AFRICAN POPULATION AND HEALTH RESEARCH CENTER

Implementation of the Maputo Plan of Action:

Opportunities and Challenges for CSO Action in Promoting Sexual and Reproductive Health and Rights in Sub-Saharan Africa

A Status Report

Chichi Undie, Latifat Ibisomi, Jacinta Muteshi, Jean Christophe and Eliya Zulu

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Promoting the well-being of Africans through policy-relevant research on population and health

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Abbreviations

ANC	Antenatal care
APHRC	African Population and Health Research Center
ARVs	Anti-retrovirals
ASRH	Adolescent Sexual and Reproductive Health
CPA	Cotonou Partnership Agreement
CSO	Civil society organisation
DFID	Department for International Development, UK
DHS	Demographic and health surveys
FGD	Focus group discussions
FP	Family planning
GBV	Gender-based violence
GDP	Gross domestic product
ICPD	International Conference on Population and Development
IMR	Infant mortality rate
IPPFAR	International Planned Parenthood Federation Africa Regional Office
KII	Key informant interviews
MDGs	Millennium Development Goals
MMR	Maternal mortality ratio
MOH	Ministry of Health
PHC	Primary healthcare
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive health
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	USAID United States Agency for International Development
WHO	World Health Organization

Table of Contents

List of Table and Figures

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Executive Summary

Introduction

Health issues have been a consistent item on the agenda of African government meetings since 2001. Paradoxically, inequalities in health persist, with reproductive health in particular described as a "continental state of emergency" by ministers of health as they moved actions in october 2005 at the 2nd ordinary Session of the Conference of African Ministers of Health in Gaborone, Botswana, and adopted a "Continental policy Framework on Sexual and Reproductive Health and Rights (SRHR)." The Continental Policy Framework called for prioritising and improving access to sexual and reproductive health (SRH) and services by strengthening the health sector through increased allocation of resources to health. The African Union (AU) Health Ministers further called for the development of a concrete and costed plan of action for implementing the framework. This culminated in the drafting of *The Maputo Plan of Action (MPoA) for the operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights* (MPoA), which was endorsed by the summit of the African Union Heads of State and Government in January 2007 to serve as a short-term plan of action for the period 2007 to 2010. The MPoA calls on AU Member States to enact policies, advocate for SRHR, build the capacity of health care providers and expand access to reproductive health (RH) services (in 8 strategic areas) in partnership with civil society organisations, the private sector and development partners. Specific supportive roles are also outlined for key stakeholders, namely, the African Union, the Regional Economic Communities (RECs), Member States and partners. These proposed endeavours are geared toward moving the African continent closer to the achievement of universal access to comprehensive sexual and reproductive health services by the year 2015.

The eight strategic areas that are meant to influence actions in line with the Maputo Plan

The eight strategic areas that are meant to influence actions in line with the Maputo Plan are as follows:

1. Integrating STI/HIV/AIDS and SRH into primary health care.
2. Repositioning family planning as an essential part of the attainment of the health MDGs.
3. Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component.
4. Addressing unsafe abortion.
5. Delivering quality and affordable services in order to promote safe motherhood, child survival, maternal, newborn and child health.
6. Resource mobilization for SRHR.
7. SRH commodity security.
8. Monitoring and evaluation.

In 2009, the International Planned Parenthood Federation Africa Region office (IPPFAR), with support from the Hewlett Foundation, commissioned the African Population and Health Research Center (APHRC) to undertake an evaluation of the status of the implementation of the Maputo Plan of Action by key stakeholders to better generate evidence to inform political and programmatic advocacy efforts around

the MPoA. This report therefore reviews the efforts underway by the European Commission as part of the EU (the EU-Africa Strategy has the Maputo Plan of Action as one of the focus areas), the RECs and three AU member states (Botswana, Nigeria and Senegal) in regard to implementing the MPoA. The report also surveys progress on key indicators contained in the MPoA in a total of nine countries, namely, Botswana, Burkina Faso, Cameroon, Ghana, Ethiopia, Nigeria, Rwanda, Senegal and Uganda.

Study Methods

Four strategies were employed to conduct the status review, namely: desk review of published, unpublished and web-based materials; secondary analysis of quantitative data; as well as collection and analysis of primary qualitative data (key informant interviews and focus group discussions) in Botswana, Nigeria and Senegal, which were selected as focal countries for gaining more in-depth information on countries' implementation of the MPoA.

In all nine study countries, a myriad of policies and legal documents supportive of the goal of universal access to sexual and reproductive health services exist, but the consistent implementation of these policies is threatened by a number of factors

Key Findings

The existence of policies relevant to the Maputo Plan of Action does not necessarily translate into action or implementation.

In all nine study countries, a myriad of policies and legal documents supportive of the goal of universal access to sexual and reproductive health services exist, but the consistent implementation of these policies is threatened by a number of factors, including inadequate financial and human resources, the lack of political will on the part of some governments, and the lack of organisation within government structures, which prevents the efficient use of existing financial resources. In regard to the latter, it is noteworthy that in some instances where financial resource commitments to health are successfully met by governments, these resources are returned because of the lack of capacity to spend the allocations, due to logistical, administrative and procurement challenges that slow down the ability of Ministries to spend their allocations in a timely manner. Additionally, several of the MPoA indicators were developed to elicit information on whether policies/plans to address a specific SRH issue are in place, stopping short of requiring data on actual implementation. This creates challenges for determining exact levels of implementation for such indicators.

The fragmentation of key SRH-related government structures limits progress in regard to the Maputo Plan of Action.

Although the strategic action areas of the MPoA are generally aligned to the efforts of Ministries of Health in the various countries, the core areas of sexual and reproductive health are often established as separate, stand-alone divisions or departments within these Ministries. As a result, there are missed opportunities for taking advantage of the synergies that such division could create with one another. Similarly, decentralised government structures in some countries result in a multiplicity of priorities at different levels of government, with no obligation for the inclusion of sexual and reproductive health as one of them. The compartmentalisation of core into individual departments also results in autonomous staff, programmes, budget lines and policies which can present administrative and co-ordination challenges that further impede integration processes. other major consequences of this fragmentation are that it is not always clear exactly where the responsibility lies for the implementation of SRHR as a national

programme, and the setting of shared priorities across autonomous decentralised regions is a challenge. Importantly, these issues pose challenges for the effective integration of SRH into primary health care – a key goal of the MPoA.

Tracking actual proportions of government budgets allocated to health is a more complex endeavour than presumed.

Although only Botswana and Rwanda have met and exceeded the call of 15% of national budgets being allocated to health (all other countries were below 10%), the budgeting approach of some countries may obscure the actual level of financial contributions to health made by some countries. A variety of sectors direct resource flows toward actions that have an impact on health, but may not necessarily be considered as part of the health budget. Therefore, some respondents pointed out that national health budgets are not always a true reflection of a country's total health expenditure. Determining the proportion of government spending on SRH specifically is a challenge primarily because health sectors are not necessarily set up to account for allocations and expenditures in this way. Ministries of Health in the study countries do not present SRH as a line budget item, and, despite the fragmentation in the operation of the core health areas, the budgets for such areas are often integrated, making it difficult to tease out the costs allocated for specifically for SRH.

The important roles assigned to regional and sub-regional bodies are hampered by a lack of human resource capacity.

The Maputo Plan of Action outlines key roles for regional and sub-regional bodies, including the provision of technical support to member countries (including training in the area of reproductive health), advocacy for increased resources for sexual and reproductive health, harmonising the implementation of national Action Plans, monitoring progress, and the identification and sharing of best practices. However, there is a severe lack of staffing and financial resources to conduct SRH-related work across most of these institutions, with entire sub-regional bodies, for instance, often having a sole staff member assigned to this role. Consequently, much of the critical work expected from these institutions is left undone.

The Maputo Plan of Action outlines key roles for regional and sub-regional bodies, including the provision of technical support to member countries

Levels of awareness of the MPoA vary among Civil Society organisations (CSos).

The role of CSos in the Maputo Plan of Action is critical if the goals of the Plan are to be achieved. Yet, CSos carrying out SRH work varied in their levels of awareness of the MPoA, with some stating that their work is guided by it or inadvertently overlaps with it, while others had heard of the MPoA but were not familiar with its content. There were also some respondents who were not aware of the MPoA, but nevertheless engaged with SRH issues as part of their work. In summary, the MPoA does not necessarily inspire the SRH work carried out by CSos, but is considered as being in line with actions that were well underway prior to its development. Country action plans developed with reference to the MPoA were not directly referenced either as guiding SRH programmes in the various countries. Indeed, donor interest in particular SRH issues seemed to play more of a role in shaping CSo actions than the MPoA itself.

CSos are demonstrating versatility and strong leadership in their SRHR work, which contributes towards the achievement of the MPoA goals.

Despite the variances in levels of awareness in regard to the MPoA, CSos are playing a critical role in building the knowledge and awareness of SRHR issues among the diverse communities they serve. They are contributing significantly to the health sector by working on SRH issues that affect women, youth, men, sexual minorities, people living with HIV/AIDS, and prisoners. In addition, CSos are playing strong advocacy roles to sustain support of SRHR issues and engage in the direct provision of SRH services with all such actions facilitating the expanded access to SRHR services. These efforts by CSos in implementing SRHR demonstrate what their leadership, knowledge and resources can accomplish in reinforcing and improving MPoA indicators. Indeed, CSos are engaged in SRH work that reinforces the MPoA priorities, but also extends beyond them.

CSos are playing strong advocacy roles to sustain support of SRHR issues and engage in the direct provision of SRH services with all such actions facilitating the expanded access to SRHR services

Key Recommendations for Advocacy Actions

Several recommendations based on this review are offered as CSo advocacy actions to stimulate further progress in implementing the Maputo Plan of Action. These advocacy actions are categorized here according to each strategic action area.

Integrating HIV, STI, Malaria and SRH services into primary health care

- Advocate for an increased focus on HIV/SRHR integration among key stakeholders such as government and CSos
- Advocate for governments to address the fragmentation/ compartmentalisation that exists among Ministries, and the negative repercussions this kind of structuring holds for progress on SRHR, by creating coordination units to secure the full implementation of national and regional SRHR plan within the wider health sector
- Encourage the strengthening of capacity of public and non-public service providers to integrate STIs, HIV/AIDS, with SRH services
- Advocate with governments to strengthen the partnerships between public and non-public providers of STI, HIV/AIDS, and SRH services
- Support creation and strengthening of regional initiatives to encourage integration of services. A good example of such an initiative is the current effort within SADC to set up a 'minimum service package' around HIV/AIDS/malaria/TB that seeks a minimum set of services that could be achieved for SADC nationals. There is need to have SADC nationals participate in this process to identify these needs
- Mobilise to develop networking platforms and forums for reflection on how work is carried out by SRH CSos across borders, what lessons can be learnt from one another, and for working together to strengthen advocacy responses, as several countries are facing similar SRH issues
- Advocate for stakeholders in the health sector to incorporate women's rights approaches and human rights in general to SRH programming. Certain groups continue to be denied services even though policies exist guaranteeing health for all, because they are either prisoners, women who are pregnant and HIV-positive, or sexual minorities.

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

- Advocate with empirical evidence on demand and gaps in the provision of underserved populations at all levels of government and with donor agencies to ensure that family planning is included in budgeting and planning.
- Mobilise government organisations with SRH mandates to better influence budget allocation processes for contraceptive supplies and delivery to PHC.
- Advocate for support of family planning in all primary health care service provision.
- Increase policymakers' knowledge and awareness of family planning as key to achieving development goals
- Encourage service providers to ensure a proper mix of contraceptive commodities so that users have methods of their choice whenever needed.
- Increase awareness among policy makers for integrating family planning with postpartum care, post-abortion care, immunization services, and HIV/AIDS services
- Encourage improvements in training and supervision of providers so that they are responsive to clients' needs.
- Mobilise government and civil society to eliminate barriers to contraceptive use and the provision of FP services, including getting men's role in contraceptive use.
- Facilitate/encourage the development of partnerships between public and private sectors to deliver FP services.

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

- Advocate for provision of comprehensive SRHR services among potential opponents (e.g., religious and civic leaders, community-members) to support acceptability, and as key to meeting the varying SRH needs of adolescents, including reducing unintended pregnancies and reducing the transmission of STIs/HIV/AIDS among young people.
- Advocate for governments and other development partners to prioritise the implementation of youth-friendly services.
- Mobilise organisations with SRH mandates to create advocacy coalitions to promote dialogue among potential opponents in support of youth friendly SRHR services.
- Encourage change in training and supervision of providers so that they are responsive to youth SRH needs.
- Work with media to promote understanding of adolescent SRH.
- Advocate around the need for parent involvement in discussing sexuality and SRH issues with their children in order to promote sexuality education.
- Promote the active involvement of young people in addressing their SRHR needs and challenges.

Addressing unsafe abortion

- Advocate for universal access to safe abortion by creating awareness among the public, media and policy makers around the health impacts and other costs of unsafe abortions.
- Call on governments to ensure post-abortion care services are

CSos are also contributing significantly to the health sector by working on SRH issues that affect women, youth, men, sexual minorities, people living with HIV/AIDS, and prisoners

available and not affected by stigma or legal penalty

- Create awareness around post-abortion care services among potential users.
- Promote dialogue among relevant stakeholders about how to reduce morbidity and deaths from unsafe abortions.
- Promote research to clarify the magnitude and consequences of unsafe abortion.

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

- Advocate for improved data and information collection for priority-setting around the enhancement of maternal and infant health outcomes.
- Advocate with evidence for governments to increase resources for health facilities (including mobile ones), properly trained health care personnel, and commodities in support of safe motherhood and child survival.
- Promote community and public discourses to address cultural beliefs and traditions about child-birth that prevent women from seeking professional maternity services even in cases where such services are accessible.
- Strengthen monitoring and evaluation and accountability systems for safe motherhood and child survival.

There is already a favourable policy environment for SRH and the study found that governments are eager to reduce maternal mortality rates (MMR) and make reproductive health services more available

Resource mobilization for SRHR

- Advocate for civil participation in national development planning and budgeting processes in order to increase transparency and accountability.
- Develop capacity among members of parliament and CSos to do budget tracking.
- Advocate among key decision-makers in the Ministries of Health and Finance to establish a specific budget line for SRH.
- Mobilise and support existing initiatives to monitor government SRH budgets.
- Advocate for governments to demonstrate more transparency in terms of their expenditures on SRH.
- Mobilise CSos to develop advocacy strategies to encourage countries to prioritise SRHR and to align resources accordingly to achieve the goals of MPoA.
- Develop advocacy strategies together with key partners in the health sector for mobilising resources for SRH.

SRH commodity security

- Advocate for the increased capacity of the government bodies responsible for distributing SRHR commodities.
- Create awareness on the potential benefits of public-private partnerships or government-donor coordination for establishing RH commodity security.
- Mobilize resources from public and non-public sources and improve management of stocks to safeguard against contractive commodity stock-outs.
- Promote generation and dissemination of research to document extent (across various sub-groups and geographical regions) and implications of commodity-stock-outs to be used for advocacy.

Monitoring and evaluation

- Advocate for CSo participation in tracking and reporting on government delivery of its SRH commitments to strengthen accountability.
- Advocate for institutional and individual capacity building and skills development in monitoring and evaluation and inclusion of credible monitoring and evaluation designs in all SRH projects.
- Advocate for CSo participation in supporting M&E capacity within government.

Conclusion and Way Forward

In order to make good international and regional commitments to improve sexual and reproductive health outcomes, African governments need to ensure that agreed actions are translated into national legislation and programmes. There is already a favourable policy environment for SRH and the study found that governments are eager to reduce maternal mortality rates (MMR) and make reproductive health services more available. However, population, fertility and human development index (HDI) indicators remain low for all nine countries in the study, suggesting that sexual and reproductive health needs remain insufficiently addressed for these countries. Furthermore, elements of SRH such as maternal and child health care, and now increasingly, adolescent sexual and reproductive health, are receiving heightened attention, while issues such as post-abortion care still remain outside the scope of most primary health care services. Additionally, HIV/AIDS has been a top priority for many countries in the region with diversion of resources to the pandemic in contexts where there is a general lack of understanding that HIV/AIDS should be a critical part of successful SRH strategies.

None of the governments represented in this review have specifically developed a national action plan for the MPoA, and indeed the MPoA does not require those that already have strategies to start afresh, but encourages a review of existing national plans against the Maputo Plan of Action to identify any gaps. However, even though comprehensive policies on SRH exist and strategies for implementation have been developed, operationalising for implementation has been very slow for a variety of reasons including inadequate financial and human resources, the lack of political will on the part of some governments, and the lack of organisation within government structures, which prevents the efficient use of financial resources when they are made available. In addition, core areas of SRH were often found fragmented across departments in the three focal study countries (Botswana, Nigeria and Senegal); thus, it is not always clear where the responsibility for the implementation of SRHR as a national programme lies.

If African countries are to meet the scale of demand for knowledge, skills, information and services needed to achieve universal access to SRHR by 2015, there is an urgent need for greater and more targeted investment in SRHR. However, it is evident that the problem of resources for health in general and SRH in particular is not always due to financial shortage. Countries might instead be burdened with institutional constraints such as staffing attitudes to SRH, inadequate capacity with regard all core SRH issues and, in some cases, challenges in spending money allocated to health due to the lack of an organised framework for such spending.

If African countries are to meet the scale of demand for knowledge, skills, information and services needed to achieve universal access to SRHR by 2015, there is an urgent need for greater and more targeted investment in SRHR

Additional recommendations by this stsudy

In addition to these advocacy action points, this study also recommends:

- Dedicated, increased and sustainable financial resources to support all the core areas of SRH.
- Strengthening of service delivery infrastructures and service providers' capacity to provide necessary SRH care through training.
- Expanding existing programmes to under-served communities and populations.
- Working in a holistic way for SRHR through coordinated multi-sectoral approaches, and making a strong call for countries to imbibe a comprehensive approach to SRHR.
- Raising public awareness and providing information about SRH policies and reformed laws so that individuals and communities are aware of services that is available for their use.
- Targeting parliamentarians to identify how national obligations to support SRH can be advanced because they appropriate funds.
- Developing monitoring and evaluation (M & E) systems and accountability mechanisms to monitor progress and help ensure that SRHR services are effectively and consistently implemented, and that financial resources for SRHR are effectively utilised.
- Focusing advocacy efforts not only at the central level, but at local levels as well.

Chapter 1

Introduction

1.1 Maputo Plan of Action

Health issues have been a consistent item on the agenda of African government meetings since 2001 (OXFAM, 2006:2). Nevertheless, inequalities have persisted in health, with reproductive health described as a "continental state of emergency" by Ministers of Health as they moved actions in October 2005 at the 2nd Ordinary Session of the Conference of African Ministers of Health in Gaborone, Botswana, and adopted a "Continental policy Framework on Sexual and Reproductive Health and Rights (SRHR)." The Continental Policy Framework called for prioritising and improving access to sexual and reproductive health (SRH) and services by strengthening the health sector through increased allocation of resources to health. The African Union (AU) Health Ministers further called for the development of a concrete and costed plan of action for implementing the framework. This culminated in the drafting of *The Maputo Plan of Action (MPoA) for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights* (MPoA), which was endorsed by the summit of the African Union Heads of State and Government in January 2007 to serve as a short-term plan of action for the period 2007 to 2010. As a non-binding, three year action plan, it calls on AU member states to enact policies, advocate for SRHR, build the capacity of health care providers and expand access to reproductive health (RH) services (in 8 strategic areas) in partnership with civil society organisations, the private sector and development partners. The ultimate goal of these endeavours is "to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa by 2015" (African Union Commission, 2006: paragraph 5, 16).

*The Continental Policy Framework called for prioritising and improving **access to** sexual and reproductive health (SRH) **and services by strengthening** the health sector through increased allocation of resources to health*

The MPoA "recognise(s) the unique circumstances of each country, [and] is made broad and flexible to allow for adaptation to countries' need. 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" (African Union Commission, 2006: paragraph 8:3).

The eight strategic action areas of the Maputo Plan of Action:

(1) Integrating STI/HIV/AIDS and SRH into primary health care;
(2) Repositioning family planning as an essential part of the attainment of health MDGs;
(3) Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component;
(4) Addressing unsafe abortion;
(5) Delivering quality and affordable services in order to promote Safe Motherhood, child survival, maternal, newborn and child health;
(6) Resource mobilization for SRHR;
(7) SRH commodity security and
(8) Monitoring and evaluation

Box 1. Source: Maputo Plan for Action: paragraph 5

The MPoA arose out of the recognition that there are several constraints that have hampered the efforts to accomplish universal access to SRHR including political, financial, human, and institutional. Furthermore, areas of work such as sexual rights (specifically around access to information and services for adolescents), abortion and sexuality have often been challenged and face resistance from a number of governments and social groups. In the absence of SRHR as a national priority issue in development planning, these constraints are exacerbated and political commitment, development of capacity of health care providers, and mobilisation of financing and advocacy are required for effective national priority-setting for SRHR.

