphasized universal access to health care, including reproductive health , safe motherhood, treatment and prevention of sexually transmitted infections (STIs), and protection from violence. Other relevant forums include the World Summit on Children, World Conferences on Women and Development, International Year of the Family; the Copenhagen World Summit on Social Development, and the Abuja Special Summit on HIV/AIDS, TB and Malaria.

The Millennium Development Goals (MDGs) adopted in 2000 at the Millennium Summit were the culmination of decades of work that addressed diverse issues, including health and social development, human rights, and the environment. The eight 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 services, is vital to strong and viable families and communities, able to collectively fight poverty and ensure neonatal, infant and child survival and development. In this regard, it is important to underscore that maternal, neonatal and infant morbidity and mortality rates are essential indicators of development.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. ***Reduce child mortality.***
5. ***Improve maternal health.***
6. Combat HIV/AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Although much has been accomplished during the last decade towards universal access to health services, much remains to be done. Africa still carries the heaviest global burden of disease. These diseases are largely preventable, yet they have led to the pervasive poverty on the continent. Women and children bear the brunt of these diseases and remain the groups most vulnerable to causes of high morbidity and mortality rates in Africa.

Consequently, the continent lags behind others in progress towards the achievement of the MDGs, particularly MDG 1 (Eradicate extreme poverty and hunger), MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, malaria and other diseases). To attain the MDG targets, Africa must invest more in its people's health and strengthen its health care delivery systems. This is in line with the recommendations of the 2000 WHO Commission on Macro-Economics and Health: Investing in Health for Economic Development (WHO, 2001).

Despite the foregoing challenges, it is essential not to lose sight of the accomplishments. As indicated in this report, some countries have indeed increased the proportion of their national budget allocations to health. Steps are also being taken in a number of countries to stem the outflow of health and medical personnel, to create new personnel structures and to build capacity for better health service delivery. Besides increased emphasis on emergency obstetric and neonatal care, maternal death audits feature in annual operational plans. Health management information systems are improving and progressive policies on gender are in place. In some countries the Paris Declaration is operational, giving better scope for government ownership of the process. Progress may still be spotty, but for a continent coping with the disease, poverty and governance challenges that confront Africa, it is commendable.

> ***In Mauritius*** Contraceptive prevalence is 75%; specialized obstetrics and gynaecological services are provided at first contact level (primary health care); and there is 1 midwife per 5,000 population.

Clearly, while countries must be commended for progress made they are urged to take further action to accelerate the implementation of the MPOA . The Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR), adopted at the 2nd Session of the AU Conference of Ministers of Health, which was held in Gaborone, Botswana, in 2005, was a call for the reduction of maternal and infant mortality in Africa (MDGs 4 and 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 on Africa Fit for Children (2001), which also comprised Africa's Common Position to the UN General Assembly Special Session on Children (2002).

Background

The 2005 Continental Policy Framework on Sexual Reproductive Health and Rights (SRHR) intended to accelerate the improvement of sexual and reproductive health and rights in Africa – a vital foundation for the achievement of the ICPD goals and the MDGs, particularly MDGs 4, 5 and 6.

The Continental Framework focuses on the following priority areas:

- Sexual and reproductive health legislation.
- Integration of sexual and reproductive health services into primary health care.
- Sexual and reproductive health communication.
- Budgeting of sexual and reproductive health activities.
- Mainstreaming gender in development programmes.
- Youth sexual and reproductive health.
- Midlife concerns of both men and women.
- The fight against the HIV/AIDS pandemic and other infectious diseases.
- Strengthening of the sexual and reproductive health programme of the AU.

> The Maputo Plan of Action calls for all stakeholders and partners to join forces and re-double efforts to achieve universal access to sexual and reproductive health in all African countries by2015.

In 2006, the Special Session of AU Health Ministers adopted the Maputo Plan of Action for implementing the Continental Policy Framework on SRHR. The goal for all stakeholders and partners was stated as (AUC, 2006b: 5):

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 key strategies of the Maputo POA include the following:

- Integrating STI/HIV/AIDS with SRHR programmes and services, including reproductive cancers, to maximize the effectiveness of resource utilization and to attain a synergetic complementary of the two strategies.
- Repositioning family planning as an essential part of the attainment of health MDGs.
- Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component.
- Addressing unsafe abortion.
- Delivering quality and affordable services in order to promote safe motherhood, child survival, and maternal, newborn and child health.
- Fostering African and south-south cooperation for the attainment of ICPD and MDG goals in Africa.

The Maputo POA also addressed the following cross-cutting issues:

- Increase domestic resources for SRHR, including addressing the human resource crisis.
- Include males as an essential partner of SRHR programmes.
- Adopt a multisector approach to SRHR.
- Foster community involvement and participation.
- Strengthen SRH commodity security with emphasis on family planning and emergency obstetric care and referral.
- 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.
- Integrate nutrition into STI/HIV/AIDS and SRHR, especially for children and pregnant women, by incorporating nutrition into the school curriculum and institutionalizing food fortification.
- Involve families and communities.
- Involve the Ministries of Health in conflict resolution.
- Ensure rural–urban service delivery equity.

Since the adoption of the Maputo Plan of Action (MPOA), some countries have:

- Increased the share of health allocations in national budgets.
- Created new incentives to retain health and medical personnel.
- Increased emphasis on emergency obstetric and neonatal care.
- Instituted maternal death audits in annual operational plans.
- Improved health management information systems.

The AUC Mandate

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" (AUC, 2006b: para 26, page 19).

