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MAPUTO PLAN OF ACTION
FOR
THE OPERATIONALISATION OF THE CONTINENTAL POLICY FRAMEWORK
FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
2007-2010

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Universal Access to Comprehensive Sexual and Reproductive Health Services
in Africa

INTRODUCTION

1. Recognizing that African countries are not likely to achieve the Millennium Development Goals (MDGs) without significant improvements in the sexual and reproductive health of the people of Africa which is crucial in addressing MDG 1 on poverty reduction, the 2nd Ordinary Session of the Conference of African Ministers of Health, meeting in Gaborone, Botswana, in October 2005, adopted the Continental Policy Framework on Sexual and Reproductive Health and Rights which was endorsed by AU Heads of State in January 2006.

2. The Continental Policy Framework on Sexual and Reproductive Health and Rights addresses the reproductive health and rights challenges faced by Africa. It also calls for strengthening the health sector component by increasing resource allocation to health, in order to improve access to services. Mainstreaming gender issues into socio-economic development programmes and SRH commodity security are also addressed. Moreover, the AU Ministers of Health recommended that SRH should be among the highest six priorities of the health sector. In harmony with this ministerial recommendation the outcome of the World Summit held in New York in September 2005 reiterated the need to attain universal access to services, including access to reproductive health care services.

3. The AU Health Ministers further called for a Special Session to discuss the issues associated with improving sexual and reproductive health and the need to develop a concrete, costed Plan of Action (POA) for implementing the Framework. This decision was endorsed by the Summit of the Heads of State and Government in Khartoum, Sudan, in January 2006.

4. The Gaborone Declaration on the Roadmap towards Universal Access to prevention, treatment and care, among other things, underlines the need for the development of an integrated health care delivery system based on essential health package and the preparation of costed health development plan.

5. This Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015. It is a short term plan for the period up to 2010 built on nine action areas: Integration of sexual and reproductive health (SRH) services into PHC, repositioning family planning, youth-friendly services, unsafe abortion, quality safe motherhood, resource mobilization, commodity security and monitoring and evaluation. The Plan is premised on SRH in its fullest context as defined at ICPD/PoA 1994 taking into account the life cycle approach. These elements of SRHR includes Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and newborn care; Abortion Care[1]; Family planning; Prevention and Management of Sexually Transmitted Infections including STI/HIV/AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing mid-life concerns of boys, girls, men and

[1] Abortion as specified in para. 8.25, of ICPD/PoA, includes prevention of abortion, management of the consequences of abortion and safe abortion, where abortion is not against the law.

women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counselling, and Health education.

6. The Plan learns from best practices and cost-effective interventions and responds to vulnerability in all its forms, from gender inequality, to rural living and the youth, to specific vulnerable groups such as displaced persons, migrants and refugees. It recognizes the importance of creating an enabling environment and of community and women's empowerment and the role of men.

7. While recognizing the need for an emphasis on SRH the Plan recognizes that this must be built into and on an effective health system and sufficient financial and human resources and that SRH interventions will be impeded until the crisis in these is resolved. It is therefore essential to mobilize domestic resources to support health programmes including complying with the Abuja 2001 commitment to increase allocation of resources to the health sector to at least 15% of the national budget.

8. Recognizing the unique circumstances of each country, the Plan is specifically broad and flexible to allow for adaptation at the country level. It provides a core set of actions, but neither limits countries, nor requires those that already have strategies to start afresh; rather it encourages all countries to review their plans against this action plan to identify gaps and areas for improvement. At the same time, the Plan, although focused on country action, blends in niche roles in the eight action areas for the African Union, Regional Economic Communities and continental and international partners. It also recognizes the role of civil society and the private sector within the framework of national programs. The Plan sets indicators for monitoring progress at these different levels.

9. In addition to the Sexual and Reproductive Health Continental Policy Framework the plan has also recognised and drawn on the Gaborone Declaration on the Roadmap Towards Universal Access to Prevention, Treatment and Care, the Brazzaville Commitment on Scaling Up Towards Universal Access and the Abuja Call for Accelerated Action Towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria Services in Africa.