The MPoA is premised on the International Conference on Population and Development (ICPD) Plan of Action (1994) with its strong provisions on SRHR, including gender based violence. The ICPD life cycle approach, which encompasses the life span of an individual from conception to old age, is further intended to be the cornerstone of MPoA programmes. The Maputo Plan also recognises and draws on other regional commitments - the Abuja (2001) call for Accelerated Action towards Universal Access to STI/HIV/AIDS, Tuberculosis and Malaria services in Africa, and the Brazzaville Commitment on Scaling up towards Universal Access (2006). Further, the MPoA outlines supportive and specific roles for stakeholders - The African Union, Regional Economic Communities (RECs), Member States and partners.

MPoA outlines supportive and specific roles for stakeholders

1.2 Study Background

In 2009, the International Planned Parenthood Federation Africa Region Office ((IPPFAR), with support from the Hewlett Foundation, commissioned the African Population and Health Research Center (APHRC) to undertake research into the status of the implementation of the Maputo Plan of Action to better develop evidence to inform political and programmatic advocacy efforts around the MPoA and to "strengthen the position of IPPF-ARO as a credible actor in SRHR" (IPPFAR, 2008:1). Towards this end, IPPFAR seeks three key outcomes:

1. The prioritisation of SRHR in the policies and budgetary allocations of the African Union and the Regional Economic Communities[1] in the African continent in order to make SRHR available and accessible to the African people;
2. Strong and credible advocates for the implementation of the Maputo Plan of Action in the African Union and Regional Economic Communities as well as among the politically strategic countries in the IPPF Africa Region;
3. Renewed strategic directions for IPPFAR as a catalytic actor in SRHR with a renewed focus on organisational/institutional learning.

A review of the status of the implementation of the Maputo Plan of Action at regional, sub-regional and national levels is thus an important step toward addressing IPPFAR's key outcomes. This report reviews the efforts underway by the European Commission (as part of the EU), the RECs and three focal countries (Botswana, Nigeria and Senegal) in regard to implementing the MPoA. The report also surveys progress on key indicators contained in the MPoA in a total of nine countries, namely, Botswana, Burkina Faso, Cameroon, Ghana, Ethiopia, Nigeria, Rwanda, Senegal and Uganda. Focus is on these countries given their "critical strategic role in the politics and decision-making of the AU, their representation in different regional economic communities across Africa, their priority status with bilateral donors, and the mix

of advocacy capacities among the Membership Associations (MAs) within these countries,"(IPPFAR, 2008:20).

IPPFAR sees the Maputo Plan of Action for the Operationalisation of the sexual and Reproductive Health and Rights Continental Policy Framework as "a landmark document" and has sought to strengthen support for its implementation from the start by organising consultative meetings "familiarising key stakeholders with the MPoA and gaining commitment from various actors such as parliamentarians, civil society organisations (CSOs), government officials and the media. Each of the meetings led to concrete CSO action plans on how the participants would return to their home countries and seek to hold their governments accountable to the promises made in Maputo" (IPPFAR, 2008:12).

1.3 Methodology

Four strategies were employed to conduct the review, namely: a desk review of published, unpublished and web-based materials, secondary analysis of quantitative data, collection of primary qualitative data via key informant interviews and focus group discussions.

IPPFAR sees the Maputo Plan of Action for the Operationalisation of the sexual and Reproductive Health and Rights Continental Policy Framework as "a landmark document"

Desk Review

A desk review of secondary evidence at national and international levels was undertaken drawing on materials such as:

- National constitutions and legislations
- Published policy and official reports
- National plans on health, and relevant SRHR plans
- National Health Expenditure Reports were availed for Botswana, Nigeria and Senegal
- African population data sheet (2008)
- World population data sheet (2008)
- UN human development report (2007/2008).
- World Health Organisation (WHO)

Secondary Analysis of Quantitative Data

For secondary data analysis, the Demographic and Health Survey (DHS) data sets of eight of the countries (not available for Botswana) were analysed to obtain information on fertility levels and family planning knowledge and behaviour.

Primary Data Collection and Analysis

The checklist (Appendix 3) for collecting data on the nine countries to capture ongoing activities in the nine countries in line with the MPoA was developed by selecting a sub-set of indicators from the Maputo Plan of Action which were considered as both important and feasible to obtain. In addition, standard indicators on socio-economic characteristics were included to provide a richer context for understanding SRH outcomes within the countries. The checklist was largely populated from information collated from the desk review and the secondary data analysis. In addition, the IPPFAR's Member Associations (MAs) in six countries (Ghana, Burkina Faso, Cameroon, Ethiopia, Rwanda, Uganda) assisted in sourcing for some checklist items/indicators due to the inadequacy of the information on government official websites. The checklists for Botswana and Nigeria were completed by APHRC researchers following country visits which were made for the purpose of collecting qualitative data.[2] The checklist table allows comparison of progress across countries.

Four semi-structured interview guides, developed by APHRC, were used for the collection of qualitative data from various categories of respondents. Specifically, key informant interviews were conducted with respondents at regional, sub-regional and national levels, as well as with civil society organisations (CSOs) and development partners in Botswana, Nigeria and Senegal. The interview guides were designed to elicit information on how and to what extent countries were promoting and implementing commitments to sexual and reproductive health rights as reflected in the Maputo Plan of Action. The three selected focal countries (Botswana, Nigeria and Senegal) are intended to be merely illustrative of perceptions around issues to do with the implementation of the MPoA. The countries were selected given the location of key RECs within some of them (e.g., SADC, ECOWAS), and given the need to gain insight into the experience of both Francophone and Anglophone settings.

The interview guides were designed to elicit information on how and to what extent countries were promoting and implementing commitments to sexual and reproductive health rights as reflected in the Maputo Plan of Action

To carry out the key informant interviews in the three focal countries mentioned above, country visits were arranged for APHRC researchers with the help of local IPPF Member Associations. They assisted in identifying relevant Ministry representatives and CSOs and development partners to be interviewed, scheduled appointments with the interviewees and provided other required logistics for the study/visits. Phone interviews were carried out with European Commission (EC) and RECs. A total of 41 people from four groups of stakeholders were interviewed as highlighted below.

The specific stakeholders interviewed were as follows:

- Government officers in the Ministries of Health, Finance/Budget Office Women, Gender and Youth
- Civil society organisations involved in the key areas of policy making, service delivery and advocacy for SRHR
- Development partners such as the UN and International Foundations
- One official each from the European Commission, the East African Community (EAC), SADC and the West African Health Organization (WAHO - the ECOWAS REC agency in charge of health issues)

In general, key informant interviews were conducted with one individual in each organisation or department, while one focus group discussion was undertaken with local CSOs in Nigeria. All interviewees that were interviewed face-to-face (rather than over the phone) signed an informed consent form describing the study and assuring confidentiality prior to being interviewed.

The transcripts of the qualitative interviews (conducted in the 3 focal countries) were analyzed thematically to provide clarity on, and deeper understanding of, the efforts underway towards achieving the goal of universal access to comprehensive sexual and reproductive

Stakeholder type	Botswana	Nigeria	Senegal	AU/EC/RECs	Total
Government	8	3	5	-	16
CSO	6	11	2	-	19
Development partner	2	1	-	-	3
AU/EC/RECs				4	4
Total	16	15	7	4	**42**

Table 1: No of stakeholders interviewed from each country

health services, as well as the challenges confronted and lessons learned in the three African countries.

The study was conducted between February and May 2009, with the qualitative field work in the three focal countries carried out over a three-week period from March to April 2009. This report describes the information gleaned from these multiple data sources on the progress in implementing the Maputo Plan of Action.

1.4 Limitations of the survey

- Sampling of CSOs was small, reflecting resources and limited time for travel to three countries, and respondents may represent somewhat of a select group, having been chosen by IPPFARs Member Associations.
- The African Union is not represented among qualitative interview respondents despite concerted efforts to establish contact on the part of researchers.
- Completion of checklist: There is a lack of responses on certain indicators on the checklist as a result of the lack of data and challenges in accessing data.
- Availability of respondents: senior government officers were not always available or were called away, even when meetings were scheduled, given the nature of their work. This led to the reassignment or cancellation of interviews, which often were a challenge re-schedule given the limited time frame for the study. For these reasons, there were some gaps in qualitative data obtained from key informant interviews with government officers in SRH departments in Senegal, for example. Recommendations for follow-up interviews with other stakeholders were not feasible given time constraints.
- The review is limited to the documents and information accessible for each of the countries. Thus, some critical information or operating practices could be missing for some countries.
- In addition, a number of the MPoA indicators are only on the availability of policies and or plans/strategies and not focussed on the implementation of such. Information on whether the plans are actually implemented is thus not available in all cases.

The study was conducted between February and May 2009, with the qualitative field work in the three focal countries carried out over a three-week period from March to April 2009

1.5 Structure of the Report

To highlight the findings of the progress of implementation of the Maputo Plan of Action, the report is organised into six chapters:

1. The introduction, explaining what the MPoA entails and why a review has been undertaken. It introduces the context for the MPoA, the methodology of the study and limitations of undertaking the review.
2. The socio-economic context of SRH in the nine study countries and the constitutional and legal setting that creates the social environment to support SRH in the countries.
3. Findings on the progress made on the MPoA strategic areas for the nine countries (Burkina Faso, Botswana, Cameroon, Ethiopia, Ghana, Nigeria, Rwanda, Senegal and Uganda). These findings are also discussed drawing from a review of recent literature on the implementation of SRHR services in the Africa region, while also incorporating the perceptions and reflections of the respondents in Botswana, Nigeria and Senegal on progress to date on the indicators underpinning the strategic action areas of MPoA.

4. The roles, actions, success and challenges that are at play in the implementation of SRHR services by key stakeholders in SRHR (primarily CSOs), drawing on experiences in the 3 focal countries – Botswana, Nigeria and Senegal.
5. Findings on the actions of the African Union and the Regional Economic Communities in supporting SRHR and implementing their specific roles in the MPoA, coupled with the challenges that are associated with carrying out these roles.
6. Conclusion and way forward.

The Appendix contains a checklist of indicators pertaining to the MPoA, as well as a list of governments, organisations, agencies and RECs participating in the study

Of note is the appendix, which contains a checklist of indicators pertaining to the MPoA, as well as a list of governments, organisations, agencies and RECs participating in the study, and a glossary of terms.

Endnotes

1 Regional Economic Communities include: ECOWAS, ECCAS, ECA and SADC.

2 Although the purpose of the country visits was to collect qualitative data, researchers used the opportunity to ask key informants questions that would help in any gaps in the checklists.

Chapter 2

Country Contexts

2.1 Socio-Economic Indicators

Across the African region, the importance of health for sustainable development is widely recognised, with increasing resources being directed towards health, although most additional health resource flows have been heavily skewed towards HIV/AIDS. African health ministers, meeting under the auspices of the African Commission in 2007, seeking to harmonise all existing health strategies, also acknowledged that recent economic growth in many African countries has contributed to health. However, they also critically noted several factors that continue to adversely impact on African health systems, and intensify the disease burden and poverty (Africa Commission 2006) (see Box 2).

The African Union Commission notes: "Reproductive health conditions are devastating the African Continent"

Furthermore, as the African Union Commission (2006:3) notes, "Reproductive health conditions are devastating the African Continent: 25 million 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 feminisation of the epidemic; 1 million maternal and new born deaths annually, an African woman having a 1 in 16 chance of dying while giving birth; high un-met need for family planning with rapid population growth often outstripping economic growth and the growth of basic social services, thus contributing to the vicious cycle of poverty and ill-health."

Socio-economic group analysis further provides evidence that the poor segment of the population use health services less and therefore have poorer reproductive health outcomes (Claeson et al., 2001), while poor reproductive health outcomes contribute to poverty mainly through their negative impact on overall health (Graham, et al., 2004).

Africa currently records the highest fertility rate in the world at about 5 children per woman. Although fertility has begun to fall in varying degrees across the region and between various sub-groups within countries, the pace of decline has been slow, particularly in many of the countries that previously had very high levels of fertility. Indeed, fertility declines have stalled in sub-Saharan Africa as funding for the promotion of family planning programmes have also generally declined (Doskoch, 2008).

Limiting and Adverse Factors on Health Systems

- The benefits of health services do not equitably reach those with greatest disease burden;
- Health interventions do not match the scale of the problem;
- Continued shortage of health workers,
- Low resource commitments to health,
- Restrictive and disruptive global policies (structural adjustment, unfair trade terms, aid conditionality),
- Gaps in governance and effective leadership,
- Ongoing conflicts, displacements and poverty,

Box 2. Source: Africa Commission, (2006) Africa Health Strategy: 2007-2015 CAMH/MIN/5 (111):1

Of the nine countries assessed in this survey, the positive relationship between the rate of natural increase (population growth excluding migration) and the number of children borne per woman (total fertility rate – TFR) seems predictable (Figure 1). Growth rate is generally high where the average number of children per woman is high. Botswana has the lowest number of children per woman as well as the lowest growth rate, while Uganda has the highest of both indicators.

High population growth raises concerns for the burden placed on health, quality of life and the alleviation of poverty

High population growth raises concerns for the burden placed on health, quality of life and the alleviation of poverty. Poverty has been compounded by a narrow economic base, inequitable gender relations, inequalities in income distribution and environmental challenges, with consequences for human development indicators for most of the nine countries. Levels of human development are generally poor in Africa due to the linkage between demographic and socio-economic issues and development. Botswana is the highest ranking of the nine countries – ranking 124, with Burkina Faso ranking 176 out of 177 countries rated worldwide. These low Human Development Indicators strongly correlate with poverty and poverty-related indicators.

The pattern of GDP basically reflects the pattern of human development in the countries. Estimates of life expectancy at birth (LEAB) also seemed to follow the same pattern except for Botswana, which is greatly affected by the HIV/AIDS epidemic, and Senegal and Ethiopia, whose high life expectancy values boost their human development indices. Literacy levels in the countries are high except for Senegal, Ethiopia and Burkina Faso.

2.2 Formal Recognition of SRHR

Introduction

Since the International Conference on Population and Development (ICPD) in 1994, which provided a broader recognition and understanding of sexual health as an integral part of reproductive health, there has been a wide array of universal and regional conventions and treaties establishing an obligation on African States to address the rights of women and girls and their health care needs. The emergence of HIV/AIDS has further raised awareness of sexually transmitted diseases and highlighted connected concerns to SRHR such as gender based violence, promotion and respect of rights of individuals, the recognition

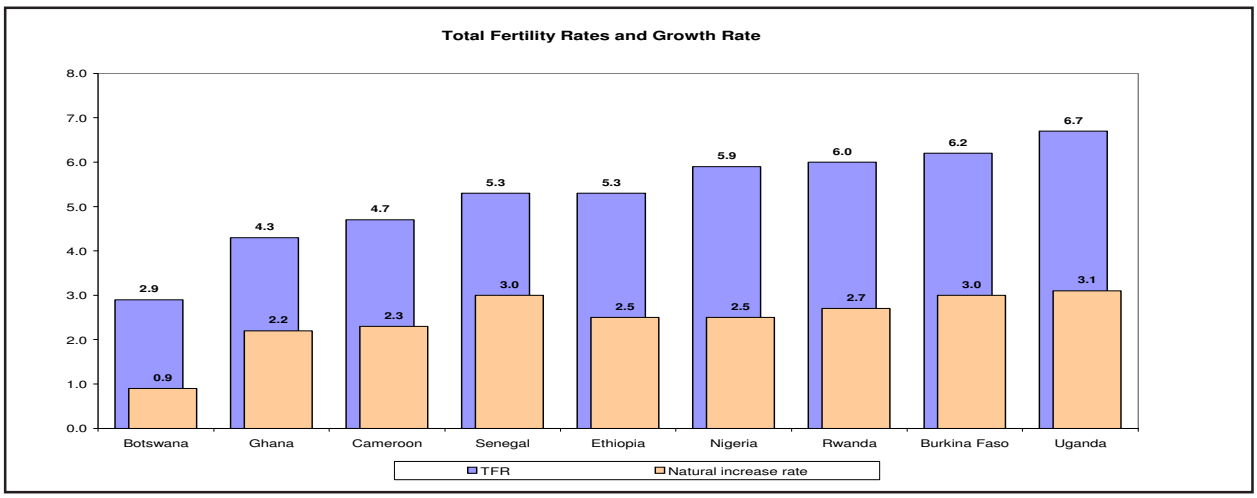

Figure 1: Population and Fertility Indicators

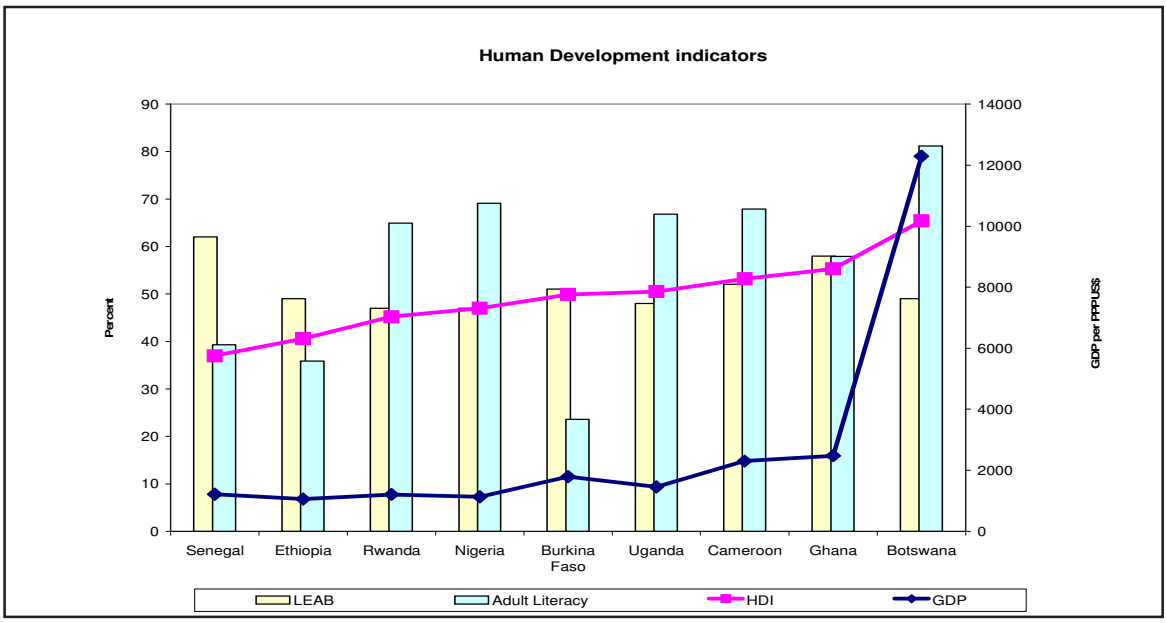

Figure 2: Human Development Indicators

of risks and vulnerability among marginalised groups, the need to reach men and young people and the challenges presented by social-cultural norms on SRH. In light of this recognition, the successful promotion of sexual and reproductive health rights (SRHR) requires the acknowledgment and explicit development of political, legal and policy environments that mobilise resources and create awareness of the relevance and importance of health rights as a necessary "condition of well-being and development" (WHO, 2004:2), while also supporting and recognising SRH as a right to be promoted and protected. Thus, laws and national policies have been developed to promote reproductive health and to order national priorities on which citizens and health professionals can move forward.

To understand the various levels of legal and policy effort underway towards achieving sexual and reproductive health and rights, a quick review of evidence of constitutional provisions covering SRHR, the right to health, and the inclusion of SRH in legislation and health policies was undertaken in the nine countries of this study.

Seven of the nine countries in this study do provide for a right to health in their constitutions

Key Research Findings: Legal recognition of SRH

The language of SRHR was not in use in most legal documents and the various issues encompassing reproductive health were explicitly addressed by only some of the constitutions of the countries under review.

Right to Health

Seven of the nine countries in this study do provide for a right to health in their constitutions. For example, in the constitution of Cameroon, individuals have "the right to a standard of living that is adequate for their health and well-being, as well as that of their families, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other forms of livelihood loss in circumstances beyond their control." The right to health is however not provided for in the constitutions of Botswana and Nigeria. Only Ghana's constitution mandates the President to report to parliament at least once a year on steps taken for the realisation of human rights, including rights to good health, specifically.