Additional elements of the Commission's mandate include:

- The 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.

- The 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.*

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

- The Africa Health Strategy (2007–2015).

Besides these, other relevant mandates include a variety of 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

It is the intention of this report to inform Member States and other stakeholders of the progress made in the implementation of the Maputo POA on SRHR. The report identifies the challenges encountered by Member States in the process of implementation, good practices and lessons learnt that can be shared among stakeholders. It also proposes recommendations for the next steps in the promotion of sexual and reproductive health and rights in Africa.

To collect and synthesize information for this report, several techniques and methodologies were adopted from primary and secondary sources, a literature review, and consultations with a number of stakeholders.

Literature Review

The literature review included available data from reliable sources to look at the state of sexual and reproductive health and rights (SRHR), with focus on maternal, infant and child health, and in the overall framework of health, population and development for Africa. Data from other continents were also utilized for comparison. The review looked at the level of performance by Member States, and identified gaps that need to be addressed to achieve the MDGs by 2015. It is noteworthy that there are considerable inter- and intra-country variations. (The full list of the 53 AU Member States indicating those that responded is annexed to the Report as Annex A.)

FACTORS AFFECTING SRHR IN AFRICA

A wide range of factors have a negative impact on the sexual and reproductive health and rights of Africans. They range from socio-demographic, including rapid population growth and a young population, to socio-economic, reflected in the region's pervasive poverty. Weak health systems, gender inequalities and others serve to compound the problem. These and other factors are summarized in the following sections.

Demographically and economically, Africa – especially South of the Sahara – is characterized by rapid population growth, high maternal mortality and morbidity, a young population, pervasive poverty and food insecurity.

Socio-Demographic Factors

In 2008, Africa's population was estimated to be 987 million, with an average annual population growth rate of 2.3 per cent from 2005 to 2010 (UNECA et al., 2009). During the 1990–2000 decade, the continent's population increased from 622.4 million to 795.7 million, an addition of 173.3 million (28.4 per cent) in ten 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 rate is not in tandem with socio-economic development, but is, instead, associated with increasing poverty and hunger in Africa.

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

Another challenge is that the population of most African countries continues to be young. The most recent estimates show that children under age 15 constitute 41.2 per cent of the population. Children and youth aged 30 and below constitute over 70 per cent 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, and high rates of new HIV infections including mother to child transmission (MTCT).

Socio-Economic Factors

Despite promises, net official development assistance flows to the least developed countries generally remain far lower than pledged.

Compared with other regions of the world, Africa suffers disproportionately from poverty and deprivation (UNECA et al., 2009). Worldwide, about 20 per cent of the population survives on less than US$1 a day; the African average is twice that. Nearly half the population of Africa lives in extreme poverty and one-third in hunger. About one-sixth of Africa's children die before the age of five – the same as a decade ago. In the continent's previously war-torn countries, the levels of poverty and hunger have stagnated and even worsened in some.

Food security in Africa is worse than it was in 1970. The proportion of the population that is malnourished has remained within the 33–35 per cent range in sub-Saharan Africa, with over 70 per cent 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. Physical and intellectual stunting related to prolonged malnutrition is irreversible. Such a picture is not conducive to health and development.

It will also be recalled that developed countries committed to providing 0.7 per cent of their GNP to developing countries, of which between 0.15 and 0.2 was to be allocated to the least developed

countries (LDCs). Despite the promises, net official development assistance (ODA) flows to these countries generally remain far lower than expected. Consequently, the social sector in general and the health sector in particular receive limited support, whereas all MDGs hinge on social development. This situation has a negative impact on maternal and child health in Africa.

Weak Health Systems

Inadequate or non-functioning describes the poor health systems in most African countries, an indication of the low priority given to the wellbeing of people and to the fundamental right to health. Health facilities are ill-equipped and basic supplies often unavailable. Staffing is generally inadequate, salaries are low and working hours are long, all of which contribute to low staff morale, which in turn affects the quality of services. Service providers usually do not have adequate training, and are not well versed in issues of SRHR. Furthermore, they are unable to provide specialized and skilled services. The few skilled medical personnel are often concentrated in urban areas or attracted to better working conditions outside the continent, further aggravating the health of women and children in Africa.

Moreover, the services that are available tend to neglect or overlook the special needs of adolescents and youths – this despite their large proportion of the populations. In addition, distances between referral points are long and the roads are often bad and frequently impassable, with poor and expensive transportation resulting in under-utilization of the available health services.

According to the UNFPA Arab State Regional Office 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 fewer deaths per 1,000 live births between 1990 and 2008. Maternal, infant and child mortality remain high by international standards, however, but these indicators drop quickly when mothers have access to medical care and emergency obstetric and newborn 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. The decline was managed through the adoption 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 effective steps to address those causes. Many countries are also seeking to increase theuse of contraception to help bolster child and maternal health as well as lower fertility and slow population growth.

In much of Africa, annual health expenditure is less than US$30 per person, far below the minimum 'survival kit' for essential health. While local health financing has generally increased over the years, it has mainly been supported by external funding. Only about ten AU Member States attained the 15 per cent target pledged by African leaders in 2001, and just a few others have reached 10% and above. According to World Bank statistics, 41 per cent of people in sub-Saharan Africa live on less than US$1 per day, although a small percentage lives on much higher amounts, comparable to developed countries. This situation cannot ensure family and community health and development.