RATIONALE

10. Reproductive health conditions are devastating the African Continent: 25 million Africans infected with HIV, 12 million children orphaned due to deaths related to AIDS. 2 million deaths from AIDS each year, women increasingly affected with the feminization of the epidemic; 1 million maternal and newborn deaths annually, an African woman having a 1 in16 chance of dying while giving birth; high unmet need for family planning with rapid population growth often outstripping economic growth and the growth of basic social services (education and health), thus contributing to the vicious cycle of poverty and ill-health. Addressing poverty (MDG1) and addressing SRHR are mutually reinforcing.

11. Today, by any measure, less than one third of Africans have access to reproductive health (RH). Under current trends and with business as usual, Africa will not reach universal access to RH. The challenge is one of scale, to redouble our

efforts and to accelerate programmes towards rapid increases in access and coverage towards the ultimate goal of universal access to RH by 2015.

12. The March 2006 Brazzaville Commitment on ScalingUp Towards Universal Access, among other things, recognizes:

i. The importance of building long-term infrastructure and systems strengthening and capacity building at all levels of the health care system for an exceptional response to STI/HIV/AIDS.

ii. That basic medicines and other commodities are a human right and should be available and accessible to all who need them in Africa.

13. The Abuja Call for accelerated action towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria services in Africa also calls for the strengthening of health systems and the promotion of an integration of STI/HIV/AIDS services in Primary Health Care. This call was supported at the UN General Assembly Special Session on STI/HIV/AIDS in 2006.

14. All the above are in harmony with the consensus reached at ICPD a decade ago and reaffirm the urgency of doubling efforts to ensure attainment of universal access.

15. The Plan of Action takes into account the growing shortage of health care personnel and the threats surrounding the production and availability of generic medicines. Consequently, a whole section is devoted to capacity building and another to the issue of availability of commodities.

OVERARCHING GOAL

16. The ultimate goal of this Maputo Plan of Action is for African Governments, civil society, the private sector and all development partners to join forces and redouble efforts, so that together the effective implementation of the continental policy including universal access to sexual and reproductive health by 2015 in all countries in Africa can be achieved

17. Key strategies for operationalisation of the SRH Policy framework:

i. Integrating STI/HIV/AIDS, and SRHRprogrammes 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
health and rights
Adopt a multisectoral approach to SRHR;
Foster community involvement and participation;
Strengthen SRH commodity security with emphasis emergency obstetric care and referral;
on family planning and

18. The strategy includes the crosscutting issues to:
Increase domestic resources for sexual and reproductive including the addressing of the human resource crisis;
Include males as an essential partner of SRHR programmes;
Put in place operational research for evidence based action and effective monitoring tools to track progress made on the implementation of this Plan of Action;
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.

Involvement of families and communities;

Involvement of the Ministries of Health in conflict resolution;

Rural-urban service delivery equity.

19. The cost estimates provided in this PoA is a global requirement for the delivery of affordable quality SRHR services in the continent during the 4-year period 2007 - 2010. This PoA will mainly be financed through domestic resources and the shortfall will have to be mobilised.

PRIORITY TARGET GROUPS

20 Reproductive Health encompasses the whole life span of an individual from conception to old age as such SRH services shall be provided to all who need them. Emphasis will be on men and women of reproductive age, newborns, young people rural, mobile, and cross-border populations, displaced persons and other marginalized groups.

EXPECTED OUTCOME

21 This Program of Action will provide a framework from which countries can draw inspiration. This will not require the elaboration of new strategies but simply the incorporation of elements of this strategy into the existing ones.

COSTING THE PLAN OF ACTION

22. Preliminary cost estimates have been made for the direct service delivery costs required to make progressive advancement to universal access to reproductive health services by 2015 (including family planning, safe motherhood, newborn health and sexually transmitted infection interventions). $3.5 billion is required for sexual and reproductive health services forAfrica in 2007 and a total of $16billion through to 2010.