Promotion and protection of maternal and infant health

The constitutions of Ethiopia, Burkina Faso, Cameroon and Ghana grant protection of maternal health and Ethiopia further guarantees rights to access information and education regarding family planning. The Ethiopian constitution was also the clearest in specifically addressing issues of maternity, pre-natal leave with full pay, harmful traditional practices, the prevention of harm arising from pregnancy, childbirth, the safeguarding of the health of women, and the right of access to family planning, education, information and capacity. In Cameroon, the constitution provides that mothers and children are entitled to special care and assistance. In Burkina Faso, the right to health and the provision of health and protection of motherhood and infancy as a right and a duty of government is provided for in the constitution. The constitution of Ghana also accords special care to mothers before and after childbirth, granting paid leave to mothers during the period, as well as child care facilities for under-fives to enable mothers to realise their full potential.

Women's empowerment and gender equality

Constitutions were also reviewed for provisions on women's rights and gender equality as these provide an important basis for advocacy and engagement with the numerous barriers women face in accessing SRH rights. In their examination of why poor women are not accessing RH care, Oomman and others (2003) note that "a formidable combination of social, economic, and cultural barriers prevent poor women from obtaining easy access to health services and care, even when quality health services are geographically within reach." Review of legislation for gender equality and women's rights has been underway in most of the nine countries in this study.

Review of legislation for gender equality and women's rights has been underway in most of the nine countries in this study

In Cameroon, Ethiopia and Rwanda, the constitutions go furthest in declaring that the State shall ensure the elimination of discrimination against women and also ensure the protection of the right of the women and the child as stipulated in international declaration and conventions. In Ethiopia, the constitution very comprehensively provides for the rights of women, recognising and addressing the political, social, economic and cultural environment of inequality, by stating that it seeks to strengthen women's access to power, resources, choices, and opportunities. Uganda has provisions recognising equal treatment of women and men.

Key Research Findings: Inclusion of SRH in National Policies

Formal recognition of SRH is also apparent within national policy documents. The expectation of the MPoA is that national plans for SRHR should be "geared towards achieving universal access to reproductive health by 2015" (African Union Commission, 2006:21). All countries in this study have national health plans and strategies that are not driven by the MPoA, often because they had been developed prior to the MPoA. Furthermore, countries have national health plans and strategies that seek to address SRH issues either as one policy document or multiple policy documents for the different core areas of SRHR, with maternal health, HIV/AIDS and ASRH being the most common stand-alone planning documents. Examples from the three focus countries (Botswana, Nigeria and Senegal) illuminate the multiplicity of plans available.

Botswana has the National Implementation Plan of Action for the National Population Policy of 1997 (1998-2008) with key thematic

area in SRH, including Family Planning (FP) and the development of service standards for SRH. Further responsive policies include the "Sexual and reproductive health programme" (still in draft), although a SRH framework document to guide implementers has already been developed by the Ministry of Health, entitled "Policy Guidelines and Service Standards: Sexual and Reproductive Health (2001, 2004)." The National Action Plan for Youth 2001-2010 lists "the promotion of health amongst young people" as a key strategy area inclusive of youth-friendly services and the broadening of reproductive health programmes for youth. However, CSO respondents in Botswana point out that even though a revised comprehensive policy on SRH exists and strategies for its implementation have been developed, operationalising for implementation has been very slow due to the lack of political will.

Respondents in Botswana's Ministry of Health point out that most core areas of the MPoA are aligned to what the Ministry of Health is undertaking but that the core areas of SRH stand as separate departments and divisions with limited collaborations, especially within their daily work. They further stated that when the MPoA was first introduced, two stakeholder workshops were carried out to provide support in understanding the content of the MPoA and to plan the way forward; however, there had been no subsequent follow up to this meeting and its report had yet to be released.

In Nigeria, a CSO respondent argued that "if the Federal Ministry of Health rolled out the MPoA, all CSOs would jump at it, while international non-governmental organisations would work toward supporting it; for, local NGOs are not addressing a document called the MPoA, but they have been moving SRH activities all along but they need support." However, a respondent from the Ministry of Finance held that political decisions determine priorities in all sectors in Nigeria, adding that within the decentralised structures of Nigeria, States determine their own priorities, and health is not on the list of priorities for many States.

A Ministry of Health respondent in Nigeria also highlighted that the recent establishment of the Department of Family Health, with several divisions addressing the core issues of SRH, shows growing commitment on the part of government to SRH issues. Several health policies exist in Nigeria relevant to reproductive health. Key is the National Health Policy and Strategy (1998) with an emphasis on improving access to primary health care (PHC) services. Nigeria first launched its family planning policy in 1988 to reduce birth rates through voluntary fertility regulation (Planned Parenthood Federation of Nigeria, 2007). Other follow up policies have included a National Adolescent Health Policy (1995), the Maternal and Child Health Policy (1994), National Adolescent Health Policy (1995), National Policy on HIV/AIDS (1997), National Policy on Elimination of female genital mutilation (1994) and Breastfeeding Policy (1994). In addition, in 2001, the "National Reproductive Health Policy and Strategy" was launched, followed in 2005 by the "Road Map for Accelerating the Attainment of the MDGs related to maternal and new-born health in Nigeria (2005-2009)."

In Senegal, there were several reproductive health responsive documents, including the second National Plan for Health "Plan National de Développement Sanitaire (2009-2018)," which highlights reproductive health as a priority. The National Programme on Family Planning

Nigeria first launched its family planning policy in 1988 to reduce birth rates through voluntary fertility regulation

(Programme National de Planification Familiale) was approved in 1991 and was followed in August 2005 by the legislation on Reproductive Health (loi no. 2005.18 du 05 Aout 2005 sur la Santé de la Reproduction), which outlines rights of access and information to family planning services and safe motherhood (Association Sénégalaise pour le Bien-Etre Familial, 2007). There is also the "Feuille de Route Pour Accélérer la Réduction de la Mortalité et de la Morbidité Maternelles et Néonatales au Sénégal (2006-2015)."

Advocacy Action: Legal and Policy Responses

A country's level of commitment to SRH is reflected by the legal and policy environment it creates to enable SRH responsive actions. In all the nine study countries, supportive policy and legal documents exist but, as the majority of respondents pointed out, the success of plans of action for the SRH priorities strongly depends on political will and the allocation of adequate resources, which are currently perceived as inadequate or inconsistently provided for.

A country's level of commitment to SRH is reflected by the legal and policy environment it creates to enable SRH responsive actions

Advocacy actions are thus required to:

- Secure a wide awareness of policy/legal documents (and of their linkages with SRHR) for all relevant stakeholders to ensure domestication and implementation at federal and State levels.
- Encourage building capacity of relevant stakeholders for engagement with policy and legal documents.
- Strengthen the capacity and understanding among parliamentarians regarding SRH issues in an effort to increase the political and financial support to the promotion of SRH.
- Request governments to put in place a coordination unit in the Ministries of Health to coordinate efforts in the reproductive health sector and secure the full implementation of the MPoA
- Request governments to put in place specific budget lines for promoting sexual and reproductive health and rights in their annual fiscal budgets.
- Support leadership, government goodwill and the adoption of performance systems to move the implementation of SRH policies.

Chapter 3

The Status of the Strategic Areas of the Maputo Plan of Action[1]

3.1 Introduction

The Maputo Plan of Action outlines 8 priority areas for SRHR to inform actions for the advancement of the continent toward the goal of universal access to comprehensive sexual and reproductive health services by the year 2015. Each priority area has several strategic domains of action, with indicators for measuring progress. This chapter is devoted to an examination of the study findings on national commitments to SRH, focusing on policy development, service provision, and knowledge-and-practice indicators categorised according to the eight priority areas of the MPoA. The indicators were largely drawn from the MPoA itself, while a few standard DHS indicators were also included to shed more light on specific issues. The indicators selected specifically from the MPoA were chosen on the basis of the feasibility of obtaining data on the measures in question. The information on the eight priority areas across the 9 study countries is enriched with deeper insights (obtained on some of the indicators from in-depth discussions in Botswana, Nigeria and Senegal) into the types of actions underway, the key issues emerging, and the challenges faced in regard to implementing the Maputo Plan. Each priority area concludes with key advocacy action points.

The integration of SRHR into existing primary health care (PHC) was strongly proposed at ICPD in 1994

3.2 Integration of SRH Services into Primary Health Care Introduction

The integration of SRHR into existing primary health care (PHC) was strongly proposed at ICPD in 1994. Integration as a model of primary health care aims to deliver essential quality services at key points in the life cycle. The purpose of integration is to offer several types of services at the same site, enabling access, efficiency and thus effective uptake of all offered services by clients. Indeed, this is the spirit of the MPoA. Furthermore, the benefits of integrated services include improved access to information and services, enhanced quality of care, better use of resources, and reduced stigma in accessing services. Integrated programmes are also expected to offer counselling on the prevention of both unintended pregnancy and HIV, and to provide contraceptives or refer clients to facilities where the products and services are available. Integrated programmes therefore have several beneficial and cost-effective impacts.

Key Research Findings

Integrated SRHR/HIV/AIDS/STIs and malaria policy documents and national plan.

All nine countries in the study stated that they have developed integrated SRHR, HIV/AIDS, STIs and Malaria policy documents and national plans.

Policies and legal frameworks in place to ensure access to comprehensive HIV/ AIDS/STI and malaria prevention, care and treatment options for pregnant women, mothers, infants, families and PLWHA.

Strategic Actions and Indicators

Integration of SRH Services into Primary Health Care

Policy actions and indicators

1.1.1 Has integrated SRHR/HIV/AIDS/STIs and Malaria policy documents and national Plan

1.1.2 Has policies and legal frameworks in place to ensure access to comprehensive HIV/AIDS/STI and malaria prevention, care and treatment options for pregnant women, mothers, infants, families and PLWHA

1.1.3a Strategies dealing with GBV developed and implemented

1.1.3b Country has laws dealing with GBV in place

1.1.4a Has programmes to address HTP

1.1.4b Has research report(s) on HTP and FGM

1.1.5 Has curricula for health workers and legal service providers that incorporate health related components of GBV

1.1.6 Has policies that ensure access to condoms especially for PLWHA

1.1.7 Policies on public private partnership on SRHR developed and implemented

1.1.8 Has multi-sectoral plans supporting SRHR

1.3.6 Has specific SRH policies for vulnerable groups, mobile populations and IDPs

1.3.8 Has policies/plans around screening and management of cancers of the Reproductive system for both men and women

*Service provision actions and indicators***

1.3.1 % of Service Delivery Points (SDPs) offering routine HIV counseling and testing in STI, family planning and maternal and newborn and reproductive cancer services

1.3.2 % SDPs offering integrated comprehensive HIV prevention, management and treatment

1.3.3. % SDPs offering STI, PEP and EC services for GBV victims% SDPs offering STI, PEP and EC services for GBV victims

1.3.4 % SDPs offering infertility management services

1.3.6 Has specific SRH services for vulnerable groups, mobile populations and IDPs

1.3.7 Has programme that ensures partnership with, support from and inclusion of men in SRHR services

1.3.9 Has services for mid-life concerns of both men and women.

Box 3 Source: Appendix 3

**- No statistical data was availed by any of the countries for the first four indicators under service provision actions and indicators

All nine study countries note that they have policy documents and national plans in place to **ensure** *access*

All nine study countries note that they have policy documents and national plans in place to *ensure access* to comprehensive HIV/AIDS/STI and malaria prevention, care and treatment options for pregnant women, mothers, infants and families. Although integration was recognised as crucial to improving access to SRH by governments, CSOs and donors, to most key informants, the actual level of integration is unclear. For example, core areas of SRH were often found fragmented across departments in the 3 focal study countries (Botswana, Nigeria and Senegal); thus, it is not always clear where the responsibility for the implementation of SRHR as a national programme lies. Ministry of Health respondents in Nigeria commented that integration of core SRH areas is taking place at the service delivery level in the context of PHC, but this was contradicted by another respondent from a government agency in Nigeria who said that "Although there are deliberate efforts to do so, SRH has not been fully integrated into PMCT systems. They often continue to run parallel." The respondent expressed uncertainty about the existence of a policy to underpin integration. CSO respondents in Nigeria also pointed out that medical service is often not integrated: "Every state is declaring free maternal health care, but it is unclear what services are included. What it really seems to be is free ante-natal care only–there is no family planning."

Integration was found to be similarly constrained in Botswana and Senegal. In Senegal, a Ministry of Health respondent observed that although the implementation of the MPoA remains a priority of government,

changes in the Ministry had seen an evolution away from a "systematic approach in the implementation of SRH plan into a piecemeal approach." Reflecting similar concerns in Botswana, a Ministry of Health respondent described one challenge they face as having to do with "understanding the complexities for women who are pregnant and living with HIV/AIDS and are pregnant. For example, PMTCT is usually provided at ante-natal clinics to HIV-positive mothers, yet these facilities are usually reluctant to extend these services to women who are HIV positive and pregnant." Agreeing with this sentiment was a UNFPA respondent in Botswana who observed that "an assessment specifically on PMTCT in 2007 shows that in many ARV centres, only ARV drugs are offered – not FP. And women on PMTCT were presenting with repeated pregnancies as FP is not moving with the PMTCT programme; yet, a policy to integrate exists." A UNAIDS respondent in Botswana echoed the same sentiment saying, "Those in the field of health continue to run parallel campaigns and interventions and therefore fail to have impact…there is a continuing need for a one-stop shop." Indeed, respondents from the Ministry of Health in Botswana acknowledged that HIV/AIDS programming in Botswana stands alone, even though "SRH services should be properly integrated to achieve results instead of addressing HIV/AIDS in isolation." There was acknowledgement from Botswana respondents, however, of some efforts been made in regard to integration. For instance, some noted that "efforts are now evident in some projects; for example, ARVs are now integrated with PMCT."

The integration of SRH services appears to face challenges from decentralised systems, for instance, setting shared priorities across autonomous decentralised regions has presented constraints for harmonised and adequate mobilisation of needed resources. In Nigeria, a Ministry of Health respondent remarked that "the coordination of human resources is a problem due to the autonomy of the [various] levels of government." Furthermore, the respondent added that "because of decentralization, if there is no buy-in by the different levels to SRH issues, then there is no mobilization of needed funds or human resources." Moreover, as a CSO respondent in Nigeria noted, "Most State activities are not known to the national office [federal level], as there is a disconnect between the two levels." Another constraint is presented by the compartmentalisation of core SRH components (especially at national ministerial levels), into individual departments with autonomous staff, programmes, budget lines and policies which can present administrative and co-ordination challenges that further impede integration processes.

Strategies dealing with GBV developed and implemented

The call for integrating interventions addressing Gender Based Violence within SRH services stems from recognition of the cultural, political and economic barriers that create vulnerability and risk for women, reducing their likelihood of accessing SRH services. Violence and coercive sexual actions against women have an impact on their sexual and reproductive well-being, restricting their ability to have choices, while sexual and physical violence against men creates denial and shame, with consequences for sexual ill-health. Seven study countries have therefore put strategies in place dealing with GBV, with the exception of Nigeria. Botswana explained that it had to date only developed a communication strategy for GBV.

Country has laws dealing with GBV in place[2]

Legislative responses have been sought to give effect to policies to

The call for integrating interventions addressing Gender Based Violence within SRH services stems from recognition of the cultural, political and economic barriers that create vulnerability and risk for women, reducing their likelihood of accessing SRH services

address GBV. Thus, several countries had passed legislation that outlaws sexual/domestic/gender based violence, namely, Burkina Faso, Cameroon, Ethiopia, Ghana, Rwanda, Senegal, and Uganda. Botswana has a bill pending in parliament and Nigeria has a bill awaiting presidential assent. Some countries have taken additional legislative steps in this regard. For instance, the Botswana Penal Code (Republic of Botswana, 1986: 141-4) includes gender-neutral provisions for the protection of sexual violence victims. A person who is convicted of rape is required to undergo an HIV/AIDS test before (s)he is sentenced, and receives a minimum sentence of 15 years (5 years more than the minimum term for standard rape) if (s)he tests positive. If it is shown that the rapist was aware of being HIV positive at the time of the rape, (s)he is sentenced to a minimum term of 20 years with corporal punishment. For the same type of crime, Uganda's parliament passed a bill in April 2007, amending its Penal Code to impose the death penalty on individuals who are aware of their HIV positive status and have sex with a child under the age of 14, with or without consent (Horváth, E. et.al, 2007). In Senegal, a National Observatory of Women's Rights has been established, which is seen as an important step by the government in strengthening the legal environment for women's empowerment.

It can be argued that all nine countries have constitutional provisions that can be interpreted as relevant to the promotion of protection from GBV

It can be argued that all nine countries have constitutional provisions that can be interpreted as relevant to the promotion of protection from GBV. For example, all countries have provisions on human dignity, right to life, right to liberty, prohibition of torture, security of persons or bodily integrity, equal treatment, and non-discrimination and equality, which can be considered as pertaining to the promotion and protection of physical and mental health and can usefully be defined as essential and relevant for GBV concerns.

Programmes to address HTP and research report(s) on HTP and FGM

Support for the elimination of harmful traditional practices (HTP) and female genital mutilation (FGM) is found in many international and regional resolutions, conventions and conferences that have been adopted by African States. However, as was noted by Rahman and Tobia (2000: xv) "addressing cultural practices that discriminate against women and that are meant to control their sexuality is a complex and highly charged political process;" hence, the reiteration by the MPoA for research and programmes that will realise the commitments made by governments for reducing violence against women and improving women's health status.

Burkina Faso, Cameroon, Ethiopia, Nigeria, Senegal and Uganda had programmes to address harmful traditional practices (HTP). There is constitutional recognition of harmful sexual practices in Senegal, Ethiopia, Ghana and Uganda that makes provisions for the elimination of harmful traditional practices and customs. These countries had also followed up with research reports and programmes addressing HTP.

In Senegal, efforts to eliminate female genital mutilation (FGM) have been underway since 1997. A respondent in the Ministry of Family Affairs highlighted the country's programmatic efforts, saying: "We have managed to convince 3,654 out of 5,000 villages that practiced female genital mutilation to abandon this practice." HTP was not an issue of concern in Rwanda and Botswana, according to key informants.

Curricula for health workers and legal service providers that incorporate health related components of GBV

Legal prohibitions against gender based violence (GBV) are important but not enough. To address GBV service providers need appropriate training support that enables them to provide information, education and treatment for GBV. The MPoA calls for the provision of relevant and adequate levels of training in gender issues for health workers, including recognising and responding to signs of gender-based violence screening and response.

Burkina Faso, Ghana, Nigeria and Rwanda noted that they had curricula for health workers and legal service providers that incorporate health-related components of GBV. There was no information availed for Ethiopia and Uganda on this indicator, while Cameroon noted that their curricula was "on course." Respondents frequently indicated that there were several curricula initiatives that had been created for SRH as well as training tools for diverse types of target groups; however, respondents were unable to state if these curricula actions also incorporate health-related components of GBV. Botswana and Senegal had not developed a GBV curriculum for health workers.

Policies that ensure access to condoms, especially for PLWHA

When people are poor and living with HIV they often do not get the services they need and more so if at the primary healthcare level the systems are under-funded, under-staffed and lack the adequate commodities required. Furthermore, PLWHA are vulnerable to social exclusion and violence and are often not consulted in the development of policies that will have consequences for them. Thus for people living with HIV and AIDS, the provision of comprehensive and integrated services not only ensures that important diseases or infections often linked to HIV, can be easily diagnosed and treated, but that other services, including reproductive choices, family planning, STI services and sexuality counselling are provided.

A review of the checklists across the study countries indicates that, apart from Botswana, all countries have policies specifically targeting PLWHA. Respondents in Botswana mentioned that although there were no policies targeting PLWHA, in the country, services for this group were at times being provided.

A review of the checklists across the study countries indicates that, apart from Botswana, all countries have policies specifically targeting PLWHA

Policies on public- private partnership on SRHR developed and implemented

Public-private partnerships are considered as a key vehicle for enhancing the capacity of the health sector in a variety of areas, including human resources, financing, and infrastructure. Such partnerships can therefore have beneficial effect on health service delivery. With regards to the development and implementation of policies on public-private partnership on SRHR, only four countries – Ghana, Burkina Faso, Nigeria and Rwanda – stated having such policies, with Ethiopia being in the process of developing such a policy.