Gender Inequalities

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 the 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 and girls' 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 make informed decisions. Examples of such practices include female genital mutilation and early marriages resulting in high maternal morbidity and mortality. Gender-based violence, armed conflict and other related harmful traditional practices remain high in some countries in Africa, and also negatively affect the health of women and girls. Whereas Africa has 11 per cent of the world's population, it experiences 49% of the world's burden of maternal deaths, 67% of AIDS cases and 26% of underweight children (UNAIDS, 2007; UNICEF, www.childinfor.org).

Gender inequality is one of the social determinants at the heart of inequity in health.

Other Factors Affecting Maternal Health and SRHR

Other factors that aggravate maternal ill-health and mortality in Africa include HIV and AIDS, malaria, other infectious diseases, under-nutrition, malnutrition and anaemia, which affect a large percentage of women and children in Africa. Underlying these diseases and conditions are the same factors detailed above, including inequality, lack of respect for people's rights, poverty, and a lack of social protection that limits access to health and other social services.

Conclusions from the Literature Review

In view of the foregoing, AU Member States and Africa as a continent have formidable challenges to overcome if the MDG targets are to be attained by 2015. These include the same issues that this progress review sought to address:

- Strengthening health systems in the broad sense for universal, integrated and comprehensive service delivery at all levels. This requires good supervision, coordination and effective referrals among others. Adolescent and school health plans should be part of general health and development plans.
- Addressing the huge burden of disease and conditions that mitigate against SRH.
- Developing the health workforce, through training but also by 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.
- Prioritizing predictable health financing at national level, supplemented by external funding. This should be a priority of national development planning and budgeting, as well as poverty reduction strategies. It should also take into account the promotion of social protection for all, particularly for vulnerable groups, and of course good planning and rational use of the available resources (more money well spent).

- Developing health information systems to improve follow up, monitoring and evaluation.
- Educating communities by giving them correct information and involving them in both planning and implementation of programmes.
- Intensifying and sustaining advocacy to fight harmful traditional practices that negatively affect SRHR by involving communities, both men and women.
- Coordinating and harmonizing partnerships with stakeholders at different levels.

REVIEW METHODOLOGY

The Progress Assessment Tool (PAT) that formed the basis of this review was designed by a Team of Experts during a meeting held in Kampala, Uganda, on 11–12 July 2009 (AUC, 2009b). The team included experts from Partners in Population and Development Africa Regional Office (PPD-ARO), UNFPA, WHO-AFRO, IPPF-AFRO, Marie Stopes International and the AUC. Thirty-seven (37) key indicators were selected from the more than 100 required for AU reporting. The tool was also intended to collect information on challenges, lessons learnt during the implementation process and recommendations for further action. (Refer to Annex B for a sample of the PAT.)

A total of 43 of the 53 AU member countries responded to the PAT – a commendable 81 per cent.

The PAT was sent to all AU Member States through their respective embassies in Ethiopia, and electronically to the Ministries of Health. It was also posted on the AU website. Country reports were, in turn, forwarded to the AU Commission through the embassies, by email, and through UNFPA and PPD-ARO.

The tool gathered both qualitative and quantitative data for analysis. For qualitative analysis, a thematic technique was used to extract key messages and a content technique to extract the commonly mentioned themes. For quantitative data, the Epi Info 3.5.1 programme with a univariate analysis of variables to generate data frequencies was used. Additional information to enrich the report was taken from progress reports on the assessment of the implementation of the Maputo Plan of Action undertaken by relevant partners.

Limitations

Among the limitations to the analysis and discussion of the report are the following:

- Some Member States did not fully respond to the questionnaire. Therefore, data on particular indicators with their respective challenges and recommendations were not captured. Furthermore, a few responses on particular indicators were difficult to interpret.
- The timeframe allocated for completion of the report was short because of delays in response from Member States. The initial deadline for submission was 31 December 2009, but the country reports for the initial analysis were not received till early April 2010. The final analysis included reports submitted by end April 2010.

- Out of more than 100 indicators, the PAT covered only 37 key indicators. Although these tried as much as possible to cover the most important national level issues for maternal, infant and child health, they do not cover all the indicators listed in the Maputo POA.

Proportion of Responses by Region

In the event, a total of 43 of the 53 AU member countries finally responded to the PAT – a commendable 81 per cent (see Annex A for the list). These are: Angola, Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Comoro Islands, Côte d'Ivoire, Djibouti, Democratic Republic of Congo, Egypt, Ethiopia, Equatorial Guinea, Gabon, Ghana, The Gambia, Guinea Bissau, Guinea Conakry, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Nigeria, Rwanda, Sao Tome & Principe, Senegal, South Africa, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Zambia and Zimbabwe (Table 1).

Table 1: Responses from the five African regions

Region	No. of countries	Percentage by region	Cumulative percentage
Central Africa	8	18.6	18.6
Eastern Africa	10	23.3	41.9
Northern Africa	3	7	48.8
Southern Africa	10	23.3	72.1
Western Africa	12	27.9	100
Total	43	100	100

SUMMARY OF FINDINGS IN EACH PRIORITY AREA

In presenting the findings of the review, this section walks through each of the nine major areas of intended action. The presentation briefly summarizes the quantitative results, gives a capsule narrative summary and where appropriate details the findings in tabular form. The nine areas and their corresponding indicators – a total of 37 of the latter – are as follows:

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: Multisector plans supporting SRHR
Indicator 3: Laws/legal instruments dealing with gender-based violence (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 and nutrition with SRHR in their curricula
Indicator 7: Percentage of SDPs (health facilities) offering integrated SRHR/STI/HIV/AIDS and malaria services

2. Strengthening of community-based STI/HIV/AIDS and SRHR services

Indicator 8: Strategy for community-based STI/HIV/AIDS and SRHR services

3. Family planning repositioning as key strategy for attainment of MDGs

Indicator 9: Proportion of health budget allocated to family planning commodities
Indicator 10: Supportive protocols and guidelines for family planning

4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing

Indicator 11: Policies/strategies supporting SRHR services for young people
Indicator 12: Youth-friendly SRHR services integrated into the training curricula

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 service delivery points (SDPs) providing post-abortion care (PAC) services

> ***Among the good practices is the case of Zimbabwe where:*** the review of the curricula for nurses, midwives and doctors has been done and includes integration of STI/HIV/nutrition.