23. Review and updating of the preliminary cost estimates, incorporating national statistical inputs, is required. (See Annex).These are provisional results, conditional on the details in the appendix. The results also reveal that the savings in other maternal, newborn and child health interventions are significantly greater than the marginal increase in expenditures for higher family planning prevalence.

24. These estimates should be reviewed and further updated on the basis of the experience gained in the implementation of the programmes. However, what is most important is that national plans include detailed definitions of interventions appropriate to meeting national needs for sexual and reproductive health and that investments reflect and improve national capacity for their implementation and monitoring.

25. The principles of the current analysis, however, should be adhered to, including that: plans should be geared to achieving universal access to reproductive health by 2015, increased investment and action to improve human resources for health are required, such plans and estimates include resources to strengthen the health system including allocations for monitoring, supervision, basic public health functions, community action and other necessary support functions, that additional resources will be needed to address elements explicitly not included (such as capital investments) and that further investment will be needed in sectors other than health that support and advance progress towards health-related objectives, including those in the Millennium Development Goals. The current estimates are indicative of the scale of the required effort and should mobilize an appropriate response by governments, donors, civil society and the private sector.

POA for Implementing the Continental Sexual and Reproductive Health and Rights Policy Framework 2007–2010

Outputs	Strategic actions	Indicators for monitoring progress
1. HIV, STI, Malaria and SRH services integrated into primary health care		
1.1Advocacy/policy	1.1.1a Integrate SRHR and STI/HIV/AIDS/STI and malaria in key national health policy documents and plans	1.1.1b # countries with integrated SRHR/STI/HIV/AIDS/STIs and Malaria policy documents and national plans
	1.1.2a Develop policies and legal frameworks for STI/HIV/AIDS prevention to support the provision of appropriate and comprehensive STI/HIV/AIDS/STI and malaria prevention, care and treatment options for all includingpregnant women, mothers, infants , families and PLWHA	1.1.2b # countries with policies and legal frameworks in place to ensure access to comprehensive HIV/ AIDS/STI and malaria care and treatment options for pregnant women, mothers, infants, families and PLWHA
	1.1.3a Develop and/or implement strategies to address Gender Based Violence (GBV) in collaboration with other relevant stakeholders. 1.1.4a Research and develop and/or implement strategies to address early marriages and harmful traditional practices (HTP) such as Female Genital Mutilation (FGM) 1.1. .5a Incorporate health management of GBV in the training curricula of health workers and providers of	1.1.3bi # Countries with and strategies dealing with GBV developed and implemented. 1.1.3bii Laws dealing with GBV in place 1.1.4b # countries with programmes to address HTP 1.1.5bi # countries with curricula .that incorporate health related components of

Outputs	Strategic actions	Indicators for monitoring progress
	legalservices.	GBV
	1.1.6a Develop policies to ensure access to condoms especially among PLWHA	1.1.6b # countries with policies that ensure access to condoms especially for PLWHA
	1.1.7a Develop policies that promote involvement of civil society and private sector in SRHR service delivery within national programmes	1.1.7bi # countries with policies on public private partnership on SRHR developed and implemented
	1.1.8a Advocate for multi-sectoral effort to create a supportive environment for promotion of national SRHR policies and programmes	1.1.8bii # Countries with multi-sectoral plans supporting SRHR
	1.1.9a Develop and implement strategies to reduce harmful traditional practices	1.1.9b # Countries with programmes and policies that address harmful traditional practices
1.2Capacity building	1.2.1a Conduct comprehensive assessments of health care delivery systems to assess management, infrastructure and resource needs for effective integration of STI/HIV/AIDS into SRHR services	1.2.1b # SDPs providing integrated STI/HIV/AIDS and SRHR
	1.2. 2a Review training curricula for service providers to incorporate integration of SRH with STI/HIV/AIDS and nutrition. 1.2.3a Provide pre- and in-service training for health service providers in the provision of integrated SRHR STI/STI/HIV/AIDS and malaria services	1.2.2b # Training institutions integrating STI/HIV/AIDS, nutrition with SRHR in their curricula 1.2.3b # Providers trained in integrated STI/HIV/AIDS, malaria and SRHR
	1.2.4a Refurbish structure and reorganise service provision to ensure effective provision of integrated services	1.2.4b # Saps providing integrated services