In Nigeria, private sector involvement in SRH has been longstanding, especially with regards to the provision of family planning services. A respondent in the Ministry of Health in Nigeria highlighted the fact that they have an established and dedicated unit on public-private partnership (PPP) within the Ministry of Health. However, the public-private partnerships on SRHR remained undeveloped in the other countries. For example, a respondent from the Ministry of Family Affairs in Senegal noted that there is reluctance on the part of the private sector to be involved in SRH issues. A CSO respondent in Botswana commenting on the private sector's role in SRH said, "The

response from this sector is not well coordinated, current initiatives by the private sector often depend on their own discretion and clear legislation on this is called for." Another CSO respondent in Botswana also commented on the "very limited partnership with the private sector;" suggesting that the reasons are "perhaps because the government has been able to provide basic primary health care [and] there have been no positive results in seeking to cooperate with the private sector – maybe because their interest is in how to increase their profit margins and 'what is in it for them' in any activity." Indeed, a member of parliament in Botswana only recalled one example of public-private partnership in the country, which had to do with the donation of a clinic in the city of Gaborone from the private sector to the government.

Multi-sectoral plans supporting SRHR

There are several cross-cutting issues that undermine reproductive health, especially for poor and vulnerable members of society, such as gender inequalities, poor infrastructure, lack of education, failing economies, poor governance, political instability, environmental degradation and food insecurity, to name a few. Thus, there is a need to coordinate SRH with the work of other sectors to strengthen reproductive health outcomes.

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A member of parliament in Botswana noted that "universal access to SRH requires multi-sectoral efforts, including that of the people themselves." The need to draw upon the resources of different sectors to contribute to positive SRH outcomes was recognised by eight of the countries in the study, who have developed multi-sectoral plans in support of SRH. Ethiopia did not provide information on this indicator.

Key informant interviews in Botswana and Nigeria highlighted initiatives that inter-linked across ministries, such as Ministries of Health, Ministries of Women Affairs, Ministries of Youth and Ministries of Education, to deliver interventions in SRH. Nevertheless, constraints may persist in working across sectors. A respondent in the Ministry of Health in Senegal acknowledged, for instance, that "after Maputo, we exchanged notes internally within the ministry, but not with other external ministries or civil society;" while another respondents in the same Ministry added that a major challenge has been "that of properly articulating the actions of the Ministry of Health and those of other Ministries."

Specific SRH policies/services for vulnerable groups and mobile populations, internally displaced persons (IDPs) and those in conflict situations

There are populations that face disproportionate health risks because of gender, lack of legal status, poverty, nomadic lifestyles or displacement because of conflicts. Given these precarious circumstance such populations often lack access to adequate health care and SRH services or oftentimes integrated SRH services will not be adequately provided for within health care services that may have been established for such populations. Additionally such populations may face logistical obstacles to access SRH services given the environment or contexts in which they live. The call by the MPoA is for policies and programmes that will specifically target the rising number of such vulnerable groups on the African continent.

There are vulnerable populations specifically identified for SRH services in some of the countries, for example, Cameroon, Ethiopia, Rwanda and Uganda. The rest of the countries acknowledged that there were

no specific SRH policies/services for mobile populations and IDPs, although respondents in Botswana said that interventions, especially by CSOs, reached out to mobile and remote populations.

There are SRH initiatives that can be identified as targeting certain vulnerable groups or at-risk populations not identified in the MPoA. In Botswana and Senegal, sex-workers were targeted for services as were prison populations in Botswana and Nigeria. In both Botswana and Nigeria, it was noted that prisoners were not provided with condoms because of laws against same-sex sexual relationships. A CSO respondent in Nigeria also stated: "We have undertaken research on vulnerable populations and facilitated public dialogue on men who have sex with men here in Nigeria;" while a CSO respondent in Botswana spoke about their human rights interventions for sexual minorities, calling for change in government responses to facilitate access to prevention services for STIs and HIV/AIDS. As a result of these interventions, Botswana's Ministry of Health had become willing to let the CSO engage with health care providers to provide prevention services to sexual minority groups.

Programmes that ensure partnership with, support from and inclusion of men in SRHR services

If the goals of development and gender equality are to be achieved, efforts have to be made to address the barriers to men's health-seeking behaviours. A major recommendation of ICPD was that men should be involved in reproductive health programmes and although programmes have continued to put greater emphasis on targeting mothers and children there are increasing attempts to target SRHR services at men. These efforts require states to take steps that build the capacity of health systems to reach and engage men in ways that recognise the gendered lived experiences of women and men in order to effectively change power imbalances that hinder women's access to decision-making, resources and services and that increase women's and men's exposure to greater health risks.

Seven countries noted that they have programmes that ensure partnership with, support from and inclusion of men in SRHR services. Burkina Faso and Ethiopia did not provide information on this area of work.

Seven countries noted that they have programmes that ensure partnership with, support from and inclusion of men in SRHR services

The need to reach men was recognised as important among key informants, especially given the context described by a Member of Parliament in Botswana who commented that "the men don't go for VCT, but wait for the woman to go and assume the result of the test of the woman – the 'my wife has tested for me syndrome.'" A Ministry of Health respondent in Nigeria referred to the success of some RH programmes in the country which was evidenced by "an increase in men's participation in FP issues." Such achievements were however seen as absent in Botswana and Senegal, where respondents pointed to the inadequacies in successfully reaching men even when such policies exist. For example, in Senegal, a respondent from the Ministry of Family Affairs outlined what she saw as the continuing challenge: "Interventions have defined women, children and the elderly as entry points. Such an approach has not included men, who are key players in reproductive health matters...the entry point should be the family, which will take into account all family members." In Botswana, a CSO respondent also held that "SRH is seen as targeting women only. The relevance for men is not seen, or it's seen as unmanly; yet, it is men who are mostly responsible [for] crafting SRH policies." Nevertheless, there are several HIV/AIDS initiatives in Botswana such as the "Zebras for Life programme," funded by PEPFAR and USAID to get men to take HIV tests. Other programmes targeting

men in Botswana include "*Including Men*" and a project launched during the research period entitled *"Multiple and Concurrent Partners Campaign,"* both of which were seen by respondents as a "deliberate attempt to address interpersonal communication, SRH and the family unit, and social norms."

Services for mid-life concerns of both men and women

Women and men need support in coping with their changing psychological and physical circumstances that may have an impact on their sexual and reproductive behaviour. SRH services needed therefore have to be inclusive of education, counselling and management of the symptoms and complications that arise. SRH Services must target those undergoing these midlife changes as well as their communities to understanding and support.

Only five countries – Ghana, Burkina Faso, Cameroon, Rwanda and Uganda – noted having SRH services that were specifically targeting the mid-life concerns of both men and women. Discussions in Botswana revealed that although policy exists to address mid-life concerns, there were real challenges of adequate human capacity to actually deliver such services. In addition, a Ministry of Health respondent in Nigeria remarked that "Offering services for mid-life concerns of men and women is basically on paper. It is not a fully-fledged program because of the problem of inadequate human resource."

MPoA calls for services to be provided for reproductive tract cancers

Policies/plans around screening and management of cancers of the Reproductive system for both men and women

The MPoA calls for services to be provided for reproductive tract cancers. Thus policies and plans to do so are needed that are targeted at four levels of service provision. Primary prevention through the provision of information on cancer prevention and behaviour change e.g. condom use, and discouraging early sex among adolescents; secondary prevention through access to screening services; thirdly early diagnosis and treatment and finally palliative care (Republic of Botswana, Ministry of Health, 2004:55). Indeed some of the most common cancers of the reproductive health system such as cervical cancer are often caused by sexually transmitted infections that are largely preventable if women have access to screening programmes.

Seven countries noted having policies/plans around screening and management of cancers of the reproductive system for both men and women while Nigeria was still in the process of developing a plan. Botswana was pilot testing with plans to scale up, and Uganda pointed out that although it has a plan, "it is scanty."

Advocacy Action: HIV, STI, Malaria and SRH Services Integrated into Primary Health Care

- Advocate for an increased focus on, and resources for HIV/SRHR integration.
- Advocate for governments to address the fragmentation/compartmentalisation that exists among Ministries, and the negative repercussions this kind of structuring holds for progress on SRHR by creating coordination units to secure the full implementation of national and regional SRHR plan within the wider health sector.
- Encourage the strengthening of capacity of public and non-public service providers to integrate STIs, HIV/AIDS, with SRH services.
- Advocate with government to strengthen the partnerships

between public and non-public providers of STI, HIV/AIDS, and SRH services.

- Support creation and strengthening of regional initiatives to encourage integration of services. A good example of such an initiative is the current effort within SADC to set up a "minimum service package' around HIV/AIDS/malaria/TB that seeks a minimum set of services that could be achieved for SADC nationals. There is need to have SADC nationals participate in this process to identify these needs.
- Mobilise to develop networking platforms and forums for reflection on how work is carried out by SRH CSOs across borders, what lessons can be learnt from one another, and for working together to strengthen advocacy responses, as several countries are facing similar SRH issues.
- Advocate for stakeholders in the health sector to incorporate women's rights approaches and human rights in general to SRH programming. Certain groups continue to be denied services even though policies exist guaranteeing health for all, because they are either prisoners, women who are pregnant and HIV-positive, or sexual minorities.

3.3 Repositioning Family Planning

Access to family planning is an essential prerequisite for improving the status of women

Introduction

Historically, family planning was viewed primarily as encompassing fertility reduction programmes addressing population concerns. However, integrated approaches to SRH have called for the repositioning of family planning into wider reproductive health programmes as an integral part of basic health service by expanding coverage, affordable methods and availing a range of products.

Access to family planning is an essential prerequisite for improving the status of women. Without the ability to space and limit births, women would be vulnerable to poor reproductive health, and their capacity to become fully empowered would be difficult, if not impossible. Family planning is also essential in achieving three of the United Nations' Millennium Development Goals: reducing child mortality, improving maternal health, and promoting gender equality. Family planning also supports achievement of the goals of eradicating extreme poverty and hunger, achieving universal primary education, combating HIV/AIDS, and ensuring environmental sustainability, since population growth exacerbates pollution and threatens fragile ecosystems (Cleland et al. 2006; Campbell et al. 2007; UNICEF, 2009).

According to Smith et al, (2009:13) the concept of "Repositioning Family Planning" is a multilateral initiative to ensure that access to quality family planning services remains a priority for policymakers and health providers. The same authors further point out that "over the last decade, attention and resources for family planning programs have been diverted in many countries in sub-Saharan Africa, even though the need remains high, as HIV/AIDS and poverty have become high priorities" (Smith et.al, 2009:13). Several respondents in Botswana did point out that "although HIV/AIDS has put condom use high on the health agenda, it has sidelined other methods or the need to address the provision of a combination of methods for HIV positives." Other challenges facing the repositioning of family planning include the decentralization of authority to lower administrative levels, where family planning may not be seen as a priority.

Strategic Actions and Indicators

Repositioning Family Planning

3.1.1	Proportion of SRH budget allocated to family planning	3.3.1b	% of women with family planning knowledge
3.1.2	Supportive legislation, protocols and guidelines for family planning	3.3.3a	Contraceptive prevalence rate (CPR)
3.3.1a	% of men with family planning knowledge	3.3.3b	Unmet need for family planning

Box 4 Source: Appendix 3

Key Research Findings

Proportion of SRH budget allocated to family planning

For this study, data were hard to come by with regards to the proportion of the SRH budget allocated to family planning because Ministries of Health in the study countries did not present SRH as a line budget item, and Ministries of Finance allocated resources to line ministries, which in turn determined allocations within their respective ministries for their various departments and specific core activities. For example, in Botswana and Nigeria, core areas of SRH such as family planning or ASRH are stand alone departments within the Ministry of Health, but their budgets are integrated with other core areas of SRH as they share facilities, staff and other costs. In addition, new financial mechanisms from donors and lenders, such as sector-wide approaches (SWAps) and Poverty Reduction Strategy Papers (PRSPs), often omit family planning or have given it a lower priority in recent years (Smith et.al, 2009:13).

All nine countries highlight supportive policies (not legislation), protocols and guidelines for family planning

However, in Senegal, a Ministry of Health respondent observed that even in the context of high ministerial turnover in decision-makers, "emphasis has been placed on securing the availability of contraceptives…and the budget allocated for the purchase of contraceptives [rose] from 46 million CFA francs in 2006 to 100 million CFA francs in 2007." Nevertheless, the same respondent pointed out that the piecemeal approach to reproductive health was "causing disruptions to the number of staff available to manage access to contraceptives."

Supportive legislation, protocols and guidelines for family planning

All nine countries highlight supportive policies (not legislation), protocols and guidelines for family planning.

Percent of women and men with FP knowledge

Knowledge of modern method of contraception is generally high across the countries, with 90% or higher of the males and females (except females in Nigeria – 77%, and Ethiopia – 86%) having knowledge of at least a modern method of contraception. Level of knowledge is found to be consistently higher among males than among females in all the countries where data are available.

Contraceptive prevalence rate (CPR)

There are varying degrees of FP service provision and uptake. As shown in Figure 3, the percentages of women with 'unmet need for contraception[3] ' were much higher than the percentages of women using contraceptives in seven of the nine countries. In Cameroon, however, the opposite is the case. In Botswana, a UN respondent

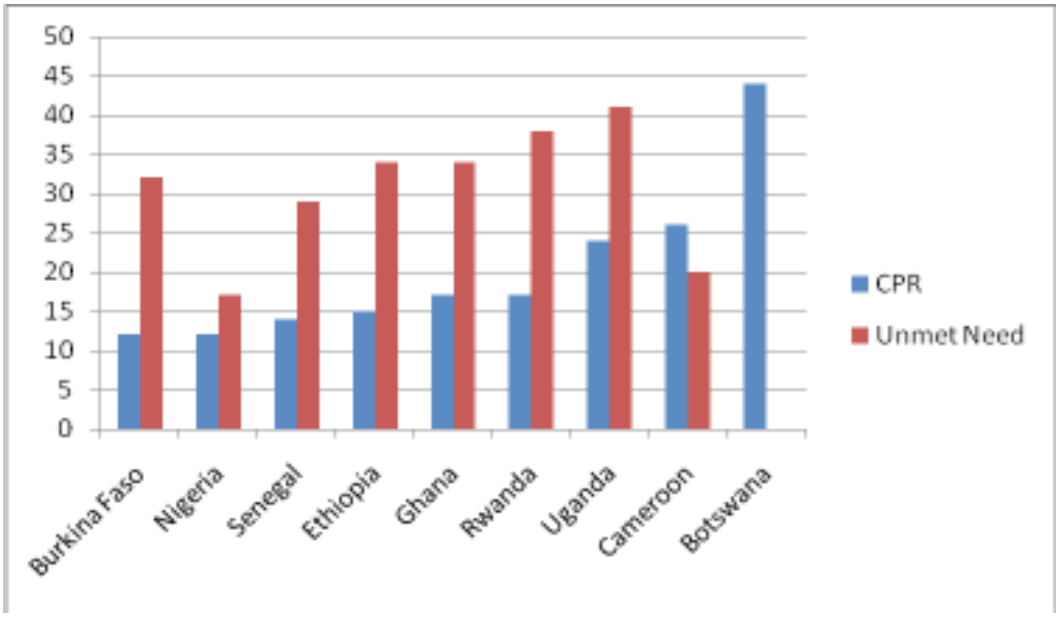

Figure 3: Contraceptive prevalence rates and unmet need for FP (unmet need data not available for Botswana.)

worried about the fact that "CPR is less than 47% and the implications of this are not well understood by government."

Unmet need for contraception
generally refers to fecund women and men (in this case, only women) who desire to limit or space their births but are not using any contraception.

Unmet need for FP
The high percentages of unmet need correspond with high fertility and contribute to continued rapid growth of population in these countries. Unmet need is an indication of a latent need for contraception and suggests that conditions for fertility decline are present in the countries.

Failure to adequately address unmet need results in a continued high number of high-risk pregnancies

Failure to adequately address unmet need results in a continued high number of high-risk pregnancies, which in turn give rise to high levels of maternal illness and death. Therefore, as Janowitz and Foreit (2006:1) assert, "governments need to be convinced that family planning is a good investment for government." Indeed, a WHO/UNFPA study (2006) found that development planning documents and PRSPS in countries that are also part of this study, such as Burkina Faso, Ethiopia, Rwanda and Senegal, mention family planning but do not provide programme details. On the other hand, Uganda's PRSP does not mention family planning, and Ghana goes the furthest with specific details about family planning, financing, logistics, quality of services and awareness-raising campaigns.

Advocacy Actions: Family planning repositioned as key strategy for attainment of MDGs

- Advocate with empirical evidence on demand and gaps in the provision of underserved populations at all levels of government and with donor agencies to ensure that family planning is included in budgeting and planning.
- Mobilise government organisations with SRH mandates to better influence budget allocation processes for contraceptive supplies and delivery to PHC.

- Advocate for support of family planning in all primary health care service provision.
- Increase policymakers' knowledge and awareness of family planning as key to achieving development goals
- Encourage service providers to ensure a proper mix of contraceptive commodities so that users have methods of their choice whenever needed.
- Increase awareness among policy makers for integrating family planning with postpartum care, post-abortion care, immunization services, and HIV/AIDS services
- Encourage improvements in training and supervision of providers so that they are responsive to clients' needs.
- Mobilise government and civil society to eliminate barriers to contraceptive use and the provision of FP services, including getting men's role in contraceptive use.
- Facilitate/encourage the development of partnerships between public and private sectors to deliver FP services.

3.4 Youth-Friendly SRHR Services

Problems pertaining to youth sexuality, such as unsafe sexual practices, remain a real concern in all countries

Introduction

Problems pertaining to youth sexuality, such as unsafe sexual practices, remain a real concern in all countries. Youth are at significant risk of unintended pregnancy and exposure to sexually transmitted infections and the incidence of HIV/AIDS is high among adolescents in the region. Furthermore, "almost half of all new [HIV] infections occur in young people, particularly women" (UNCEF, 2008:33). There are also concerns for adolescent mothers who tend to have poorer health during pregnancy through less frequent use of health care services and biological constraints associated with age (POLICY Project, February 2007). There are therefore calls for supportive strategies geared toward appropriate age groups and parental involvement and education to address the sexual and reproductive health needs of youth (FHI, 2008).

The ICPD proposed several actions for ASRH to ensure access to information and services and the MPoA reflects these proposals. There has been increasing recognition in most countries of the need to address young people's demand and needs for SRH services. There is also acknowledgment by most policy makers and service providers that mainstream health systems have rarely been "friendly or accessible because young people feel judged when they seek out services," as most respondents indicated. However, the location of youth services within mainstream public health clinics continues to pose constraints on youth uptake of SRH services. Yet, potential solutions are readily available, as a UN respondent in Botswana argued: "One-fifth of clinics (in Botswana) can be converted to youth friendly services, taking advantage of the young nurses that are already in the system to reach young people."

In the three focal study countries of Botswana, Nigeria and Senegal, most SRH programmes targeting youth are often located in Ministries of Health, even where Ministries of Youth exist. In all three focal countries, efforts that involve Ministries of Health and the Ministry of Youth have addressed the modalities of SRH interventions for youth in the following ways:

- In Nigeria, interventions are underway to create separate services for young people, aided by the establishment of National

Strategic Actions and Indicators[4]

Youth-Friendly SRHR services

4.1.1	Has developed policies to support SRH services for young people
4.1.2	Celebrates day of SRHR Services for young people
4.2.1	Has IEC/BCC strategies that promote abstinence and condom use
4.2.3	Has IEC strategies for parent education for young people
4.3.1b	% young people with knowledge about condoms
4.3.2a	% Condom use at last sex among sexually active young people
4.3.2b	% of teens with pregnancy or have had a child
4.3.3	Adolescent fertility as a percentage of total fertility
4.3.4	Age of sexual debut

Box 5 Source: Appendix 3

Youth Centres – a recent programme by government to provide for integrated youth services targeting entrepreneurship, health and recreation.

- In Botswana, the effort involves collaboration between the adolescent programme division in the Ministry of Health and local governments to put in place separate spaces for the provision of ASRH services.
- In Senegal, the Ministry of Youth has to date implemented 8 "Espaces Jeunes" (spaces for youth). This is a Presidential initiative to establish a special facility in every administrative region where youth can obtain skills, training, and access to internet and hold cultural, sports and entertainment events. Most importantly, the Ministry of Youth has agreed to integrate adolescent SRH into these facilities (Diop and Diagne, 2007:4)

In Senegal, the Ministry of Health has developed and implemented plans to mainstream ASRH into its activities since 2004

Key Research Findings

Has developed policies to support SRH services for young people

All countries have national plans that are inclusive of adolescent sexual and reproductive health concerns, and that have begun to respond to the numerous challenges facing youth. For example, in Botswana, there is the National Action Plan for Youth 2001-2010; Nigeria has the National Adolescent Health Policy (1995); and in Senegal, there is National Strategy on Adolescents and Young People's Health (2007).