6. Access to safe motherhood and child survival services increased

Indicator 16: Road map for the reduction of maternal and newborn morbidity and mortality
Indicator 17: National action plan to operationalize the road maps
Indicator 18: Preservice curricula incorporating emergency obstetric and neonatal care (EmONC) for all appropriate cadres
Indicator 19: Functional referral system from community to health facility
Indicator 20: Availability of protocols for the integrated management of childhood illnesses (IMCI)
Indicator 21: Proportion of EmONC sites with access to adequate supply of safe blood
Indicator 22: Programmes and strategies to scale up prevention of mother to child transmission (PMTCT) of HIV
Indicator 23: Proportion of HIV-positive mothers who have delivered and are receiving anti-retroviral drugs (ARVs)

7. Resources for SRHR increased

Indicator 24: 15 per cent of national budget allocated to health
Indicator 25: Proportion of health budget allocated for SRHR
Indicator 26: SRHR integrated into national poverty reduction strategy papers (PRSPs), or other development plans
Indicator 27: No. of midwives per population

8. SRH commodity security strategies for all SRH components achieved

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

9. Monitoring, evaluation and coordination mechanism

Indicator 32: Censuses, Demographic and Health Surveys (DHSs), and maternal and neonatal death reviews conducted regularly
Indicator 33: A monitoring and evaluation system institutionalized
Indicator 34: Operational research findings utilized
Indicator 35: Resource allocation and utilization regularly monitored
Indicator 36: Best practices documented
Indicator 37: Functional coordination and harmonization mechanism in place

Integration of STI/HIV/AIDS, Malaria and SRH Services into Primary Health Care

All countries that submitted reports responded to this indicator, but some did so only partially. Many countries have plans in place and some are already implementing them, but a few do not yet have the plans. The main challenge noted relates to weak health systems, including inadequate human resources, unsatisfactory coordination, and the fact that some well-funded programmes are still vertical and not ready to take on other programmes (Table 2).

Table 2: Integration of STI/HIV/AIDS, malaria and SRH services into PHC

Indicators	Done	In progress	Not done
Integrated SRHR/STI/HIV/AIDS and malaria policy documents and/or national plans	33 (76.7%)	6 (14%)	4 (9.3%)
Multisector plans supporting SRHR	22 (52.4%)	13 (31%)	7 (16.7%)
Laws/legal instruments dealing with gender-based violence (GBV) in place	30 (69.8%)	9 (20.9%)	4 (9.3%)
Strategies dealing with GBV developed and implemented	22 (51.2%)	19 (44.2%)	2 (4.7%)
Policies and programmes against harmful traditional practices	27 (65.9%)	8 (19.5%)	6 (14.6%)
Training institutions integrating STI/HIV/AIDS and nutrition with SRHR in their curricula	31 (72.1%)	8 (18.6%)	4 (9.3%)

Three (12%) countries reported that integrated SRHR/STI/HIV/AIDS and malaria services are available in 2–40% of their service delivery points, and nine (36%) offer the services in 50–87%. Twelve (33%) countries provide integrated SRHR/STI/HIV/AIDS and malaria services in all their service delivery points. Only one country (4%) does not offer the services in any of its service delivery points (indicator 7).

Good practice from Nigeria:
Health partner forums are held regularly.

Strengthening Community-Based STI/HIV/AIDS and SRHR Services

Strategies for community-based STI/HIV/AIDS and SRHR services are in place in 25 (59.5%) countries. Another 14 (33.3%) say they have initiated action, while 3 (7.1%) have not done so (indicator 8). Many countries have plans in place and some are already implementing them. Communities, including youths and men, should be involved in all levels of planning and implementation for better results.

Repositioning Family Planning as a Key Strategy for Attainment of the MDGS

Only 16 (37.2%) countries reported on the proportion of their health budget that is allocated to family planning commodities. Among these, four (25%) said they do not specifically budget for family planning, as support to this area is derived from the global health budget. Seven (43.8%) countries indicated that they allocate 1–5% of the health budget to family planning commodities, while four (25.2%) others allocate 10–15%. Only one (6.3%) country reserves 16% of its budget to family planning (indicator 9).

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, information, education and communication (IEC) activities, and community involvement, as well as regular supplies of commodities. All of these present challenges of one degree or another for many countries to overcome. Policies and strategies have been articulated and adopted in most countries, but their effective operation is still a problem. Education institutions, youth and other groups, and community-based organizations (CBOs) are important partners in this regard.

Supportive protocols and guidelines for family planning are in place in 35 (83.3%) countries. The process is under way in six (14.3%) countries, but in one (2.4%) no action has been taken (indicator 10).