	1.2.5a Develop an HR plan for training various cadres for local consumption: distribution, utilisation, and retention of health workers at all levels	1.2.5b Proportion of health workers per population
1.3Services	1.3.1a Ensure access to routine HIV counsellingand testing in STI, family planning and maternal and newborn and reproductive cancer services	1.3.1b % Service Delivery Points (SDPs) offering routine HIV counsellingand testing in STI, family planning and maternal and newborn and reproductive cancer services
	1.3.2a Integrate comprehensive HIV/STI prevention, management and treatment with SRHR, including dual protection	1.3.2b % SDPs offering integrated comprehensive HIV prevention, management and treatment
	1.3.3a Ensure access to services that address gender-based violence including management of sexual abuse, emergency contraception and HIV post-exposure prophylaxis and STI treatment in an integrated and co-ordinated manner	1.3.3b % SDPs offering STI, PEP and EC services for GBV victims
	1.3.4a Ensure integration of services for prevention and management of infertility	1.3.4a Prevalence of childlessness
	1.3.5a Provide appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services	1.3.5b Wide availability of appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services
	1.3.6a Provide services for the SRH needs of all persons including vulnerable groups and mobile populations especially migrant women, IDPs and those in conflict situations	1.3.6b Coverage for SRH services by target group
	1.3.7a Develop and implement programmes that ensures partnership with, support from and inclusion of men in SRHR services.	1.3.7b % Men with favourable attitude to SRHR (FP, assisted delivery,)
	1.3.8a Provide screening and management services	1.3.8b Proportion of SDPs offering screening

	for cancers of the reproductive system	and management services for cancers of the Reproductive system for both men and women
	1.3.9a Provide services for the management of mid-life concern of both men and women, menopause and andropause	1.3.9b Proportion of SDPs offering mid-life concerns of both men and women
	1.3.10a Integrate nutrition education and food supplementation programmes with SRHR and STI/HIV/AIDS/STI services and training	1.3.10bi Prevalence of underweight by age group 1.3.10bii Prevalence of anaemia in pregnancy
	1.3.11a Develop and implement strageties for ensuring blood safely	1.3.11b # SDPs with blood screening facilities
2. Strengthened community-based STI/HIV/AIDS/STI and SRHR services	2.1.1a Build capacity of community structures and referral networks to provide a continuum of STI/HIV/AIDS services within SRHR SDPs 2.1.2a Build capacity of all categories of SRHR service providers (including nurses, traditional birth attendants [TBAs], community-based distributors [CBDs], etc.) to facilitate effective integration of STI/HIV/AIDS into SRHR service delivery	2.1.1b RH coverage statistics 2.1.2b # countries with integrated STI/HIV/AIDS into SRHR service delivery
	2.1.3a Build capacity and empower communities to effectively partner with SRHR/STI/HIV/AIDS SDPs for enhanced community-based responses	2.1.3b # SDPs with community partnerships

2.1.4a Develop and implement behaviour change communication strategy for community mobilisation and education on health promotion and utilisation of integrated SRH with STI/HIV/AIDS, malaria and nutrition.
2.1.4bi # countries with comprehensive BCC strategy

2.1.4bii % Knowledge for SRH with STI/HIV/AIDS, malaria and nutrition.Services

3.Family planning repositioned as key strategy for attainment of MDGs		
2.1 Advocacy/ policy	2.1.1aMobilise political will and leadership for provision of quality family planning services. 2.1.2a Develop and/or implement gender and culture sensitive policies/legislation to ensure universal access to quality FP services	2.1.1b Proportion of SRH budget allocated to family planning 2.1.2bi Supportive legislation, protocols and guidelines for family planning
2.2 Capacity building 2.3 Service delivery	2.2,1a Develop or implement structures and systems for increasing access to FP 2.2.2a Train health care providers for the delivery of a comprehensive range of FP services 2.3.1a Develop gender and culture appropriate information to enhance FP knowledge in the target populations	2.2.1b# Countries with functional structures for FP service delivery 2.2.2bi Proportion of health workers trained in FP 2.3.1b Knowledge leves for FP for both men and women