In Senegal, the Ministry of Health has developed and implemented plans to mainstream ASRH into its activities since 2004 when ASRH was first included in the Norms and Guidelines in Reproductive Health during its revision process. With the current ASRH policy, several strategies have been developed in collaboration with several stakeholders and implemented. With the support of its partners, especially Population Council, ASRH services are to be scaled-up across Senegal (Diop and Diagne, 2007).

Celebrates day of SRHR Services for young people

Botswana, Ethiopia and Nigeria were the only countries stating that they have set aside a day to bring attention to adolescent SRH issues.

IEC/BCC strategies that promote abstinence and condom use
All countries state that they have IEC/BCC strategies that promote abstinence and condom use. Adolescent SRH initiatives in Botswana and Nigeria were noted as encompassing strategies that promote abstinence and condom use. In Nigeria, however, CSO respondents noted that the promotion of condom use was targeted toward out of school youth, and not toward all young people. A Ministry of Youth respondent criticized the use of the terms "adolescents", "youth" and "young people" interchangeably which she saw as confusing and failing to appreciate the specificity of these categories. She said this is because in policies, these terms tend to represent specific/different age groups and therefore appropriately targeted activities for each group.

The percentage of male youth that used condom at last sexual intercourse was substantially higher than the females that did in all the countries where data is available

In Botswana, a three year project known as the African Youth Alliance (AYA) was implemented from 2003-05 with several implementing partners and CSOs to address the SRH concerns of youth. A UN respondent highlighted that AYA encompassed various components of coordination and dissemination, policy and advocacy, BCC, life skills development, and youth friendly services. These components clustered around various stakeholders, which included government, CSOs, and university. The AYA project ended in 2005, however, there has been no follow up of the programme due to what the same respondent described as "a lack of leadership with innovative ideas to give direction." CSOs also concurred with this view. For example, although the AYA initiative has since informed government's SRH programme for youth, it is facing challenges with regards to the provision of adequate human and financial resources. The CSOs working in the youth health sector in Botswana noted that opportunities and possibilities for the continued success inherent in AYA have not been sustained due to the absence of bold leadership and political will to give sustained support to ASRH. In Nigeria, collaborative efforts between the Ministry of Education and a local CSO that grew out of the CSO's work on a Family Life HIV Education Curriculum, have led to the implementation of IEC/BCC strategies to address sexuality education for young people across the country.

IEC strategies for parent education for young people
Burkina Faso, Ethiopia, Ghana, Nigeria, Senegal and Rwanda state that they have strategies for parent education for young people. Botswana noted that it did not have such strategies and Uganda pointed out that its existing strategy was "scanty." The extent to which these strategies are being implemented in the vast majority of these countries remains unclear, however. For example, a CSO respondent in Nigeria pointed out that only a handful of States in the southern part of Nigeria (in particular, Lagos State) are implementing this activity.

Knowledge of condoms
Figure 4 shows that, just as found in the general population, over 90% of male youth have knowledge of condom. This level is much higher than found among the female youth in all the countries, and is particularly low for females in Nigeria and Ethiopia.

Percent of Condom use at last sex among sexually active young people
The percentage of male youth that used condom at last sexual intercourse was substantially higher than the females that did in all the countries where data is available. There could be a number of reasons behind this disparity, including the age difference between

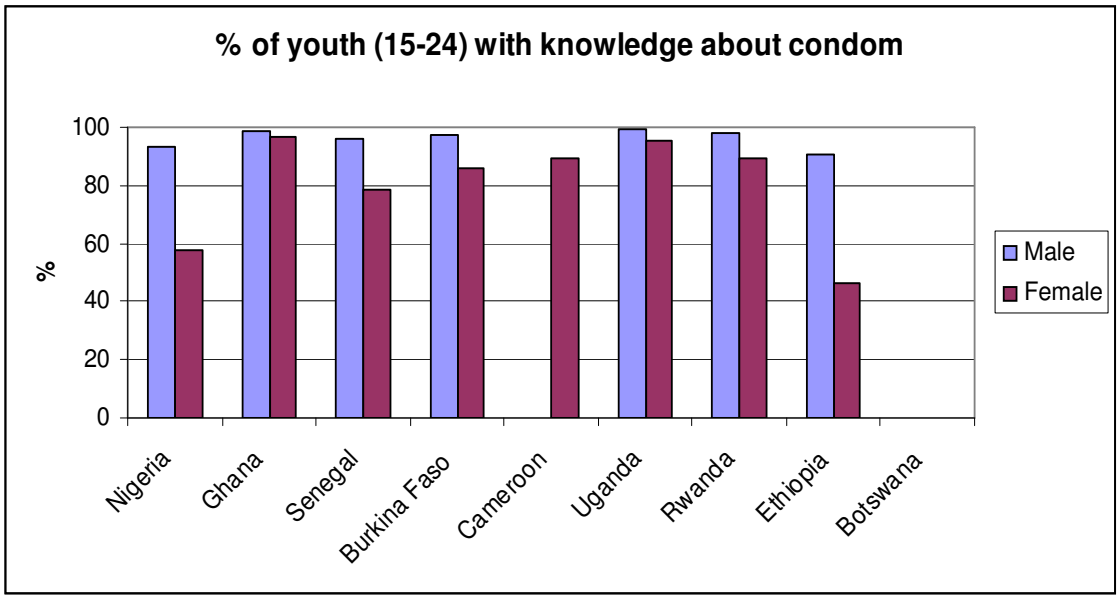

Figure 4: Percentage of Youth with knowledge about Condom (data not available for Botswana)

female youth and their sexual partners (with the former often being younger than the latter as well as less sexually experienced). This phenomenon has been linked to the higher prevalence of HIV among young women vis-à-vis their male counterparts.

Age at sexual debut; Teenage pregnancy and motherhood; and Adolescent fertility as a proportion of total fertility

Circumstances such as poverty and poor school performance are increasingly being recognised as predisposing young women to have premarital sex or to marry early (Melhado, 2008). Age at sexual debut ranged between 17 and 19 years for the females and 19 (in Cameroon) and 21 years for the males (in the other 8 countries). Figure 6 shows no clear-cut relationship between ages at sexual debut of the females and the percentage of teens that were pregnant or have had children as at the time of the surveys, implying that there are many more factors associated with teen pregnancy. Over 20% of teenagers in Cameroon, Uganda, Nigeria and Senegal were

Figure 5: Percent condom use among sexually active youth (15-24 years) (data not available for Botswana)

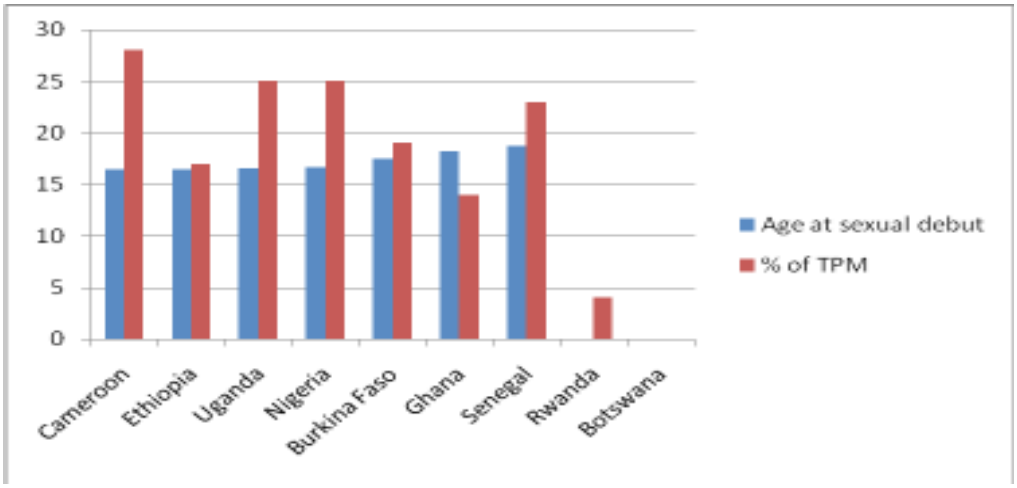

Figure 6: Age at sexual debut and percentage of teenage pregnancy and motherhood (data not available for Botswana)

either pregnant or had had at least one child as at the time of the surveys. However, adolescent fertility as a percentage of total fertility is less than 5% in all the countries, except Cameroon, where it is 12.34%. Data on this indicator are not available for Botswana (see further details in appendix 3).

Advocacy Actions: Youth Friendly SRHR Services positioned as key strategy for youth empowerment, development and wellbeing

- Advocate for provision of comprehensive SRHR services among potential opponents to support acceptability, and as key to meeting the varying SRH needs of adolescents, including reducing unintended pregnancies and reducing the transmission of STIs/ HIV/AIDS among young people.
- Advocate for governments and other development partners to prioritise the implementation of youth-friendly services.
- Mobilise organisations with SRH mandates to create advocacy coalitions to promote dialogue among potential opponents in support of youth friendly SRHR service.s
- Encourage change in training and supervision of providers so that they are responsive to youth SRH needs.
- Work with media to promote understanding of adolescent SRH.
- Advocate around the need for parent involvement in discussing sexuality and SRH issues with their children in order to promote sexuality education.
- Promote the active involvement of young people in addressing their SRHR needs and challenges.

Women have abortions irrespective of prevailing laws

3.5 Incidence of Unsafe Abortion Reduced

Introduction

Women have abortions irrespective of prevailing laws, religious proscriptions or social norms, so write the authors of "Unsafe Abortion: The Preventable Pandemic," who go on to add that it is "one of the most neglected sexual and reproductive health problems in the world today" (Grimes, et al, 2006:5). Further, abortion remains one of the most contentious among SRHR issues, for, in addition to the tensions between secular and religious views about the subject, it raises the issues of the right of women to have control over their bodies, the

Strategic Actions and Indicators

Incidence of Unsafe Abortion Reduced			
5.1.1	Has Status Report on the magnitude and consequences of unsafe abortion	5.1.3	Has action plans to reduce unwanted pregnancies and unsafe abortion
5.1.2	Has legislative/policy framework on abortion		

Box 6 Source: Appendix 3

duty of the State and the conflicting rights of women, mothers and the unborn (United Nations Department of Economic and Social Affairs, 2001). Similar challenges marked the development and ratification of the MPoA.

Key Research Findings

Status Reports of magnitude and consequences of abortion
Status reports were available for Ghana, Burkina Faso, Ethiopia and Nigeria, while Cameroon was in the process of developing one. Botswana has interventions to address unsafe abortion although no status report on magnitude exists. Uganda did not provide information on any of the indicators pertaining to unsafe abortion.

Legislative and policy framework
Abortion laws remain restrictive; however, abortion for the purposes of saving a woman's life is legally permitted in all African countries (IPAS and Family Care International Organisation, 2005). With the exception of Rwanda, the rest of the countries allow abortions in very specific circumstances as outlined in their national laws, with Ethiopia revising its law in May 2005 to include the provision that "poverty and other social factors may be grounds for reducing the criminal penalty for abortion."[5]

Abortion for the purposes of saving a woman's life is legally permitted in all African countries

Action Plans to reduce unwanted pregnancies and unsafe abortion
Survey findings were that most countries had such action plans except Cameroon, while Uganda provided no information. Respondents in Botswana noted that a pilot project training health care workers in post-abortion care was underway with the plan to roll it out to all clinics and hospitals, although there was a sense that post-abortion care received the least emphasis out of all the SRH components.

Advocacy Actions: Incidence of unsafe abortion reduced

- Call on governments to ensure post-abortion care services are available and not affected by stigma or legal penalty.
- Create awareness around post-abortion care services among potential users.
- Advocate for universal access to safe abortion by creating awareness among the public, media and policy makers around the health impacts and other costs of unsafe abortions.
- Promote dialogue among relevant stakeholders about how to reduce morbidity and deaths from unsafe abortions.
- Promote research to clarify the magnitude and consequences of unsafe abortion.
- Promote awareness of safe-abortion services for women who qualify under existing laws and promote review of existing laws to accommodate more circumstances that force women to seek abortions.

3.6 Access to Quality Safe Motherhood and Child Survival Services

Introduction

In the most recent State of the World's Children Report on Maternal and Newborn Health , the United Nations Children's Fund (2009) highlights that 95% of maternal deaths and 90% of neo-natal deaths that occur in Africa and Asia are preventable or treatable with access to essential maternity and basic health care services. The report goes further to state that services are most effective when integrated into a continuum of care that is provided to women and children at critical points throughout their life cycle (UNICEF, 2009).

High maternal and infant mortality and morbidity have remained a major concern for Africa

High maternal and infant mortality and morbidity have remained a major concern for Africa and are cause for calls to action to ensure safe motherhood. There is continuing evidence that delays in decisions to seek care, delays in reaching care and delays in receiving care[5] are the key stumbling blocks for women (Elabd, nd). Moreover, the lack of access to quality health care services and poverty undermine the quality of those services and sustain high maternal and infant morbidity and mortality. The Maputo Plan of Action therefore draws important attention to safe motherhood and child survival.

Key Research Findings

Roadmaps for the reduction of maternal and newborn morbidity and mortality

All countries noted that have developed a roadmap for addressing maternal and new born morbidity and mortality. In Botswana, Nigeria and Senegal, addressing safe motherhood was high on the agenda. Senegal[7] and Nigeria[8] have developed Roadmaps for accelerating the attainment of maternal and newborn health as a result of funds availed for that purpose from the Millennium Development Goals initiative. Furthermore, in 2007, the government of Nigeria began implementing the first phase of a national integrated maternal, newborn and child health strategy that will be rolled out in three phases. A roadmap is also under development in Botswana, although it was noted that the collection of data for both MMR and IMR that help inform the roadmap faced severe constraints. This concern is confirmed by the State of the World Report (UNICEF, 2009:7) which notes that, generally for many countries, "measures of MMR are prepared with a margin of uncertainty given challenges in data collection and

Strategic Actions and Indicators

Access to Quality Safe Motherhood and Child Survival Services

6.1.1	Development of national roadmaps for reduction of maternal and newborn	6.3.2	% of pregnant women and children vaccinated
6.1.2	Commemorate safe motherhood days	6.3.3	Immunization coverage at one year
6.1.3	Coverage of supervised delivery	6.3.3b	Prevalence of under-weight children
6.2.1b	Maternal Morbidity Ratio	6.3.4a	Availability of IMCI protocols,
6.3.1a	Peri-natal mortality Rate	6.3.4b	IMR
6.3.1b	Neo-natal mortality Rate	6.3.4c	Under-5 mortality

Box 7 Source: Appendix 3

measurements." In Senegal, the National Population Policy (1998-2008) has also included clear objectives and targets for reducing maternal and infant mortality rates.

Commemorates safe motherhood days

The commemoration of safe motherhood, usually involving the setting aside of a day, week or utilising existing international day(s) for women to bring attention to this important issue, was found in most study countries, the exceptions being Senegal and Botswana.

Pregnant women and children vaccinated, immunisation coverage and coverage for supervised delivery

The most effective interventions for achieving safe motherhood are the provision of supervised delivery, promoting antenatal care and also access to essential obstetric care. In Senegal, a Ministry of Health respondent noted that they have created a focal point on all issues relating to the mother and infant, which is to be replicated at the local level with the establishment of obstetric care and neonatal emergency facilities, while the training curriculum for reproductive health professionals has been modified to incorporate issues related to the new-born.

The most effective interventions for achieving safe motherhood are the provision of supervised delivery, promoting antenatal care and also access to essential obstetric care

However, Figure 7 shows that having two or more tetanus toxoid vaccinations during pregnancy and delivering the baby under the supervision of skilled health professionals are often not related. In three of the nine countries surveyed (Ethiopia, Uganda and Senegal), percentages of women vaccinated during pregnancy exceeded the percentages of women that had supervised delivery, especially in Ethiopia, where only 6% of deliveries were supervised by skilled attendants. More surprising is the fact that in four of the nine countries (Nigeria, Uganda, Cameroon and Senegal), both the percentages of women that got vaccinated during pregnancy and those that delivered under skilled supervision were greater than the percentage of children aged 12-23 months that were fully immunized. The situation was particularly dismal in Nigeria where only 11% of children aged 12-23 months are fully vaccinated.

Maternal Mortality Ratio (MMR) and Under-5 mortality

Progress has been limited in reducing MMR and under-5 mortality for many African countries (UNFPA, 2009). Across the 9 study countries, estimates of infant mortality rates (IMR) tended to be high where

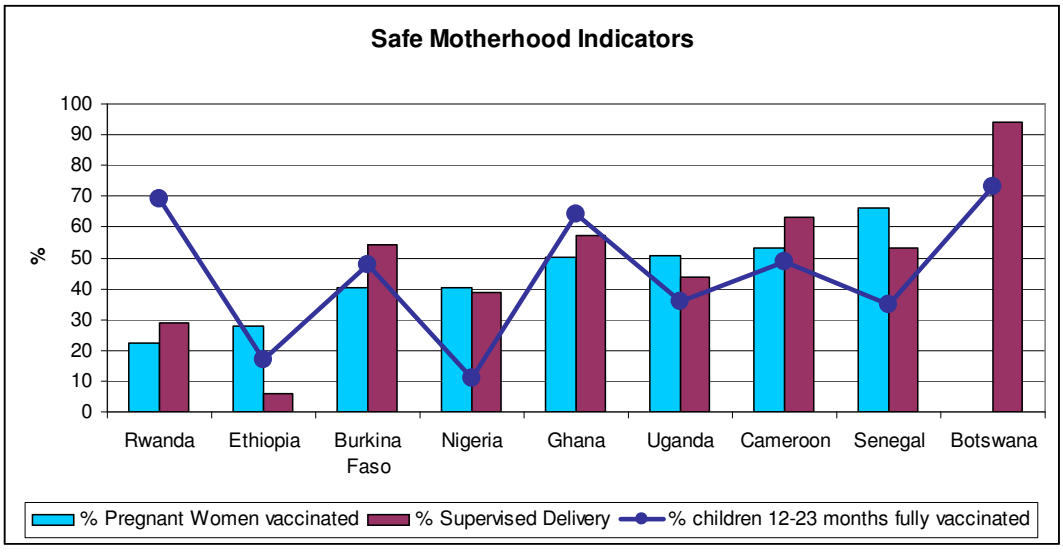

Figure 7: Safe Motherhood Indicators

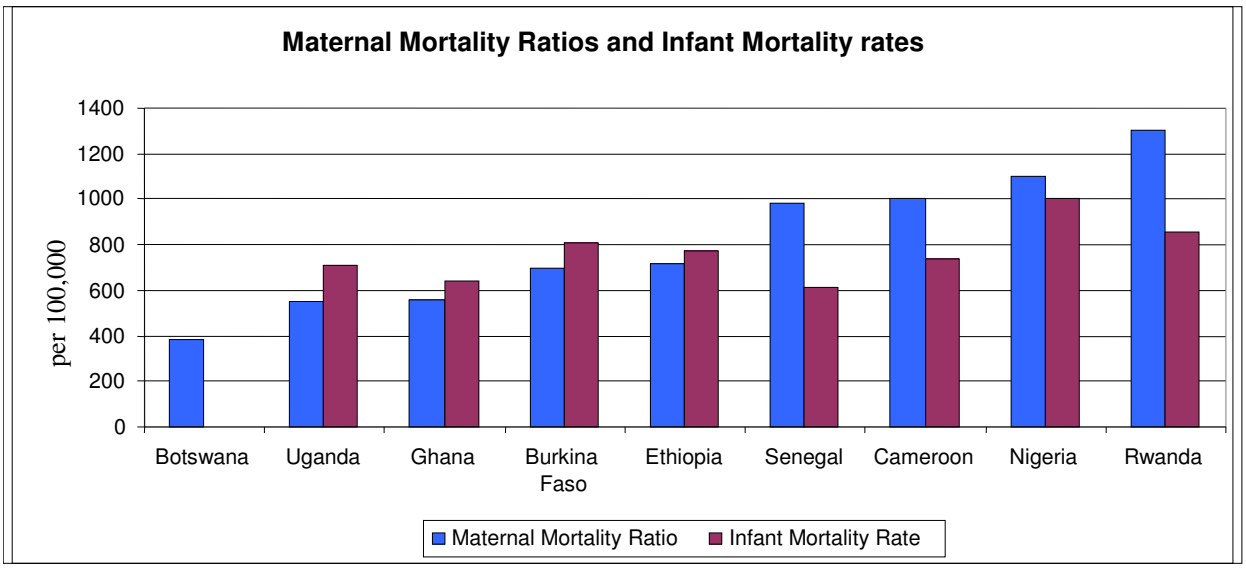

Figure 8: Maternal Mortality and Infant Mortality rates

maternal mortality ratios (MMR) are high. IMR are however higher than MMR in four countries (Burkina Faso, Ethiopia, Ghana, Uganda) and lower than MMR in the other four (Cameroon, Nigeria, Senegal, Rwanda). MMR in Cameroon, Nigeria and Rwanda are 1000 or more per 100,000 live births. IMR also stood at 1000 per 100,000 live births in Nigeria. The need to lower these two indicators cannot be overemphasised to enable the countries meet the MDG targets 5 and 6 (Figure 8).