Youth-Friendly SRHR Services Positioned as a Key Strategy for Youth Empowerment, Development and Wellbeing

In South Africa, the health system is based on the principles of primary health care; and all training institutions incorporate and articulate all dimensions of SRHR according to the National Policy Framework, which is clear on required adolescent health services. This is another example of good practice that needs to be scaled up.

Nearly two-thirds of the reporting countries – 27 or 64.3% – say that they have policies/strategies in place as well as centres supporting SRHR services for young people. Twelve countries (28.6%) are in the process of developing them, whilst 3 (7.1%) have nothing in place (indicator 11).

Youth-friendly SRHR services have been integrated into the training curricula in 22 (53.7%) countries, while action has been initiated in 11 (26.8%). Nothing has been done in this area in eight (19.5%) countries (indicator 12).

Although most countries have policies and strategies in place, effective operation is still a challenge. Other challenges include strategies that are not flexible, cultural constraints and high rates of teenage pregnancies in some countries. Education institutions, youth and other organizations, and CBOs are important partners in these efforts.

Incidence of Unsafe Abortion

In 24 countries (55.8%) legislative/policy frameworks on abortion have existed for many years. These are being developed in 7 countries (16.3%), but 12 (27.9%) have not yet begun to address this matter (indicator 13).

Moreover, 28 (65.1%) countries have in place programmes, strategies and action plans to reduce unwanted pregnancies and unsafe abortion. While the process is under way in another eight (18.6%) countries, no action has been taken in seven (16.3%) (indicator 14).

Eleven (42.3%) countries report that 8–50% of their service delivery points provide post-abortion care (PAC) services, while 15 (57.7%) countries have more than 50% of their service delivery points providing PAC services (indicator 15).

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 PAC is still unsatisfactory. A strategy for advocacy and education to raise awareness among youth and to improve the attitude of health workers, teachers and the community at large to abortion should be adopted. The media can play an important role here.

Sudan sets a good example where women in the informal sector are covered in the national fund for health insurance.

Access to Safe Motherhood and Child Survival Services

Road maps for the reduction of maternal and newborn morbidity and mortality have been developed by most countries (88.4%) and are being implemented in some. However, providing adequate services – including regular supplies – as well as accessing services for emergency obstetric and neonatal care (EmONC) country-wide still pose a challenge to safe motherhood and child survival (Table 3).

Table 3: Access to safe motherhood and child survival services

Indicators	Done	In progress	Not done
Road map for the reduction of maternal and newborn morbidity and mortality	38 (88.4%)	4 (9.3%)	1 (2.3%)
National action plan to roll out the road maps	34 (79%)	6 (13%)	3 (7%)
Preservice curricula incorporating EmONC for all appropriate cadres	30 (69.8%)	9 (20.9%)	4 (9.3%)
Functional referral system from community to health facility	15 (34.9%)	20 (46.5%)	8 (16.6%)
Availability of IMCI protocols	34 (79.1%)	1 (2.3%)	8 (18.6%)

Nine (30%) countries say that 100% of their EmONC sites have access to an adequate supply of safe blood and 11 (36.6%) countries reported 50–80%. Another 10 (33.4%) countries indicate less than 50% for this service (indicator 21).

Programmes and strategies to scale up PMTCT are in place in 36 (83.7%) countries. Four (9.3%) countries are developing them, and three (7%) have nothing in place (indicator 22).

Two (7.4%) countries reported that 100% of their HIV-positive mothers who have delivered are receiving ARVs. Another 14 (51.8%) had 50–91% coverage, while 11 (40.7%) manage to cover less than half (indicator 23).

Resources for SRHR

The available resources are mainly within the general health budget, which is limited in some countries. A few countries do assign limited but specific budget lines for SRHR including family planning. Many programmes are donor dependent, which means that their sustainability is not assured. Local resources should be mobilized including from the private sector, and supplemented by external funds (Table 4).

Table 4: Resources allocated to health and to SRHR

Indicators	Done	In progress	Not done
National budget allocated to health	5 (11.6%)	12 (27.9%)	26 (60.5%)
SRHR integrated in national PRSPs & other development plans	32 (76.2%)	5 (11.9%)	5 (11.9%)

Five (41.7%) of the 12 countries that responded to this indicator allocated 10–15% of the health budget to SRHR, three (25%) allocate 1–2%, and two (6.5%) allocate 6–7%. Two (16.7%) countries have no specific budget allocation for SRHR (indicator 25). Inadequate supervision was noted as an added challenge.

Some countries found it difficult to report on this indicator, as they have only estimates or have not yet tried to measure the capacity of this important human resource. Staffing shortages are compounded by high turnover, low salaries and other challenges to do with motivation. The shortage of midwives is generally more acute in rural areas. One country recorded 41 midwives per 10,000 population and another recorded 30 midwives per 10,000 population. Three countries said they have 11 midwives per 10,000 people, while another three recorded 5 per 10,000. In six countries there are 2–4 midwives per 10,000 people and in seven there are only 1–2 midwives serving that population. One country reported having <1 midwife per 10,000 people (indicator 27).

Botswana has attained and surpassed the 15% allocation of the national budget to the health sector.

SRHR Commodity Security Strategies

Namibia has promoted intersector cooperation to help reduce stock-outs.

Although SRHR commodity security strategies and action plans are in place, their operation is still a challenge, sometimes because of inadequate or delayed funding. This results in stock-outs especially in rural areas. Many countries recommended that reproductive health commodities be included in the essential medicines list. Government ownership – or the lack thereof – is sometimes a challenge, as external partners support commodity supply in some countries (Table 5). The Pharmaceutical Manufacturing Plan for Africa provides a framework for promoting local or regional production and should be explored.