2.3.2a Develop systems to increase coverage for FP services, including community based distribution and alternative models of service delivery
2.3.3a Integrate and provide FP as a component of MNHCH service package
2.3.2b Proportion of SDPs offering range of FP services

2.3.3bi CPR

2.3.3bii Couple Year Protection (CYP) 2.3.3biii Unmet need for FP

2.3.3iv % of clients accessing FP through community based mechanisms and alternative models

3.Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing		
3.1Advocacy/ policy	3.1.1a Strengthen implementation and/or advocate for policies that support the provision of SRHR services addressing the needs of young people	3.1.1b # countries that have developed t policies to support SRH services for young people
	3.1.2a Introduce an African youth SRH day	3.1.2b #No countries celebrating an African youth SRH day
	3.1.3a Cerebrate a day for the SRHR Services for young people	3.1.3b # countries cerebrating day of SRHR Services for young people
3.2 Capacity building	3.2.1a Develop and implement information and communication strategies that support both abstinence and condom use as effective strategies to	3.2.1b # Countries with IEC/BCC strategies that promote abstinence and condom use

	prevent STI/HIV/AIDS/STIs and unplanned pregnancies and link information to service delivery	
	3.2.2a Build capacity of SDPs and all levels of service providers to provide a comprehensive, gender sensitive package of care for young people	3.2.2b # countries with youth-friendly health services within their training curricula
	3.2.3a Develop and implement IEC strategies for parents and educators to communicate to young people.	3.2.3b# Countries with IEC strategies for parent education for young people.
3.3Service delivery	3.3.1a Assess and establish/ strengthen youth-friendly services at SDPs 3.3.2a Integrate provision of youth friendly services including promotion of abstinence and dual protection methods within existing services 3.3.3a Develop alternative service delivery mechanisms to reach young people including outreaches, peer education, CBD and social marketing 3.3.4a Provide sexuality education for young people in and out of school	3.3.1b # youth-friendly SDPs, per population 3.2.1b % young people with knowledge about both abstinence and condom use 3.3.2bi % Condom use among young people 3.3.2biiTeenage pregnancy rate 3.3.3b Adolescent fertility as a proportion of total fertility 3.3.4bAge of sexual debut
	3.3.5a Support the meaningful participation of young people, including young PLWHA, and communities in the positioning and delivery of youth-friendly services	3.3.5b Level of involvement of young people including young PLWHA and communities in the positioning and delivery of youth-friendly services

4. Incidence of unsafe abortion reduced		
4.1Advocacy/policy 4.2 Capacity building	4.1.1a Compile and disseminate data on the magnitude and consequences of unsafe abortion, 4.1.2a Enact policies and legal frameworks to reduce incidence of unsafe abortion 4.1.3a Prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion 4.2.1a Train service providers in the provision of comprehensive safe abortion care services where national law allows 4.2.2a Refurbish and equip facilities for provision of comprehensive abortion care services	4.1.1b # countries with status report on the magnitude and consequences of unsafe abortion. 4.1.2b # countries with legislative/policy framework on abortion. 4.1.3b # countries with action plans to reduce unwanted pregnancies and unsafe abortion 4.2.1b # Service providers trained in safe abortion care 4.2.2b Proportion of SDPs providing PAC services
4.3Service delivery	4.3.1a Provide safe abortion services to the fullest extent of the law 4.3.2a Educate communities on available safe abortion services as allowed by national laws	4.3.1bi # facilities providing safe abortion care 4.3.1bii Abortion related MMR 4.3.2b # of countries with community awareness programmes on abortion issues.
	4.3.3a Train health providers in prevention and management of unsafe abortion	4.3.3b # countries with critical mass of trained providers in place