IMR stood at 1000 per 100,000 live births in Nigeria

Availability of IMCI protocols

Integrated management of childhood illness (IMCI) protocols were available in Burkina Faso, Cameroon, Ethiopia, Ghana and Uganda, but no data were availed on this indicator for the other four countries.

Advocacy Actions: Access to Quality Safe Motherhood and Child Survival Services Increased

- Advocate for improved data and information collection for priority-setting around the enhancement of maternal and infant health outcomes.
- Advocate with evidence for governments to increase resources for health facilities (including mobile ones), properly trained health care personnel, and commodities in support of safe motherhood and child survival.
- Promote community and public discourses to address cultural beliefs and traditions about child-birth that prevent women from seeking professional maternity services even in cases where such services are accessible.
- Strengthen monitoring and evaluation and accountability systems for safe motherhood and child survival.

3.7 Resource Mobilisation for SRHR

Introduction

The MPoA provides two scenarios of estimated costing of SRHR services. The first scenario suggests that in 2007, Africa would require an expenditure of US$ 3.5 billion, increasing to 4.6 billion by 2010. The second scenario outlines the total SRH/HIV prevention costs for direct services provision at US$5.8 billion, health system development

at US$7.4 billion and supportive activities at US$8.3 billion, in the years from 2007 to 2010. Much of this expenditure is expected to be raised from domestic and donor resources. However, global expenditures to date for SRH portray a constrained context for resource mobilisation for the core areas of SRH. Without sufficient government funding, the largest financial burden will continue to be borne by consumers, with the poor bearing the greatest burden (Dennis, 2009).

Reviewing global expenditures into SRH and population activities, UNFPA data for 2005[9] (Figures 8. 9, 10 & 11) are illustrative of the changes that have been occurring as reflected in the extraordinary

Expenditures by ICPD Category as a Percentage of Toatal Population Assistance, 1995-2005[10]

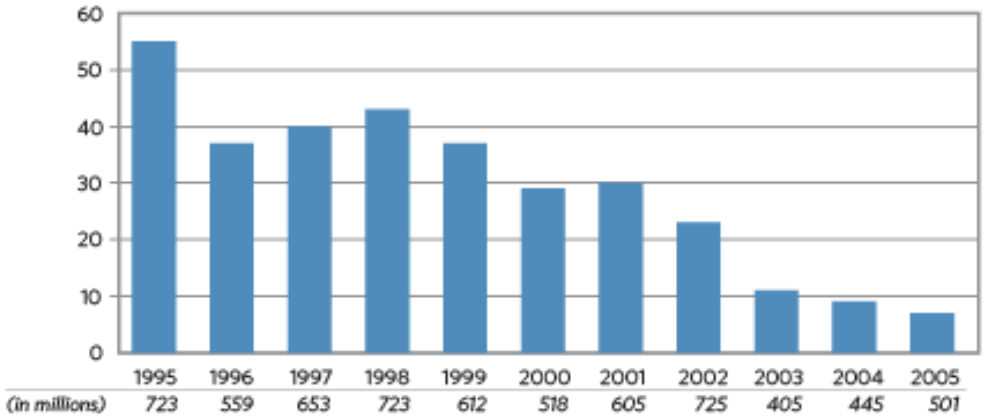

Figure 9: Family Planning

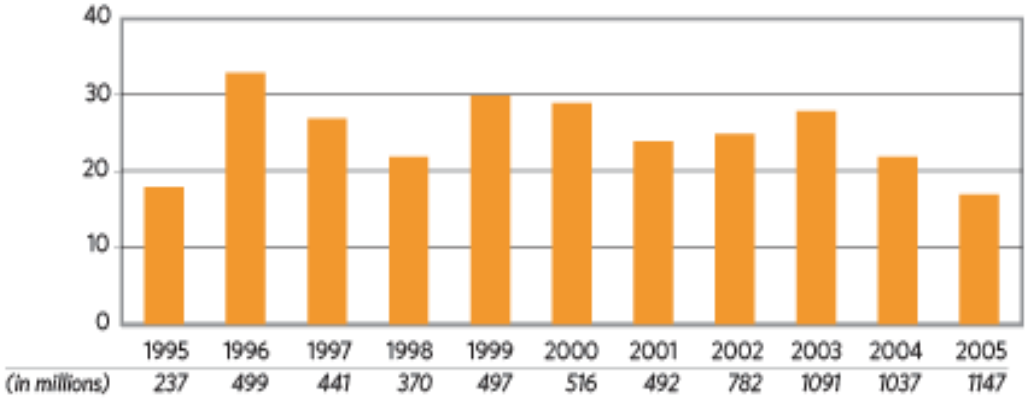

Figure 10: Reproductive Health

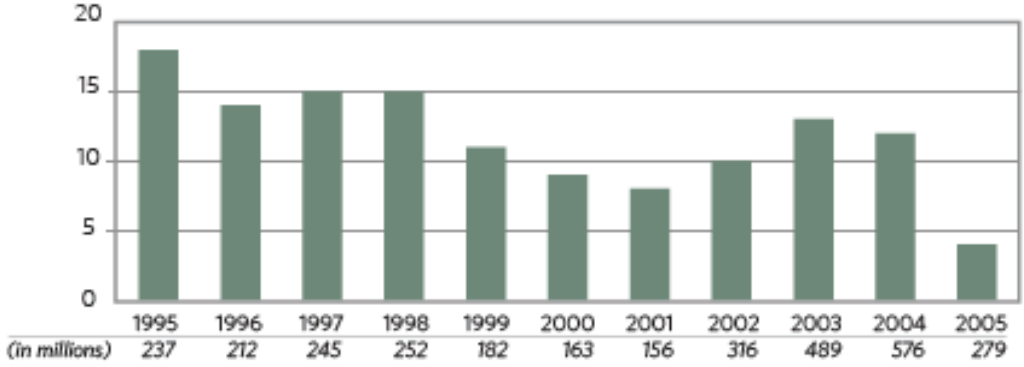

Figure 11: Research, Data and Policy Analysis

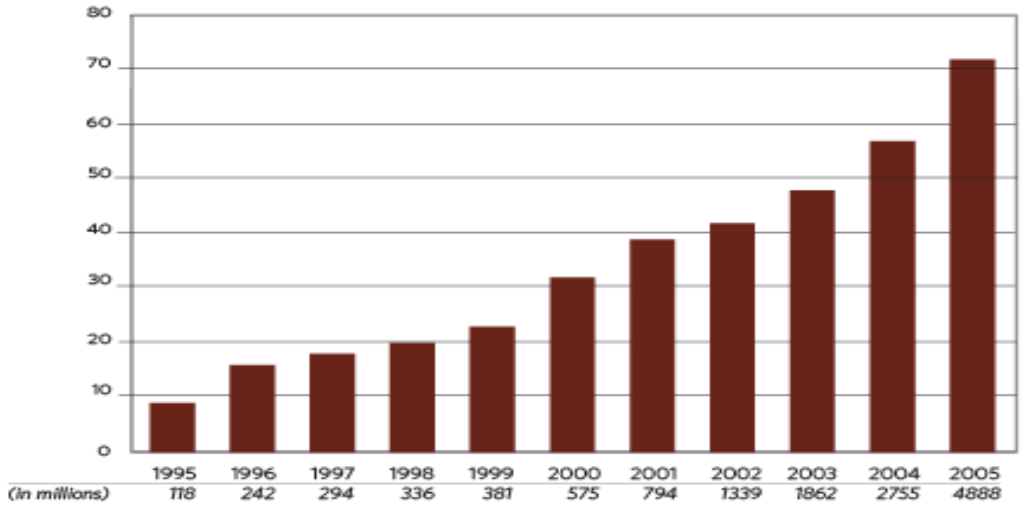

Figure 12: STD/HIV/AIDS

SWAPs, a donor financing mechanism targeting a specific development sector, have remained important in the health sector

resource increases to HIV/AIDS and enormous decreases to family planning.

In 2009, UNFPA released updated (since 1994) cost estimates of the minimum resource requirements to meet ICPD goals (United Nations, 2009) that show that on the whole, donor funding for reproductive health had increased and reached almost US$1.5 billion in 2006, yet was still falling short of required levels to meet ICPD or MDG goals for reproductive health averaged as US$7.8 billion annually.

It is important to note that tracking donor funding for SRH is becoming increasingly challenging given that aid funding mechanisms have been influenced by the Paris Declaration on Aid Effectiveness.[11] As a result of this Declaration, financing from donors is moving towards General Budget Support to governments whose potential for increasing investment to SRH is not assured in the absence of SRH as a national priority health need, or in contexts of resistance to SRHR, or with failure to detail how SRH programmes are benefiting from financial flows. On the other hand, Sector wide approaches (SWAPs), also a donor financing mechanism targeting a specific development sector, have remained important in the health sector, especially given that certain donors have always traditionally supported SRH (for example, UNFPA, SIDA, DANIDA, DFID and Ford Foundation) and seem set to continue to do so; however, the present study did not explore this trend.

Key Research Findings

SRHR in National PRSP and Development Planning

In order to ensure and direct resources towards SRH, countries need to reflect SRH issues in their development plans or Poverty

Strategic Actions and Indicators

Resource Mobilisation for SRHR

7.1.1a	15% of budget allocated to health	7.1.2a	SRHR in national PRSP or development plans
7.1.1b	Proportion of health budget allocated for SRHR	7.1.2b	% national health budgets allocated to SRHR

Box 8 Source: Appendix 3

Reduction Strategy Papers (PRSP) very explicitly so that budgets can be tracked and governments held accountable. All nine countries noted that they have SRHR in their national PRSPs or development plans.

A study by WHO/UNFPA (2006) that explored the role of PRSPs in prioritising SRHR for increased spending spotlighted Senegal, among other countries, and found that "health ministries were at a disadvantage in dialogues with finance ministries because they lacked staff with macroeconomic competencies." Furthermore, the same study notes that there was "weak evidence of reproductive health being valued in PRSP." There was also selective mention of "maternal health" that did not "reflect the holistic definition of reproductive health….while the multiplicity of documents has contributed to weak implementation" (WHO, 2005:3). For example, the SRH issues that Botswana has specifically sought to address are maternal health and child mortality in its Vision 2016 national development plan. However, discussion with respondents in Botswana illuminates that some HIV positive groups, such as pregnant women, prisoners, and sexual minorities have been ignored or have struggled to access SRH services; and yet, addressing HIV/AIDS is a government health priority.

In Nigeria, changes in political administrations had presented new development agendas, as is the case with the current "7 Point Agenda" in which health is not an explicit priority. It was argued by government officers, however, that "it [health] is implied within the other agenda priorities." Local CSOs and foundations, however, questioned the clarity of the 7-Point Agenda, as well as its commitments to health and, therefore, SRH.

In Senegal, a Ministry of Health respondent argued that "reproductive health is a priority," but went on to add that unlike in the past, the Ministry is not approaching RH in a systematic way or giving it the priority it deserves. The respondent further added that the development of actions around the MPoA for Senegal should have taken a grassroots approach, rather than the current centralised approach to its development. The respondent further said that there had been little involvement of medical professionals in neonatology and obstetrics, and non-participation of women and communities in the development of an MPoA action plan for Senegal.

Only Botswana and Rwanda have met and exceeded the call of 15% of national budgets being allocated to health

15% of budget allocated to health

Only Botswana and Rwanda have met and exceeded the call of 15% of national budgets being allocated to health. In Botswana, health services are increasingly accessible to all citizens as financial barriers have been removed. Most countries in the study were below 10%. However, a Ministry of Health respondent in Nigeria provided important insight into the budgeting approach employed by some countries, saying: "Our budget figures [for health] are not a true measure of all contributions to health matters through all kinds of bodies that have an impact on health." In other words, a variety of sectors direct resource flows toward actions that have an impact on health, but that may not be considered as part of the health budget. Therefore, national health budgets may not necessarily be a true reflection of total health expenditures.

In Senegal, the WHO/UNFPA (2006) study had found that "health and education were referred to as 'non-productive and therefore subject to low resource allocation and even budget cut-backs,' receiving second level investment priority."[11] Even when there are

resource commitments to health, government respondents in Botswana, Nigeria and Senegal stated that resources in their sector have often been returned because of the capacity to spend the allocations, due to logistical, administrative and procurement challenges that slowed down the ability of a Ministry to spend its allocations in a timely manner.

Percent of national health budget allocated to SRHR

Resources to health in general have increased and some countries note and foresee improved resource allocations for SRH. A respondent in the Ministry of Finance responsible for health matters in Senegal pointed out that SRH has always been in national planning but with very little resources until 2007 when there was a marked increase from the previous 50 million CFA to 600 million CFA. Most CSO respondents in Botswana, Nigeria and Senegal said that there remained a need for significant additional resources if SRH services are to be fully implemented. Indeed, the role of government in Botswana as a potential funder of services provided by CSOs is beginning to be explored by local CSOs. A CSO respondent in Botswana highlights this point saying that "It is the responsibility of government to support the work of CSOs because government resources is our money and should be distributed among us, as CSO activities are focused on the people of the country."

Resources to health in general have increased and some countries note and foresee improved resource allocations for SRH

A recent article by Oluwole (2008) on policy development in sub-Saharan Africa points out that "the call for increased development assistance and action towards health has seen the creation of several funding mechanisms and initiatives that have brought much needed resources into some of the core areas of SRHR, for example: MPoA, International Health partnership (for the health MDGs), Global Fund against AIDS, TB and Malaria, US President's Malaria Initiative, US President's Emergency Fund for AIDS Relief, Road Map for Accelerating the attainment of the MDGs related to Maternal and newborn health in Africa, African Union Framework for Child Survival and the African Union Health Strategy." However, these initiatives have been sites of tensions and debates (with regards to where and on what core areas of SRH resources will be allowed to support)[13] while a "dearth of health workers has reduced the capacity of African nations to take full advantage of these new sources of funds to the health sector" (Oluwole, 2008:6).

Although resources are being directed towards SRH in all the study countries; it was challenging, as noted earlier, to establish the proportion of the national health budget allocated to SRH because often SRH issues are not a budget line item. This is mostly as a result of the fact that the health sectors were not necessarily set up to account for allocations and expenditures in this way.

A Ministry of Health respondent in Nigeria also indicated that "financial resources are not a constraint; rather, it was bureaucracy and logistics in accessing, applying and the release time for funds that are a major stumbling block to allocations and expenditures in health" in Nigeria. Also echoed by a Ministry of Health respondent in Senegal was the fact that "there is no problem with [mobilising] resources" for SRH and some of the evidence provided was that the Ministry of Health had succeeded in securing the budget for contraceptive products, while another respondent in the Ministry of Family Affairs in Senegal further added that they had advocated for increased resources from the Ministry of Finance and "the authorities have agreed to double

the budget allocated for reproductive health, and there is more sustained involvement of donors."

Advocacy Actions: Resource Mobilisation for SRHR

- Advocate for civil participation in national development planning and budgeting processes in order to increase transparency and accountability.
- Develop capacity among members of parliament and CSOs to do budget tracking.
- Advocate among key decision-makers in the Ministries of Health and Finance to establish a specific budget line for SRH.
- Mobilise and support existing initiatives to monitor government SRH budgets.
- Advocate for governments to demonstrate more transparency in terms of their expenditures on SRH.
- Mobilise CSOs to develop advocacy strategies to encourage countries to prioritise SRHR and to align resources accordingly to achieve the goals of MPoA.
- Develop advocacy strategies together with key partners in the health sector for mobilising resources for SRH.

3.8 Commodity Security for SRHR

Introduction

Sustainable and secure supplies of SRH commodities and essential medicines would require the strengthening of human capacity in health, as well as procurement, supply, monitoring and distribution systems. Increasingly, countries need to plan, given the decline in donor-provided contraceptives. As Janowitz and Foreit (2006) posit, such donations have been key to the provision of diversified method mix, but this is unsustainable while the cost of commodities for family planning is set to increase substantially.

Increasingly, countries need to plan, given the decline in donor-provided contraceptives

Key Research Findings

Plans for reproductive health commodity security

The survey findings on this issue point to the existence of plans for RH commodity security in Burkina Faso, Botswana, Cameroon, Ethiopia, Ghana, Nigeria, Senegal, Rwanda and Uganda. This study neither explores what these planning processes look like, nor their intent; however, strategies that ensure sustainability in an environment of growing demand need to be supported.

Reproductive health commodities in essential medicines list

Seven countries (Botswana, Burkina Faso, Cameroon, Ethiopia, Ghana, Nigeria, Rwanda and Senegal) have RH commodities on the essential medicines list, and no information was provided for Uganda.

Strategic Actions and Indicators

Commodity Security for SRHR

8.1.1	Has plans for reproductive health commodity security
8.1.4	Has reproductive health commodities in essential medicines list
8.2.2	Experiences stock outs

Box 7 Source: Appendix 3

Experiences stock outs
Despite these planning efforts, all countries, with the exception of Rwanda, note that they experience occasional stock-outs, while Uganda did not provide information on this indicator. However, a respondent from Nigeria's Ministry of Health noted that Nigeria's experiences with stock-outs on contraceptive commodities are rare, as UNFPA has been supporting consistent supplies. When stock-outs do occur, they are usually brought about by the introduction of new contraceptive commodities which often spark initial high demand from would-be consumers. In Botswana, a UN respondent mentioned that "when there are stock outs, the causes are often logistical." A Ministry of Health respondent in Senegal pointed out that financial resources to secure commodity supply had been substantially increased in the country.

Advocacy Action: Commodity Security for SRHR
Advocacy actions

- Advocate for the increased capacity of the government bodies responsible for distributing SRHR commodities.
- Create awareness on the potential benefits of public-private partnerships or government-donor coordination for establishing RH commodity security.
- Mobilize resources from public and non-public sources and improve management of stocks to safeguard against contractive commodity stock-outs.
- Promote generation and dissemination of research to document extent (across various sub-groups and geographical regions) and implications of commodity-stock-outs to be used for advocacy.

Reliable, relevant, timely, sex-age disaggregated and accessible data must be collected and this requires adequate M&E systems

3.9 Monitoring and Evaluation of SRHR

Introduction

Monitoring and evaluation (M&E) supports decision-making. Thus, reliable, relevant, timely, sex-age disaggregated and accessible data must be collected and this requires adequate M&E systems. For efficient monitoring and evaluation of sexual and reproductive health rights issues, both quantitative and qualitative data are required – the former to better inform the setting of SRH targets, and the latter to understand client needs and quality of care of SRH services.

Key Research Findings

Regularly conduct census
With the exception of Nigeria, all countries in the study submitted that they had regularly conducted a census.

Strategic Actions and Indicators

Monitoring and Evaluation of SRHR

9.1.1a	Regularly conducts census	9.2.1	Mechanisms and database for monitoring the implementation of the MPoA
9.1.1b	Regularly conducts DHS	9.3.1	Has institutionalised M/E systems
9.1.1c	Regularly conducts annual Maternity reviews	9.3.6b	Best practice web platform established

Box 8 Source: Appendix 3

Regularly conducted DHS
With the exception of Botswana, all countries in the study submitted that they regularly carried out a DHS.

Annual Maternity reviews
With the exception of Ethiopia and Uganda, all the other seven countries had regularly carried out maternity reviews.

Monitoring the implementation of the MPoA
Burkina Faso, Cameroon, Ethiopia and Rwanda stated that they have systems in place to monitor the implementation of the MPoA, although the respondents in Cameroon further noted that their monitoring system is not functional.

There were challenges noted with M&E in the three focal study countries. According to a CSO respondent in Nigeria, "We have tools for monitoring but we have not begun to implement them. It is therefore not yet clear what SRH achievements have been possible. We are also not in a position to ascertain the impact of our work because we are not alone – there are many players." However, another Nigerian CSO described their own efforts at setting up the monitoring of local health facilities to respond to client service needs. In Botswana, the Ministry of Health respondents mentioned that they check in periodically with implementers to monitor their activities, and in Senegal, a Ministry of Health respondent noted that there was a monitoring and evaluation division within the RH department, but the challenge was to decentralise beyond the Ministry to local levels and to ensure, through training, that the monitoring of the MPoA had the involvement of national and local stakeholders.