Table 5: Commodity security for SRH

Indicators	Done	In progress	Not done
National RH commodity security strategy & action plans in place	33 (78.6%)	7 (16.7%)	2 (4.8%)
RH commodities in essential medicines list	38 (90.5%)	3 (7.1%)	1 (2.4%)
National budget line for SRH commodity security	21 (50%)	3 (7.1%)	18 (42.9%)

Prolonged reproductive health commodity stock-outs were reported by seven (16.7%) countries. Ten (23.8%) had occasional stock-outs and 25 (59.5%) did not experience stock-outs (indicator 31).

Monitoring, Evaluation and Coordination Mechanisms

Many countries have institutionalized monitoring and evaluation (M&E) systems or are in the process of doing so. Competing priorities, inadequate supervision and coordination, and limited human resources are some of the challenges countries face in this area. It was recommended that a Coordination Committee be put in place in the Ministries of Health if such does not exist. Heath information systems in African countries should be developed and managed properly for effective M&E and information sharing (Table 6); data should be disaggregated by gender and age.

Table 6: Monitoring, evaluation and coordination mechanism

Indicator	Done	In progress	Not done
Censuses, DHSs, and maternal and neonatal death reviews conducted regularly	29 (69%)	6 (14.3%)	7 (16.7%)
A monitoring and evaluation system institutionalized	28 (66.7%)	12 (28.6%)	2 (4.8%)
Operational research findings utilized	19 (45.2%)	18 (42.9%)	5 (11.9%)
Resource allocation and utilization regularly monitored	21 (50%)	10 (23.8%)	11 (26.2%)
Best practices documented	19 (45.2%)	11 (26.2%)	12 (28.6%)

Functional coordination and harmonization	23 (54.8%)	13 (31%)	6 (14.3%)

ACTION UNDERTAKEN BY AU AND PARTNERS (2007–2010)

Following its adoption, the Maputo POA was disseminated to the Member States. They were urged to put it into operation at national level. Further, Members were encouraged to work 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.

A 2008/09 assessment by UNFPA found an unprecedented effort in Africa to revise, update and develop policies, strategies and plans related to the different components of SRHR highlighted in the Maputo Plan of Action.

As a follow-up to the Maputo POA, the April 2008 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. Action in this area was deemed very important because if deaths are not registered, the underlying causes of death cannot be addressed. 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.

In 2008/09, UNFPA conducted an assessment of the status of development of the Maputo POA, including the National Maternal Newborn Health Road Maps (UNFPA, 2008). The main highlights from that assessment generally concur with the findings in this progress report on the Maputo POA.

The UNFPA assessment noted that an unprecedented effort is ongoing in Africa to revise, update and develop policies, strategies and plans related to the different components of SRHR as highlighted by the Maputo Plan of Action. Specifically on the maternal and neonatal health (MNH) road maps, however, the assessment found a number of issues needing attention and action. Among these were the following:

- The quality of the situation analyses was generally poor and could have negatively affected the identification of strategies and activities to be implemented.
- Family planning programmes are not clearly integrated with the MNH plans.
- Human resources development and management plans for EmONC are not well developed.
- Community involvement/mobilization is addressed, but not all countries have defined detailed interventions for newborn/child health and HIV at community level.
- Complications of abortion, which constitute one of the major causes of maternal death and disability in most African countries, are poorly addressed in general, even in countries where abortion is legal.
- Although many countries have developed MNH road maps, a significant number do not have plans for scaling-up the key strategies and interventions.
- Many MNH plans have been costed, but responses to the budget issues were generally poor.

- Although the maternal and newborn health initiative requires massive investments, available resources are limited. Only a few countries had developed strategies for resource mobilization.

- Monitoring and evaluation of the implementation of MNH road maps requires a work plan, budget and a multi-disciplinary team, but not all countries had these requirements in place.
- While key MNH indicators are included in the national health management information system (HMIS) in many countries, integrating these plans within national health plans and financing processes is now a challenge the majority of countries are facing.

One of the lessons learnt during the implementation of MPOA is that incentives are needed to motivate staff, especially those in rural areas. This also contributed to reverse the health workforce crises.

The UNFPA report concluded that although planning is important, real progress in newborn, child and women's health will be made by implementing and scaling up cost-effective, well-defined priority interventions and monitoring them to track progress and improve the plans in a cyclical planning process. Immediate and long-term activities are necessary, to be implemented at the same time with strong political support and appropriate investments. UNFPA, UNICEF, WHO and the World Bank (H4), working together with donor countries, global funds and foundations, and regional and international NGOs, can be instrumental in providing the necessary support to countries toward the achievement of MDGs 4 and 5.

No woman should die while giving life!

The deliberations of the 4th Session of the AU Conference of Ministers of Health, held in Addis Ababa in May 2009 with the theme *Universal Access to Quality Health Services: Improve Maternal Neonatal and Child Health,* served as a reminder to Member States to scale up implementation of the Maputo POA and other relevant commitments. Recommendations for promoting universal access to health services and improving maternal, neonatal and child health were adopted. The Campaign on Accelerated Reduction of Maternal Mortality (CARMMA) was also launched, with the slogan ***No woman should die while giving life!*** The goal set for CARMMA is to "contribute to further advancement of social development in the continent through proactive support to national efforts aimed at reducing maternal mortality in Africa" (AUC, 2009a). CARMMA was welcomed as an important advocacy tool and subsequently launched in many Member States. It is also well-supported by the international community.