5. Access to quality Safe Motherhood and child survival services increased		
5.1 Advocacy	5.1.1a Develop and/or roll out the Road Map for the reduction of maternal and newborn morbidity and mortality. 5.1.2a Observe a Safe Motherhood Day	5.1.1b # countries that have developed Roadmaps for the reduction of maternal and newborn morbidity and mortality 5.1.2b # countries that commemorate safe motherhood days
	5.1.3a Intensify maternal and neonatal tetanus vaccination campaigns	5.1.3b # Pregnant women and children vaccinated
5.2 Capacity Building	5.2.1a Develop and implement national strategies for rapid production, deployment and retention of midwives, includingharmonisation and accreditation of curriculum at regional level 5.2.2a Incorporate Emergency Obstetric Care in pre-service training of health care providers 5.2.3a Develop systems for rapid transport for women with obstetric and gynaecological complications including strengthening the referral system	5.2.1bi # midwives per population 5.2.1bii Coverage for supervised delivery 5.2.2b # countries that have pre-service curricula incorporatingEmOC for all appropriate cadres 5.2.3b # countries with functional referral system from community to health facility.
	5.2.4a Strengthen the production of mid-level staff production	# Mid level staff per population

5. 3.5a Integrate STI/HIV/AIDS, malaria and nutrition services into obstetric care

	5.2.5a South-South Staff exchange	# Countries exchanging staff
5.3 Services	5.3.1a Scale up safe motherhood services through the implementation of the Road Map for the reduction of maternal and newborn morbidity and mortality	5.3.1bi Maternal Mortality Ration (MMR) 5.3.1bii Peri-natal mortality rate 5.3.1bii # facilities per 500,000 population providing basic and comprehensive EmOC
	5.3.2a Scale up neonatal care services including the creation of neonatal resuscitation care in maternity units 5.3.3a Increase coverage of child survival services (expanded programme for immunization [EPI], oral rehydration solutions [ORS]), early initiation of breast feeding, and other appropriate nutritional intervention, 1st week consultations	5.3.2b Neonatal mortality rate 5.3.3bi Immunisation coverage at one year 5.3.3bii Prevalence of under-weight children
	5.3.4a Adopt integrated management of childhood illnesses (IMCI) 5.3.4a Develop a mechanism for provision of adequate safe blood supply	5.3.4bi Availability of IMCI protocols 5.3.4bii IMR 5.3.4biii U-5 mortality 5.3.5b Proportion of EmOC sites with access to adequate supply of safe blood.

5.3.5bi Prevalence of newborn HIV infections 5.3.5bii Proportion of malaria cases managed

		with 24 hours.
6 . Resources for SRHR increased		
6.1 Advocacy/poly	6.1.1a Implement the Abuja Heads of State Declaration on national budgetary allocation for health to at least 15% of the total national budget, with an appropriate proportion of that for SRHR 6.1.2a Advocate for prioritisation of SRHR in national poverty reduction strategy papers (PRSPs) and other national development plans 6.1.3a Advocate for increased support to SRHR programmes from donors and development partners	6.1.1b # countries with 15% of budget allocated to health 6.1.1b Proportion of health budget allocated for SRHR 6.1.2bi # countries with SRHR in their national PRSP or development plans 6.1.2bii % national health budgets allocated to SRHR 6.1.3b % of total SRHR budget, mobilized from donors/development partners.
6.2 Capacity building	6.2.1a Develop partnerships with local & international institutions, private sector and civil society organizations (CSO/) for technical and financial support, and for advancing the implementation of the Plan of Action.	6.2.1bi # partnerships formed with each sector.
	6.1.2a Institutionalise National Health Accounts (NHA)	6.1.2b # No of countries with updated NHAs
	6.1.3a Develop and implement human resource strategy to orient and train, deploy and retain health system workers	6.1.3b Cadre of staff per 100,000 population