There were challenges noted with M&E in the three focal study countries

Institutionalised M&E systems
All countries stated that they had such systems in place, but Botswana and Cameroon pointed out that they are not functional and it remains unclear how fully functional these systems are in the other countries in monitoring SRH issues.

The establishment of best practice web platforms
The purpose of these web platforms is to disseminate information on successful interventions which other African countries can learn from. Findings on this indicator showed that only Burkina Faso, Ethiopia and Rwanda state that they have established such a platform, although the web addresses were not accessible.

Advocacy Actions: Monitoring and Evaluation of SRHR

- Advocate for CSO participation in tracking and reporting on government delivery of its SRH commitments to strengthen accountability.
- Advocate for institutional and individual capacity building and skills development in monitoring and evaluation and inclusion of credible monitoring and evaluation designs in all SRH projects.
- Advocate for CSO participation in supporting M&E capacity.

Endnotes

1 Consolidated list of all nine countries presented in Appendix 3.
2 Although these laws are intended to be beneficial for SRH concerns, we acknowledge that some may seem potentially problematic for other human rights issues.
3 Unmet need for contraception generally refers to fecund women and men (in this case, only women) who desire to limit or space their births

but are not using any contraception.

[4] Indicators 3.2.1b (% young people with knowledge about both abstinence and condom use) and 4.3.2a (% condom use among young people) within the MPoA are substituted here with the standard DHS indicators of 'knowledge of condoms' and '% condom use at latest sex among sexually active young people', respectively. These were considered to be more useful measures.

[5] Membership Association: Family Guidance Association of Ethiopia (FGAE) "Membership Association Profile" (2007) fgaeed@ethionet.org www.fgae.org

[6]

[7] Republique Du Senegal, Ministere De La Sante Et De La Prevention Medicale, (2005) 'Feuille De Route Pour Accelerer La Reduction De La Mortalité Et De La Morbidité Maternelles Et Néonatales Au Sénégal' (2006-2015), Dakar, Senegal.

[8] Federal Ministry of Health, Nigeria,(2005) 'Road Map for Accelerating the Attainment of the MDGs Related to maternal and newborn health in Nigeria' Federal Ministry of Health and World Health organisation, Abuja Nigeria.

[9] 2005 is the most recently available data for these core areas of the ICPD.

[10] www.unfpa.org

[11] The Paris Declaration on Aid Effectiveness is an agenda that sought to reform the mechanisms for the delivery of aid based on five principles of Democratic ownership of development, Alignment of aid to national plans, Harmonisation of donor strategies, Management of development for results and Mutual accountability for development.

[12] In January 2009 President Obama revoked the gag rule, thus facilitating immediate access to US government resources and partnering for NGOs and UN agencies such as UNFPA to provide family planning and reproductive health services.

Chapter 4

Implementing SRHR Actions: The Role of CSOs in Botswana, Nigeria and Senegal

4.1 Introduction

Countries remain far from reaching the MPoA targets. Nevertheless, there have been slow but steady steps forward. A very critical role has been played by Civil Society Organisations (CSOs) in building the knowledge and awareness of SRHR issues among the diverse communities they serve, as CSOs contribute significantly to the health sector by working on SRH issues that affect women, youth, men, sexual minorities, people living with HIV/AIDS, and prisoners. In addition, CSOs play a strong advocacy role to sustain support of SRHR issues and engage in the direct provision of SRH services with all such actions facilitating the expanded access to SRHR services. These efforts by CSOs in implementing SRHR demonstrate what their leadership, knowledge and resources can accomplish in reinforcing and improving MPoA indicators.

In this chapter, we present qualitative evidence collected from CSOs in the three focal countries of Botswana, Nigeria and Senegal. Besides discussing their understanding of the MPoA and the extent to which they were carrying out roles assigned to CSO actors within MPoA, discussions with CSOs sought to understand what their successes, challenges and lessons learned had been in regard to engaging with the MPoA, as well as in regard to fulfilling their specific roles as outlined in the MPoA.

In the three focal countries, CSOs varied in their levels of awareness of the MPoA

4.2 Aligning CSO Plans with National/Regional Needs and Priorities

The Maputo POA outlines a specific role for international and national civil society organisations and other development partners. It states that such organisations *'will align their financial and technical assistance and cooperation plans with national and regional needs and priorities for implementation of the plan of action.'* This section explores the realities of carrying out this role.

Opportunities

Very early in the launch of the MPoA, country action plans were developed during civil society consultative meetings organised with the Regional Economic Communities (RECs), with the support of IPPFAR. The country action plans are varied in their strategic choices with regards to their alignments with the Maputo Plan of Action. Although in Botswana, Nigeria and Senegal, the CSOs interviewed are very active in implementing SRH strategies as integrated services or have core RH areas of competence and mandates, they did not directly reference their country action plans as guiding their programmes.

In the three focal countries, CSOs varied in their levels of awareness of the MPoA, with some stating that their work is guided by it or

inadvertently overlaps with it, while others had heard of the MPoA but were not familiar with its content. There were also others who were not aware of it, but nevertheless engaged with SRH issues as part of their work. Thus, when asked if MPoA inspires the SRH work they do, a CSO respondent in Senegal said, "The Maputo Plan is in line with the actions that were well underway before its advent," although she further added that "the Maputo plan is less known amongst local civil society."

With the exception of UN agencies and international NGOs with SRH mandates, local CSOs interviewed noted that they are able to carry out their SRH interventions because they have identified development partners for whom SRH issues are of interest. According to respondents, donor interest in SRH issues has also informed local CSO programming in SRH in Nigeria and Botswana.[1]

The vast amount of global resources geared towards HIV/AIDS has also created opportunities for aligning new resources toward SRH interventions for some CSOs

The vast amount of global resources geared towards HIV/AIDS has also created opportunities for aligning new resources toward SRH interventions for some CSOs. One local CSO in Nigeria described their strategy of using the stark reality of HIV/AIDS risks to bring legitimacy to their ASRH work. This strategy also permits them to tap into funding flows toward HIV/AIDS for the implementation of their ASRH initiatives.

In Nigeria, CSOs at a focus group discussion session highlighted their key role of delivering services in an environment of good comprehensive policies for SRH. Thus, seizing the opportunity under the auspices of the Planned Parenthood Federation of Nigeria (PPFN), a national coalition of CSOs launched in 2008 and composed of SRH stakeholders, has begun a process to track the budget for SRH at the federal level. Representatives of the coalition mentioned that they had found support from the government. They further plan to create mechanisms that will facilitate their participation in national budget processes. Additionally, CSO respondents explained that their coalition will support advocacy directed at "policy formulations to provide services and … articulate demand for services."

Constraints

CSO respondents argued that there is an absence of ownership of the MPoA at the highest political levels – a fact which impedes progress in regard to the implementation of the Maputo Plan. However, in Senegal a respondent in the Ministry of Family Affairs reported: "We have put in place a framework for monitoring and coordinating the Maputo Plan and we have already sent a first report to the Economic Commission for Africa." Yet, CSO respondents stated that none of the governments of Botswana, Nigeria or Senegal have developed specific national plans for the implementation of the MPoA, although they have developed policy documents on SRH issues along the lines of which CSOs and development partners can align their diverse resources. Furthermore, describing the funding priorities of his organisation, one development partner in Botswana noted that they align resources to those health issues that are identified in national plans, and in the absence of such plans, "donors prompt stakeholders to identify issues for support." On the other hand, an international Foundation in Nigeria said that it "doesn't wait for government to state what it would do," but rather, proceeds to fund its own identified priorities. This view was corroborated by reports from UN partner respondents in Botswana who noted that, rather than aligning behind national priorities, "development partners are

still coming up with their own agendas and therefore failing to support what government really wants to do... the UN should assist in this. … Programming in health has come on the basis of the interest of donors, not the country that is the recipient of those resources." Respondents further added that "HIV/AIDS and disease-based funds for stand alone issues" were also "culprits" in reflecting the interest of donors rather than aid recipient countries. Similar concerns continued to be voiced by another UN respondent in Botswana who worried that the integration of SRH as outlined in the MPoA is constrained by situations where donors pick and choose what to fund, leading countries to struggle with issues of focus, prioritising and financing SRH. Indeed, a CSO in Botswana said that there were certain types of key activities that they had identified but that found little financial support, as "not all donors fund advocacy work." Yet, advocacy is a key activity for building interest and support for SRH work. Another Botswana CSO further explained that "lobbying an MP requires resources that will support the sponsoring of Bills (research, crafting, etc), especially, private member bills that are at a huge cost to MPs. Evidence-based [lobbying and programming] requires resources."

African governments have a major role to play, however, in facilitating work around the MPoA. Nonetheless, the general impression of respondents was that governments were not prioritising SRH as much as they could. In Nigeria, for example, some CSO respondents noted: "The Federal government is not prioritising SRH … it was only in 2003/04 that there was ever a budget line item for RH, but it has since disappeared. There have been no federal government allocations since – not even for maternal health initiatives." An international CSO in Nigeria also raised some of the unique concerns that challenge their specific role of aligning resources to national needs, explaining that "getting State governors to co-invest in SRH initiatives can't get political support. Politicians fear backlash if they publicly support SRH; however, politicians will support our technical work – but will not speak about it."

African governments have a major role to play, however, in facilitating work around the MPoA

4.3 CSO and Development Partner Engagement with the Maputo POA: Successes in Contributing toward the Implementation of the Maputo POA

CSOs and development partners need an enabling institutional and policy environment to be able to implement activities supportive of SRH, and all three focal countries had developed policies and plans for SRH. Key informant interviews conducted in Botswana, Nigeria and Senegal with CSOs who have mandates for SRH issues revealed the numerous and diverse roles they had successfully undertaken. Indeed, CSOs are engaged in SRH work that extends beyond the MPoA priorities. This section provides an overview of the kind of SRH work CSOs are implementing within the focal countries.

Advocacy, Expansion of SRH rights and articulation of demands of diverse groups

- A CSO in Botswana whose strongest roles are on issues of health rights provides legal aid with regards to SRHR issues and has taken legal actions against government in the past on SRH issues. They reported several successful actions, for example:

  - ✓ Empirical work on HIV positive pregnant women revealed

the reluctance to provide services to these women. They used that research to advocate government, the National Aids Co-ordinating Agency (NACA) and health care providers to ensure provision of services for HIV positive pregnant women.

- ✓ Most recently, advocacy was carried out for the provision of pap smears to address cervical cancer concerns. At the time of data collection for the present study, ARV clinics began to provide such services.

- ✓ They have also taken up SRH interventions on behalf of sexual minorities who are not addressed by the MPoA, by (for example) providing space for this population and calling for change in government responses to facilitate access to prevention services for STIs and HIV/AIDS. As a result, the Ministry of Health has been willing to let the CSO engage with health care providers to provide prevention services to sexual minorities and will now articulate similar concerns to National AIDS Coordinating Agency. The same CSO has also highlighted the lack of support for SRHR for people living with HIV/AIDS.

CSOs take up interventions for groups often not reached for services for a variety of cultural, social or political reasons

- As previously demonstrated, CSOs take up interventions for groups often not reached for services for a variety of cultural, social or political reasons. In Nigeria, it was observed that CSOs are "working in difficult to reach areas and communities, for example, among the nomadic Fulani, and among Muslim clergy. We are working in areas where there were [previously] no systems, no basic clinics, and no access to health care facilities for delivery." In Senegal, a local CSO stated that their activities towards building community dialogue between beneficiaries and providers of RH services, and their development of religious guidelines on actions for RH has resulted in the greater involvement of women and religious groups and reinforced positive actions on RH issues.

- In Nigeria, a local CSO pointed to the advocacy of local CSOs as key to the increased resources of the national budget going to health in Nigeria, currently at 8% (although one CSO respondent observed that "it is the MDG (health) budget that accounts for much of the money pumped into the Federal Ministry of Health"). The same CSO also played other successful intervention roles:

  - ✓ Getting information on MPoA to government

  - ✓ Continued advocacy work around the MPoA to increase resources for maternal health and capacity building for PHC to deliver maternal health services. The CSO argued that free ante-natal care (ANC) services in Nigeria were introduced widely after advocacy in six states saw successful uptake. However, another respondent sees this as a very limited response by States, for there has been no integration of family planning into this free service – a possible missed opportunity.

Strengthening of SRHR Services

- Local CSOs in a focus group discussion in Nigeria also shared

other important successful interventions they have been carrying out, including the following:

- ✓ Recruiting 1 or 2 health workers every month as volunteers to attend to people's health issues in their homes as well as mobilise them to seek health services at health facilities. Services they provide include ANC; re-instituting female school drop-outs back to schools; the establishment of parent-child communication on RH; the establishment of guidance and counselling in 18 schools in Delta State; and the establishment of peer educators' HIV clubs. Pre- and post-test analyses show the impact of their intervention and have led to the extension of the programme to Nassarawa State in April 2009.

- ✓ Training TBAs so that they are able to attend to emergencies, especially if the health worker does not turn up at health facilities; mobilising the *OKADA* (motorcyclists) Union to get pregnant women to health facilities whenever required.

- ✓ Formation of RH clubs in 3 schools; distribution of millions of pamphlets titled '1001 ways of having sex without doing it.'

- ✓ The right to knowledge about sexual rights for young people (10-24) is an opportunity that has been presented in schools.

- A Nigeria CSO that was established primarily to reach youth for SRH services also shared some successes it has been having:

  - ✓ Creation of opportunity for youth friendly services: started such services in 1994 and by 2000-01 they had facilitated the establishment of such services in 6 States where HIV prevalence was high. They now have a total of 774 model youth friendly service centres at local level in Nigeria, the result of demand created by the Federal government initiatives of providing youth friendly information on RH services.

  - ✓ "Family Life HIV Education" is their biggest project in terms of coverage. They are in 326 schools in Lagos State, most of them in southern Nigerian States, and are currently carrying out an evaluation.

- In its youth centres, a CSO in Botswana is providing integrated services as well as outreach services to institutions that cater for people with various physical disabilities, PLWAs support groups and community mobile clinics. They also provide outreach counselling and services to commercial sex workers.

- In Nigeria, the monitoring of health facilities by a local CSO using cell phones purchased for community based volunteers has been helping to monitor the health centres within their locality so that they can call service providers whenever anything is amiss. Through advocacy, the same CSO was able to get 6 states to commit to free ANC services in 2004 and almost all states, especially in northern Nigeria, have joined thereafter.

The right to knowledge about sexual rights for young people (10-24) is an opportunity that has been presented in schools

- A Nigerian CSO set up to extend continental wide dialogue on sexuality notes that their interventions have helped develop capacity and leadership as they have trained over 70 young professionals to expand work on sexuality and rights across Africa.

- A CSO in Senegal notes that it is their efforts at promoting the professionalism of midwives that has supported the repositioning of family planning by promoting family planning and community dialogue supportive of the latter, and by safeguarding the rights of users of family planning. The same CSO has also now expanded its efforts and established a presence in television with regular programming on SRH matters.

Education, Awareness, Training and Curriculum Development for SRHR

There have been several initiatives directed at education on and awareness of SRH issues.

The creation of curricula and training tools has been targeted at diverse types of groups

- The creation of curricula and training tools has been targeted at diverse types of groups. Diop and Diagne's, (2007) research highlights several examples from Senegal; in regard to curricula for adolescent reproductive health, the Utilization of the Findings from the Youth Reproductive Health Project (2004-07) yielded a curriculum entitled "Grandir en Harmonie" which has been utilised with a variety of groups, such as pre-service training of sports teachers and sports inspectors and peer educators in the Ministry of Youth. A curriculum called "le Devenir Accompagne" has been implemented for school teachers. In 2007, both curricula were used for a national training of trainers for health providers. Family Life Education Modules have been introduced in Koranic schools.

- In Botswana, there is a project called "Ringing the Bell" in selected primary schools which is geared toward teaching SRH/HIV/AIDS from a very young age, recognizing that by junior school, some young people may have become sexually active. The training project is run by a CSO with the Ministries of Health and Education partly funding it.

- In Nigeria, a CSO respondent said that they are providing training to teachers using the Family Life HIV Education Curriculum that they have developed and which the government now utilises in schools and teacher training. To date, they had trained pre-service teachers and created 20 master trainers on Family Life and emerging health issues. There were also curriculum actions emerging from government. A Ministry of Health respondent in Nigeria stated that there was government provision of Expanded Life Saving Skills training and Emergency Obstetric Care training for doctors and Modified Life Saving Skills training for service providers at local levels, adding that, in collaboration with WHO, the Ministry put in place an intervention by training National Youth Service Corp (NYSC) doctors on emergency obstetric care. Similar work is underway by CSOs. A CSO respondent in Nigeria explained that their organisation had moved to pre-service training and had developed a National Curriculum on SRH with emphasis on post-abortion care for community health providers.

Empirical work and provision of expertise
A CSO in Botswana has developed and used research on adolescent reproductive health issues, and this work helped inform the programming of the Africa Youth Alliance (AYA) project for the co-ordination and provision of youth friendly SRH services. This CSO has also used the same empirical evidence to lobby and advocate for review of legislative policies in support of adolescent reproductive health.

4.4 The Challenges Faced by CSOs in Implementing SRH Programmes

Several challenges emerged in respondents' discussions about engaging with the Maputo Plan of Action in their work. These challenges were connected to the lack of human and financial resources, weak monitoring and evaluation systems, and socio-cultural barriers to the realisation of sexual and reproductive health and rights. This section elaborates further on these issues.

Human Resources
All CSO respondents bewailed shortages in human resource capacity and inadequate or un-certain funding as constraining their ability to have adequate staff to deliver services. They also noted this predicament as posing a threat to their continued existence.

- ✓ According to a CSO respondent in Nigeria, "Health workers do not turn up for work, especially in remote areas. Such attitudes affect the success of programmes." Other types of staffing problems that confront this sector were evident in Botswana where respondents remarked that "trained personnel are leaving for developed countries." As a UN respondent stated, "Service providers are simply overwhelmed."

- ✓ Human resources are also seen as very limited and overstretched, challenged by the fact that donor funding does not necessarily support administrative costs.

- ✓ CSOs in Botswana mentioned that they often lose service providers to the government because the government pays better, or because CSOs do not have the resources to pay adequately. For example, a CSO in Botswana that depends on nurses from government hospitals went without the services of skilled nursed for 4 months in 2008. In their words, "Our requests for government to post nurses to their service points is yet to be fully met; yet, government can place them, but on government payroll".

Human resources are also seen as very limited and overstretched

Financial Resources
On the whole, CSOs in all three study sites were heavily dependent on donor funding to successfully deliver on their mandates for SRH. Thus, according to respondents, CSOs are often hindered by resource constraints.

- ✓ In Botswana, only two CSOs received part of their regular financial resources from the government and efforts are underway, led by the CSO umbrella body, to develop a CSO policy that would call for financial support to all CSOs from the government. Botswana as a "middle income" country is beginning to experience a decline of resources from donors (except in regard to HIV/AIDS); thus, CSOs

will increasingly need access to domestic funding. Most CSOs have been steadily losing funding from development agencies. It is thus difficult to sustain several of their initiatives, and most CSOs operate with volunteers.

- ✓ Governments generally did not fund CSOs however there were exceptions as noted in Botswana and in Nigeria one CSO said that it received contracts with the Ministry of Education.

- ✓ All CSOs acknowledge that HIV/AIDS has diverted resources away from SRH. CSO respondents in Nigeria argued that this is a reflection the failure to grasp that HIV/AIDS is a component of SRH and that it will only be successfully addressed when integrated into SRH plans of action. Resources for SRH, and therefore CSO work in this area, are being seriously affected by the shift of health resources to HIV/AIDS.

In all three focal countries, organisations may have developed monitoring tools, but they had not begun to implement monitoring and evaluation processes

Monitoring and Evaluation

To increase their effectiveness and establish the legitimacy of their work, CSOs need M&E tools and processes.

- ✓ In all three focal countries, organisations may have developed monitoring tools, but they had not begun to implement monitoring and evaluation processes. This was an area noted as lacking resources in terms of both funding and capacity thereby, creating weak monitoring systems. The exception was the case of one CSO in Nigeria which is addressing ASRH and which reported having consistently carried out both monitoring and evaluation of all their programmes.

Social and Cultural issues

- ✓ Cultural barriers are seen by CSOs in both Nigeria and Senegal as the greatest challenge faced with regards SRHR, and is reason for the specific interventions currently underway, including targeting religious leaders and women in both Nigeria and Senegal.