In line with the AU Gender Policy, the African Women Decade was extended to 2010–2020. One of its objectives is to continue raising awareness and mobilizing support and political will for implementing the agreed international, continental, regional and national commitments on gender equality. Implementation is focusing on the following priorities, among others: Education; health and maternal mortality; and gender-based violence including harmful practices, which covers early marriage and female genital mutilation (FGM).

Action to implement the Maputo POA at national level is supported by the UN agencies, bilateral and multilateral partners, intergovernmental agencies, and foundations. The immense support is commendable, but should well-coordinated and harmonized, and in line with national priorities and programmes.

It will be recalled that the *Road Map for Accelerating the Attainment of MDGs related to Maternal and Newborn Health* was adopted in 2004 by the WHO Regional Committee for Africa. The Road Map's 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 directly linked to that of the Maputo POA.

The annual progress reports on the status of implementation of the MDGs indicate that Africa is making forward strides on some of the goals, but unfortunately the worst performance is still on MDG 5 – Improve maternal health. In line with the Continental Policy Framework, the WHO Regional Committee for Africa launched *Women's Health Day* in the Africa Region in September 2009. A Commission on Women's Health has also been established to coordinate and follow up on recommended advocacy and action. The whole continent should join hands and support this important initiative.

In the framework of the increasing partnerships between Africa and other regions, as well as with specific developed countries and their development agencies, action to promote maternal, newborn and child health in Africa is being undertaken both at the AU and in Member States: Bilateral and multilateral cooperation, Africa–EU cooperation, Africa–USA cooperation and Africa–G8 parliamentarians. With all that, 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 AND LESSONS LEARNT

The main challenges and lessons as highlighted by almost all countries under each priority area relate to inadequate resources, weak health systems, inequities in access, weak multisector response, low priority accorded to health in national development plans, and inadequate data. These are echoed, as well, in the 2008/09 UNFPA Report on the MPOA Review (UNFPA, 2008).

National Level Challenges

The implementation of the Maputo Plan of Action encountered significant challenges at national level. Arranged by broad categories, these include the following:

- **Human resources**
  - Inadequate health workforce as a result of limited training, lack of incentive particularly to work in rural settings, quick turnover and migration.
  - Shortage of skilled health workforce, especially midwives.

- **Weak health systems**
  - Weak general infrastructure.
  - Weak intersector cooperation.
  - Inadequate involvement of communities.
  - Limited centres offering comprehensive services.
  - Low integration and decentralization.
  - Weak and inadequate health information systems.
  - Conflicting priorities with other health programmes.
  - Difficulty in setting standards and removing barriers such as user fees in the private sector.
  - Weak management and coordination.

- Limited operational research.
- Inadequate implementation of recommendations on mortality reviews.
- Poor service delivery and under-utilization of existing services.
- Under-utilization of contraceptives including condoms.
- Reduced access to health services because of poor infrastructure and communication.
- Low utilization of available services by communities.
- Problems related to procurement and distribution leading to stock-outs especially at district level.
- Poor health outcomes resulting from underlying diseases and conditions such as HIV/AIDS and malaria, especially among pregnant women.

- **Inadequate health financing**
  - Limited financial resources.
  - Limited national budgets with heavy donor dependency.
  - Poor planning and non-rational use of available resources.
  - Shortage of funds as a result of the global financial crisis.

- **Poor coordination of interventions**
  - Continued existence of vertical programmes.
  - Weak political leadership.
  - Inadequate community mobilization.
  - Weak coordination of partnerships.

Among the various lessons learnt during the implementation of MPOA is that sexual rights are compromised through cultural values and practices that limit women's understanding of their sexuality and thus reduce their abilitv to make informed decisions.

- **Unfavourable legislation**
  - Limited implementation of legal instruments, some of which are archaic or outdated in many countries.
  - Lack of commitment by policy makers.
  - Safe abortion not supported by laws.

- **Traditional harmful practices**
  - Gender-based violence in a number of forms.
  - Negative socio-cultural attitudes towards SRHR.
  - Low male support and participation in SRHR issues.

- **Behaviour change communication**
  - High rates of teenage pregnancies and unplanned pregnancies.
  - Limited programmes for both in-school and out-of-school youth.
  - Inadequate community mobilization (men and women), including the use of IEC.

Lessons Learnt

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

Lessons from Zambia:
Maternal, newborn and child health should be put as a priority second to human resources for health if MDG 4 and 5 are to be attained.

Facilitating Factors

Factors facilitating implementation include the following:

- Partnerships at all levels have contributed significantly to the achievements made by Member States and the AU in rolling out the Maputo POA. Increased partnerships with good coordination, supervision and harmonization (including regional cooperation), all following the same road map, are important for scale-up and rational use of scarce resources.

- Promotion of integration with comprehensive coverage of all SRH services (including family planning) at all levels ensures the implementation of a single focused plan.

- Leveraging resources from different programmes that are better funded has helped promote SRHR, while sector-wide approaches provide predictable funding for services.

- Developing and implementing the road map for accelerating the reduction of maternal, neonatal and child mortality (including maternal death reviews) provides information to use as a resource mobilization tool.

- Resources alone are not enough, however. In addition, there should be a plan for the rational use of resources, as well as for enhancing demand as implied by the unmet need for family planning.

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

Lessons from Uganda:
Early attempts to pass local by-laws to regulate FGM backfired and met with strong opposition from the very community. Therefore, starting with community mobilization and education by working with local CBOs and NGOs to reach traditional leaders, candidates circumcision, and putting in place alternative rites of passage, were important for setting the stage for successful legislation.