7.SRH commodity security strategies for all SRH components achieved		
7.1 Advocacy	7.1.1a Develop national/regional strategies and action plans for forecasting, procurement and distribution of RH commodities	7.1.1b # countries with plans for RHCS
	7.1.2a Establish a national and/or regional RHCS committee	7.1.2b # countries/regions with national/regional RHCS committees
	7.1.3a Develop national and where appropriate regional RHCS strategy and action plans	7.1.3b Regional/national RH commodity security strategy and action plan(s) in place
	7.1.4a Revise essential medicines lists to include reproductive health commodities 7.1.5ai Establish a budget line for SRH commodities	7.1.4bi # countries with RH commodities in essential medicines list 7.1.5bii % health budget allocated to RH commodities 7.1.5biii # countries with a national budget line for SRH commodity security
7.2 Capacity building	7.2.1a Develop and implement logistics management system (LMS) for RHCS 7.2.2a Train relevant staff in LMS for RHCS	7.2.1b # countries maintaining and regularly updating statistics on commodities' stocks and flows. 7.2.2b # countries experiencing stockout
	7.2.3a Establish effective commodity management system for the full range of commodities 7.2.4a Develop capacity for bulk purchasing through pooling of purchase orders at national and regional levels	7.2.3b # countries with commodity management systems in place 7.2.4b # countries with integrated systems of bulk purchasing and supply

	7.2.5a Provide training in commodity management	7.2.5b # persons trained in management logistic systems
8.Monitoring, evaluation and coordination mechanism for the Plan of Action established		
8.1 Advocacy/policy 8.2 Capacity building 8.3 Data collection and utilization	8.1.1a Advocate for allocation of national resources for conducting regular censuses, DHS, and annual maternal death reviews 8.2.1a Establish a continental monitoring and tracking system to aggregate, analyse and disseminate data received from the national level 8.3.1a Institutionalise M&E at the public administration and NGOs levels and allocate adequate human and financial resources to support it.	8.1.1b # countries that regularly conduct censuses, DHS & annual maternal death reviews 8.2.1b Continental mechanism and database for monitoring the POA in place 8.3.1b # countries with institutionalised M&E systems .
	8.3.2a Collect, analyse and disseminate minimum national level information required for a continental database	8.3.2b # countries that make timely submission of information to the continental database
	8.3.3a Support operational research for evidence based action	8.3.3b # countries utilizing operational research in their planning.
	8. 3.4a Collaborate with UN and donor agencies in harmonizing data collection systems to ensure consistency	8.3.4b Harmonized data collection system in place
	8.3.5a Put in place coordination mechanisms to monitor and evaluate the efficient allocation of resources and implementation of laws	8.3.5b # countries able to monitor & evaluate allocation of resources and implementation of laws
	8.3.6a Institutionalise exchange and sharing of best practices including south-south technical exchanges	8.3.6bi # Institutions in formal strategic partnerships for technical exchange 8.3.6.bii Best practice web platform

		established and maintained
	8.3.7a Develop and/or implement coordination and supervisory structure and mechanism for implementation of SRHR at regional and national levels.	8.3.7bi # countries with functional coordination structure and mechanism established 8.3.7bii Regional coordination structure and mechanism established.

ROLE OF STAKEHOLDERS

(a) The African Union

26. The African Union will, among other things, play advocacy role, resources mobilisation, monitoring and evaluation, and dissemination of best practices and harmonisation of policies and strategies.

(b) Regional Economic Communities

27. Regional Economic Communities will, among other things, provide technical support to Member countries including training in the area of reproductive health, advocate for increased resources for sexual and reproductive health, harmonise the implementation of national Action Plans, monitor progress, identify and share best practices.

(c) Member States

29. Member States will adapt and implement the Action Plan for the operationalisation of the Continental SRHR Policy Framework. They will also put in place advocacy, resource mobilisation and budgetary provision as a demonstration of ownership and monitoring and evaluation. They will also invite civil society and the private sector to participate in national programs.

(d) Partners

28. In line with the Paris principle multi-lateral and bi-lateral organizations; international and national civil society organizations and other development partners will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of the plan of action.

CONCLUSION

29. African leaders have a civic obligation to respond to the Sexual and Reproductive Health Needs and Rights of their people. This Action Plan is a clear demonstration of their commitment to advance Sexual and Reproductive Health and Rights in Africa.