- Micro-finance projects, especially for women, are a useful tool for promoting maternal and child health.

- 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.

- The launch of CARMMA is creating more awareness, and the UN and other agencies' support for this or other programmes makes a difference.

Impeding Factors

Implementation is impeded by following:

- Weak health systems continue to be a major challenge to quality service delivery.
- Top-down (vertical) approaches negatively affect community participation.
- The lack of a dedicated budget for SRH has a negative impact on service delivery.
- Inadequate legislation on safe abortion or criminalization of abortion does not reduce the incidence of abortion.

Recommendations to Address the Challenges

In line with the identified challenges, a number of recommendations are made to implement SRHR strategies more comprehensively. By general category, these included the following:

- **Human resources**
  - Ensure availability of adequate skilled human resources for SRH.
  - Motivate health workers and put retention incentives in place.

- **Health systems**
  - Promote adequate, integrated and comprehensive health systems.
  - Strengthen health information with emphasis on establishment of M&E offices/committees.
  - Promote research as a priority.
  - Ensure that emergency preparedness and response plans for undertaking activities upon demand are always in place.

- **Service delivery**
  - Strengthen emergency obstetric care.
  - Make adequate funding available for reducing unsafe abortion.
  - Improve logistics and commodity management and integrate HIV/STI and other disease programmes into reproductive health.
  - Mobilize the community – including men – to participate in and utilize available services.
  - Include SRH products and commodities in the list of essential medicines.

- **Health financing**
  - Strengthen financial systems with resource mobilization.
  - Increase the percentage of national budget resources allocated to health care to at least 15%, as called for in the 2001 Abuja Declaration.

Lessons from Sudan and Uganda:
Availing services is necessary but not sufficient for improving access to services: Demand has to be enhanced as shown by the unmet need for family planning services.

- **Coordination of interventions**
  - Ensure national ownership – i.e., government not donors – of the reproductive health programme, including regulating the health sector.
  - Promote coordination through the establishment of Intersector Committees.
  - Improve coordination and supervision of people, activities and expenditures.

- **Legislation**
  - Undertake advocacy towards the adoption and implementation of more tolerant laws and instruments.
  - Decriminalize abortion in order to promote SRHR and prevent back street abortions.

- **Harmful traditional practices**
  - Put in place or revise appropriate legislation as might be required in certain instances, in such matters as gender-based violence (including FGM), abortion, early marriage and inheritance.
  - As a corollary, scale up IEC campaigns against gender-based violence including harmful traditional practices.

- **Behaviour change communication and education**
  - Promote the development of strong school health programmes.

Lessons from Kenya:
Government stewardship and ownership are imperative.

- Increase the focus on the empowerment of youth and adolescents (both in and out of school) through SRHR education.
- Promote and facilitate communication among health care providers including peer educators at various levels.
- Promote community mobilization and participation, including income generation, and with a special focus on the involvement of men.

GENERAL RECOMMENDATIONS AND WAY FORWARD

The following recommendations are made to achieve the realization of the Maputo POA on SRHR:

- The Maputo POA should be extended for the period 2010–2015 to enable further and more effective implementation of the POA, and to coincide with the targets of the MDGs. In that regard, the Maputo POA indicators should be revised and harmonized with those of the MDG targets.

- Implementation during the period 2010–2015 should be comprehensive and integrated, and undertaken with more zeal. It should cover maternal, infant and child health, and incorporate relevant national, continental and regional policies on maternal, neonatal and child health and development.

- Nutrition and food security, as well as HIV/AIDS, TB, malaria and other infectious diseases, should be simultaneously addressed. The linkages with cross-cutting issues such as poverty reduction and financial crises, civil strife, armed conflict, and climate change should be taken into account.

- Member States should accelerate efforts to implement the Maputo POA within the framework of their respective national strategies on maternal, neonatal and child health through an integrated, and multisector approach. CARMMA should be consolidated as an advocacy tool.

- Each stakeholder at regional, continental and international level should play its respective role in urging and supporting Member States to accelerate action to implement the Maputo POA in the period 2010–2015, as well as other strategies on maternal, infant and child health and survival.

- More domestic and international resources should be mobilized and used rationally, with specific allocations made for maternal, infant and child health including family planning in Member States. The AU, regional economic communities (RECs) and regional health organizations (RHOs) should also mobilize resources for Member States and their own respective programmes.

- For effective implementation and rational use of limited resources, partnerships should not only be strengthened, but also coordinated and harmonized better at all levels, under government stewardship at national level and the AU at continental level.

NEXT STEPS

The following actions will be undertaken to support the full implementation of the recommendations of this review:

1. After adoption by the AU Conference of Ministers of Health, the (extended) Maputo Plan of Action on Sexual and Reproductive Health and Rights (2010–2015) will be submitted to the Executive Council and Assembly of Heads of State and Government in July 2010 for endorsement.

2. It will then be disseminated for implementation with fresh commitment by Member States and other stakeholders and partners at all levels. Such implementation should be linked to the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the Plan of Action on Africa Fit for Children and other relevant commitments.

Subsequently, the following are also necessary to ensure the effectiveness of the endeavour:

3. Annual progress reports should be submitted to Ordinary Sessions of the AU Conference of Ministers of Health, and/or other relevant regional and continental forums.

4. A comprehensive five-year review report on the status of implementation should be submitted to the AU Organs in early 2015, in preparation for the review of the MDGs the same year.

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