Annex:

METHODOLOGY AND RESULTS OF COSTING OF SRHR SERVICES

1. The principles of this costing estimate include the expectation that: plans should be geared to achieving universal access to reproductive health by 2015, increased investment and action to improve human resources for health are required, such plans and estimates include resources to strengthen the health system including allocations for monitoring, supervision, basic public health functions, community action and other necessary support functions, that additional resources will be needed to address elements explicitly not included (such as capital investments) and that further investment will be needed in sectors other than health that support and advance progress towards health-related objectives, including those in the Millennium Development Goals.

2. Estimates were conducted, using available information, on a national level and aggregated up to regional totals. These costs reflect direct service delivery requirements to reach coverage targets directed towards the universal access to reproductive health ICPD goal, which would also advance health related ICPD and MDG goals. These calculations propose that each country in Africa rapidly increase access to an essential package of integrated reproductive health services that would reduce by nearly half by 2010 their current gaps on the way to universal access by 2015. Countries with 40 per cent coverage in 2006 should aim to reach 66% coverage by 2010, those with 60 per cent should aim to exceed 75% and those with 75 per cent should aim for 85%. Additional adjustments are then made to the resulting direct costs.

3. These adjustments include a doubling of medical and paramedical salaries required to increase commitment, staff retention when supplemented with other non-monetary incentives, motivation and service quality: issues well recognized in both the prior and current African Union deliberations, as well as in other settings. The adjustments include a 37% adjustment comprised of the following elements added to total direct costs, including salaries: strengthening management systems (including financial management) at 20%; improving monitoring, evaluation, and quality assurance at 15%; and, building capacity for basic research and development at 2%. In addition, a 67% increment is required for general overhead (support staff, electricity, etc., and maintenance), public health functions (including community demand generation) and regulatory requirements. In toto, these additions reflect the effort required for direct service provision, health system development and several crucial supportive activities. Direct service inputs of salary and drug/equipment provision therefore account for less than half of the total estimate.

4. SRH-related prevention interventions were estimated by specifying the share of the UNAIDS-identified prevention activities that relate to SRHR. For example, all condom distribution and STI management, substantial shares of youth-based and special population interventions and small shares of harm exposure and blood safety interventions (in the latter case, proxied by an estimate of the proportion of transfusions needed for maternal hemorrhage) are included. These analyses, based on UNAIDS data, produce estimates for SRH-related prevention interventions increasing from $2.2 to $3.6 billion over the same period. Additional resources would be needed for the remaining proportions of prevention, treatment, care and support services.

5. Annex Table 1 reflects the estimated requirements for service delivery of SRH services, aggregated up from national level analyses, under two scenarios: (1) the United Nations Population Division Medium Variant projection of fertility decline during 1997-2010 and (2) fertility and contraceptive prevalence levels associated with progressively eliminating current unmet need for family planning before 2015. The results presented for this latter scenario capture the prevalence increase early in the sequence of progress.

6. The results suggests that delivery of sexual and reproductive health services for Africa under two scenarios will require in 2007 the expenditure of $3.5 billion and will increase to about $4.6 billion by 2010. The total SRH/HIV prevention costs for direct service provision, health system development and crucial supportive activities therefore total $5.8, $6.6, $7.4 and $8.3 billion, respectively in the years from 2007 to 2010. Family planning expenditures are higher in the unmet need scenario but total expenditures for other SRH interventions

7. The resulting totals for SRH and STI/HIV/AIDS prevention correspond to per capita expenditures increasing from $6.03 to $8.14 (of the $34 per capita recognized by the AU as needed for health) during this period. In comparison, the 2005 direct expenditures for SRH are estimated at roughly $2 per capita (not including system investments).

8. Review and updating of the estimates, incorporating national statistical inputs, is required. These are provisional results, conditional on the details above. The results also reveal that the savings in other maternal, newborn and child health interventions are significantly greater than the marginal increase in expenditures for higher family planning prevalence