4.5 CSO Engagement with the Government to Operationalise the Maputo POA

African governments are expected to bring civil society organizations (and/or the private sector) on board to participate in national programs that are geared toward achieving the goals of the MPoA. This section describes the ways in which governments and CSOs are engaging with one another in order to operationalise the MPoA in the focal countries.

Successful engagement with government

- Access to set agendas, policy and actions for SRH

- ✓ In Botswana and Nigeria, CSOs working in SRH provided several examples of their engagement with government, including being invited to government planning meetings, sitting on government technical committees of health, being recognised by government for their competencies and expertise and, thus, called upon for consultations on SRH issues with government. In Senegal, it was noted by Ministry of

Health respondents that civil society and the private sector are members of a national committee for the fight against maternal mortality, while a respondent in the Ministry of Family commended CSOs, noting that "civil society is a key player because it has high level experts, provides another view of things we may not be aware of at the Ministry level, and its contact with people allows it to better understand their needs."

- ✓ CSOs have always been very involved in health issues. They are an important vehicle for the transfer of services to communities. Thus, all CSOs said that their governments recognise their efforts in the field of SRH and, indeed, in Senegal, a respondent from the Ministry of Health acknowledged that "The debate on family planning was initially raised by civil society before government took charge of the matter. It is therefore important that the Ministry of Health associates with civil society in its actions." Furthermore, in Senegal, forums organised by CSOs are often attended by government representatives. Some CSOs illuminated how government has called upon them or collaborated with them to develop resources and materials for SRH. As a CSO respondent in Nigeria noted, "Our sexuality education curriculum for young people was in response to a policy request (from government)." In Senegal, a CSO working on the promotion of the profession of midwifery remarked that as a result of their interventions, revisions have been made to the national training curricula for midwives and to the standards and protocols relating to RH care.

Most CSOs acknowledge that the work they do requires the infrastructure of government in order to be accomplished

- Most CSOs acknowledge that the work they do requires the infrastructure of government in order to be accomplished. The infrastructure in question was described primarily as structures or mechanisms such as staff, clinics, commodities and regulations.

  - ✓ Ministries of Health in Botswana, Nigeria and Senegal said they recognise that CSOs were reaching populations not reached by government (such as religious communities, out of school youth, nomadic and remote communities) to expand access to SRHR, and that CSOs were spearheading actions not usually undertaken by government, such as community dialogue and empowering women in their communities.

  - ✓ In Senegal, a CSO respondent pointed out that their work has been greatly aided by the fact that the government has developed policy and guidelines on SRH that supports their efforts, and by the personal involvement government officials in SRH issues. For example, the Head of State's call for "a godmother in every neighbourhood to promote prenatal care" and interventions organised by the First Ladies of West Africa as outlined in their Vision 2010[2] goals for RH, have helped to create a supportive environment for engagement with SRH issues in Senegal.

  - ✓ Some CSOs carrying out SRH work in Botswana were also receiving funding from the government, while a recent SRH teaching project in select primary schools run by a

local CSO was partly funded by Botswana's Ministries of Health and Education. In Nigeria, the government does not traditionally fund CSOs, although one CSO respondent in Nigeria remarked that their contracts with the government were a source of funds.

- ✓ In Nigeria, the Ministry of Health has established a reproductive health working group for networking, advocacy and identifying best practices, and a CSO respondent mentioned that their organisation was a member of this group.

- ✓ Although a CSO in Nigeria points out that it is hard to claim success as a result of ones' advocacy, they nevertheless indicated that in the past, when the government had shown great reluctance to support pregnant, HIV positive women, it was CSO advocacy efforts that led the government to put out advertisements encouraging HIV positive women to visit their service providers for advice and services.

All sites considered the lack of political will in their contexts as a reason for the failure to fully operationalise the MPoA

- ✓ Although some CSOs in Botswana were of the opinion that "government is reluctant to support human rights – it closed down when it comes to issues of rights and quality of services," there were some clear examples of successful advocacy efforts in Botswana. For instance, as a result of one CSO's interventions, the Ministry of Health has been willing to let the CSO engage health care providers in discussions about providing services to sexual minorities, and to engage with decision makers such as the NACA on access issues.

- ✓ In Nigeria, a CSO was able to work in schools because of the government's support for a project in selected primary schools geared toward teaching SRH/HIV/AIDS from a very young age. The project is run by a CSO, and the Ministries of Health and Education partly fund it.

Challenges in engagement with government

- Political Will

  All sites considered the lack of political will in their contexts as a reason for the failure to fully operationalise the MPoA.

  - ✓ All the focal countries acknowledge that SRH efforts are not commensurate with the demands of their respective populations. A respondent from an international Foundation in Nigeria argued that at state level, "SRH initiatives can't get political support. Politicians fear backlash … however, politicians will support our technical work, but will not speak about it." In Senegal, a CSO respondent noted that "One of the biggest challenges is to get the involvement and contribution of local authorities." Although a respondent in the Ministry of Health in Senegal acknowledged the challenges presented by the differences in approaches between government and CSOs, he nevertheless perceived the differences as providing opportunities for "mutual enrichment."

- Resources

  Governments are indeed recognising the key role played by CSOs in the delivery of services in the health sector, yet

governments have generally resisted funding or adequately providing for CSOs, even in those countries where such resources could be availed – for example, in Botswana and Nigeria.

4.6. Lessons Learned

CSOs and development partners shared a number of lessons that they had learned over the years in regard to working in the SRHR domain. These lessons are summarised here and categorised according to the themes that emerged on this subject, namely, advocacy; resources; socio-cultural issues; monitoring and evaluation; SRHR in the context of national development; and partnerships.

Advocacy

- Parliamentarians should be a target of SRH advocacy as
- Evidence-based advocacy (as opposed to adversarial approaches) can be more effective in reaching government.
- For various reasons (including financial constraints), advocacy strategies often involve targeting a sole level of a particular target group. However, for maximum impact, efforts are needed to ensure all levels of a target group are reached with advocacy messages.
- Cross-country collaboration around advocacy could potentially strengthen responses to common SRH issues in Africa, and might be more effective than national advocacy alone.

Resources

- Donors cannot take the place of African governments. The role of donors in financing SRH work is necessarily a limited one. For there to be a lasting difference, African governments must play a major role in financing the initiatives that will positively affect SRH in their nations.

Donors cannot take the place of African governments

Socio-cultural issues

- Many negative SRH outcomes stem from socio-cultural barriers to better health. In the quest to achieve universal access to SRH services therefore, socio-cultural issues should be continually investigated and addressed.

Monitoring and evaluation

- Monitoring and evaluation systems are often either weak or non-existent. Such systems typically involve the collection of quantitative data, but should also incorporate qualitative data in order to provide insight into the reasons behind emerging issues. Proper M&E can also help generate data to facilitate evidence-based approaches to advocacy.

SRHR in the context of national development

- More efforts are needed in the area of social mobilisation. Because policies and reformed laws are poorly-understood and not widely-disseminated to the public, individuals and communities are often not empowered with SRH-related knowledge that would help them realise their rights.

- Without strong ownership of national/international development plans, the priorities of African countries are perpetually at risk of acquiescing to donor agendas, which may not always align with national priorities.

- A multi-sectoral approach is required to holistically address

SRH issues. Engaging with Commissions/Ministries of Finance and Planning, for instance, on SRH issues is necessary for advancing work around health in general and SRH in particular.

Partnerships

- Partnerships and collaborations are critical, enabling organisations to pool their resources, build synergy and capacity, and jointly achieve SRH goals.

Endnotes

1 No respondents from donor organisations were interviewed in Senegal.
2 We are unable to obtain a copy or have access to this document.

Chapter 5

The Status of Implementation of the MPoA by Regional and Sub-regional Bodies

5.1 Introduction

The Maputo Plan of Action defines specific roles for the African Union and Regional Economic Communities. According to the Plan, 'the African Union will, among other things, play [an] advocacy role, resource mobilisation, monitoring and evaluation, dissemination of best practices and harmonisation of policies and strategies', while 'the 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' (African Union Commission, 2006: paragraphs 26 and 27, 20).

The realisation of the outputs of the Maputo Plan of Action requires that regional and sub-regional bodies focus and agree on their role and involvement in the implementation of the Plan of Action

The realisation of the outputs of the Maputo Plan of Action requires that regional and sub-regional bodies focus and agree on their role and involvement in the implementation of the Plan of Action. In order to make SRHR available and accessible to people in the African Region by 2015 – the deadline universally set as the year by which the Millennium Development Goals (MDGs) are to be attained – SRHR must be a priority in the policies and budgetary allocations of the African Union and the African Regional Economic Communities (RECs).

Universal access to SRHR is the rallying call for all stakeholders and the Maputo Plan of Action evinces a strategy to ensure that stakeholders play appropriate roles to move toward the goal of universal access. In regard to the roles regional and sub-regional bodies, the African Union (AU) is to undertake advocacy and resource mobilisation at the continental level in support of the implementation of the Maputo Plan. Further, the AU has the role of assisting the RECs and Member States in developing their own costed implementation plans and monitoring frameworks. Regional Economic Communities in turn are to develop their own SRHR costed implementation plans, provide technical support to member countries, advocate for increased resources for SRHR, monitor progress and identify and share best practices.

In line with the Paris Declaration, bi-lateral, multi-lateral and international organisations committed to align their cooperation plans and financial and technical assistance with national as well as regional level health priorities.

In reviewing the status of the implementation of the MPoA at regional and sub-regional levels, this chapter looks at the crucial roles and steps that have been undertaken by relevant institutions to help facilitate the progress on SRHR and goes further to highlight some

of the challenges to achieving this goal. The chapter draws on interviews with representatives from the East African Community, the Southern Africa Development Community, the Economic Community of West African States, and the European Commission. Despite concerted efforts to establish contact with other critical interviewees, such as representatives from the African Union, interviews were not conducted with this organisation. In summary, three major themes emerged from interviews with informants in regard to the implementation of the MPoA among key decision-makers, namely, the lack of commitment, ownership, and financing around the Plan.

5.2. East African Community (EAC)

According to an EAC respondent, the Maputo Plan of Action did not enjoy initial popularity in the East African region. Indeed, the EAC Council of Ministers delayed the signing of the EAC Regional Strategic Plan on Sexual and Reproductive Health and Rights 2008-2013 for six months, due to the concern that the terms "sexual" and "rights" in this document might be geared toward the promotion of homosexuality. Nonetheless, in 2008, the EAC, in collaboration with IPPF-Africa Region, held a meeting to formulate strategies for the implementation of regional health plans that aligned with the MPoA. As a result, country delegations prepared implementation plans. With these plans, the EAC respondent noted that SRH issues would become prioritised. As evidence of this, there is currently a technical working group on RH, ASRH and child health; however, the EAC strategic plan on SRH still remains to be operationalised – a process which requires funding and staff, both of which are currently at very inadequate levels.

The East African Legislative Assembly has committed to making funds available for SRH and has played an advocacy role for increased resources for SRH

Other challenges raised by the respondent suggested a lack of ownership for the MPoA. Noting that the Plan was spearheaded by UNFPA, the respondent observed that there has been a lack of adequate support from the AU itself for the MPoA, as well as an absence of advocacy for the MPoA by the AU, which also lacks adequate RH staffing. Inadequate staffing and financing are also seen by the EAC as limiting its ability to identify and support the specific SRH priorities of its member countries.

The key role of the EAC in the MPoA process was summarised by the EAC respondent as being "to cascade the MPoA into and through EAC systems and structures." To this end, as a first step, the EAC developed its own SRHR strategic plan. The respondent however pointed out that he was the only health staff member at the EAC and that there was as yet no recruitment of RH staff. Other roles that the EAC seeks to undertake include the provision of support to EAC parliamentary committees on reproductive health and Ministers of Health.

There is, however, some emerging support for SRH actions in the EAC. The East African Legislative Assembly has committed to making funds available for SRH and has played an advocacy role for increased resources for SRH. The German Foundation for World Population (DSW) signed an MOU in August 2008 with EAC to support the implementation of the MPoA, among other health and population related activities. IPPF will also fund one EAC staff member and negotiations are underway with UNFPA to support further staff recruitment. The respondent called for the AU and UNFPA to take a stronger lead with the MPoA in bringing together relevant partners such as IPPF with the RECs, and in monitoring countries' progress.

5.3. Southern Africa Development Community

The first conference of Health Ministers that adopted the "Continental Policy Framework on Sexual and Reproductive Health and Rights" was held in Gaborone, which is also the regional headquarters of the Southern Africa Development Community (SADC). Thus, according to the SADC respondent in this study, this Regional Economic Community was well-placed from the onset to participate in the ministerial conference and most of their submissions at this conference were accepted in the final plan of action.

The respondent stated that SADC is "convinced that what countries are doing is a hundred percent in line with the MPoA" and that SADC has also developed a supportive regional strategic plan of action for SRHR. With the development of the SADC SRHR strategy, a committee with representation from the 15 member States of SADC was established to receive country reports on the implementation of the MPoA and in turn report once a year to the Ministers of Health. To date, however, this committee has mainly monitored countries' progress on allocating 15% of their budgets to health.

A number of countries in the region have revised their national plans to include SRH and launched 'Roadmaps' to achieve the MDG targets. However, similar to the EAC, SADC has not been able to monitor the implementation of SRH activities given serious financial and human resource constraints. Currently, there is only one person holding responsibility for SRH at SADC.

A number of countries in the region have revised their national plans to include SRH and launched 'Roadmaps' to achieve the MDG targets

As a regional body, SADC is mandated to provide technical support to its Member States, but this role has been difficult to carry out given the institution's lack of capacity. The SADC respondent however pointed out that at country level, IPPF is present to assist countries, leaving SADC to focus on regional level issues such as bringing countries together to share experiences in areas of SRH and identifying lessons from best practices. To facilitate this process, SADC plans to develop a tool for collecting best practices.

Some members of SADC are also members of EAC; thus, these two regional bodies have been working together to learn from each other, share information and determine areas for possible collaboration. SADC partnerships with international organisations that support SRH were noted as being underdeveloped, however. For example, the respondent observed that SADC "doesn't have close collaborations with IPPF," which was seen as posing a challenging to carrying out SRH activities. SADC however intends to seek to develop partnerships to leverage resources for SRH.

The SADC respondent pointed out that MMR has remained a persistent challenge in the region arising from the failure to address SRH issues as development issues and in an integrated manner. Furthermore, the growth of global funds such as those for HIV/AIDS has not facilitated integrative opportunities, and the current global financial crisis means there is no assured continuity of even these types of resources.

Even though SADC countries had seen an overall increase in the cadre of health workers, the respondent nevertheless voiced the concern that the absence of adequate capacity given migrations out of the region and a failure to retain and train staff are critical factors compounding SRH concerns in the SADC region and need to be urgently addressed.

5.4 Economic Community of West African States (ECOWAS)

The West African Health Organisation (WAHO), an agency of ECOWAS with the mandate for health, has had the role of providing technical support to its member states, including training in support of reproductive health. According to the respondent from WAHO, the organisation also has the role of "organising for the implementation of the MPoA and monitoring its progress." To date, the activities outlined as having been carried out by WAHO include training workshops for public sector health workers, managers of reproductive health activities, and CSOs working in collaboration with IPPF. These training workshops led to the establishment of a steering committee at WAHO, composed of permanent representatives of member states and CSOs that will bring a special focus on moving forward issues concerning maternal mortality and the repositioning of family planning. WAHO has also assumed responsibility for setting up a secretariat for Vision 2010 (of the First Ladies of West Africa) to address maternal health. Concurrently, there is a policy initiative underway to harmonise under a regional work plan and strategy the activities of diverse reproductive health organisations and member states. The respondent however acknowledged that WAHO is "not concentrating on reproductive health issues because there are other demands like malaria, AIDS, and strengthening health information systems. … In Africa, everything is a priority for us – even apart from the health sector, everything is a priority. … Our leaders always say that the health sector has many partners. I think for me, this is one of the weaknesses we have to address. Convince the leaders that the health sector is one of the priority areas." Thus, an important focus for WAHO, which the respondent argued would be supportive of the MPoA, is for WAHO to make contributions towards strengthening the capacity of overall health systems to gather monitoring data and coordinating this information for member states.

The West African Health Organisation (WAHO), an agency of ECOWAS with the mandate for health, has had the role of providing technical support to its member states

Key constraints faced by WAHO were highlighted by the respondent as emanating from the different levels of commitment among member states, and the challenges in coordinating the activities of the diverse players involved in health activities. Other limitations include low resource contributions being made by governments to the health sector in general because it is not a priority development area, and weak health information systems. The respondent further noted that member states are faced with numerous initiatives that address reproductive health besides the MPoA: "Everyday, there is a new initiative. … The level of implementation in each country is different because we have at the same time the Millennium Development Goals projects. We have so many initiatives the country should look at." Consequently, the Maputo Plan is more often than not simply "part of the general actions the country has to take to address its reproductive health problems."

5.5 The European Union and European Commission

Recognising the need to enhance the financial and capacity resources for implementing the MPoA, this AU document also highlights the supportive role of international partners. For example, the European Union (EU), through its cooperation agreements with African countries, and international organisations have been important stakeholders in strengthening services and accessibility for SRH, guided by regulations

"on aid for policy and actions on reproductive and sexual health and rights in developing countries" (European Commission, 2003:9) that is informed by the ICPD and MDGs and the Monterrey Conference for increasing development assistance for the benefit of health. The European Commission (EC) has also followed this path and is guided by its development policy framework, *The European Consensus on Development*, having the goal to achieve universal access to reproductive health by 2015 through "budget or sector support combined with policy dialogue at global and country level."

An AU-EU partnership on the MPoA provided for financial support to the SRH Conferences of the Ministers of Health in Gaborone and Maputo, and the resulting Maputo Plan of Action is noted by the EC respondent as being "very comprehensive [and] a good monitoring framework." Subsequently, there has been a funding line from the EU for the AU to develop its own capacity on several of its mandates, with SRH included. However, the EC respondent explained that there have been several stumbling blocks; for example, the ability to develop the action plan for building capacity is hampered by the inadequate number of personnel (who are on contract, rather than being permanent staff) in the health sector within the AU: "In a way, it could have been their job to monitor the MPoA; they could have used their EC funding for that, but it's not happening." Reminiscent of the interview with WAHO, the EC respondent also indicated that at the AU level, the focus has been on maternal, newborn and child health and "it is not touching on a number of issues such as access to family planning issues, unsafe abortion which are all part of the MPoA."

EC support for SRH received very few resources, except in regard to HIV/AIDS programmes

Further, given that SRH is often not a priority focal sector for several AU member countries, EC support for SRH received very few resources, except in regard to HIV/AIDS programmes. As the EC respondent said of her programming goals, "I have put the MPoA as a deliverable…but [the EC] does not have any implementation mandate in-country. We can all say that [the MPoA] is very good and important, but if African countries don't decide to put money in their budgets for implementing the MPoA, it is not going to happen. In the end, it all comes down to whether African countries prioritise it or not." The same respondent argued that since SRH was not high on the health agendas of African states, it was therefore not always part of the EC country strategy paper. The EC interviewee was therefore convinced that the main obstacle was not one of funding, but rather, a cultural issue as well as an issue of interest and commitment to SRH. This notwithstanding, the respondent reaffirmed the EC's commitment to advocating for SRH issues.

As mentioned previously in this report, a major limitation of this study is that interviewing any AU representatives proved impossible; therefore the views of the AU on many of these issues are not available. It is plausible, for instance, that the incentives from the EC (in regard to the implementation of the MPoA) could be stronger than they are currently. Furthermore, EC funding for SRHR is comparatively less than its funding for other areas, and funding for SRHR to the European Development Fund countries is limited (Wuyts, 2009 - personal communication).

Like the EAC, the EC sees a role for organisations such as IPPF and UNFPA in negotiating with their partner countries to have budget lines on SRH issues and, in this vein, highlighted the UNFPA campaign

on "The Roadmap" (examples on this from Nigeria and Senegal have been previously mentioned in this report) as a good implementation tool for MPoA. NEPAD's (the New Partnership for Africa's Development) peer-review mechanism concept was also noted as having the potential to stir countries toward action.

Chapter 6

Conclusion and Way forward

In order to make good progress on international and regional commitments to improve sexual and reproductive health outcomes, African governments need to ensure that agreed actions are translated into national legislation and programmes. There is already a favourable policy environment for SRH and the study found that governments are eager to reduce MMR and make reproductive health services more available. However, population, fertility and HDI indicators remain low for all nine countries in the study, suggesting that sexual and reproductive health needs remain insufficiently addressed for these countries. Furthermore, elements of SRH such as maternal and child health care, and now increasingly, adolescent sexual and reproductive health, are receiving heightened attention, while issues such as post-abortion care still remain outside the scope of most primary health care services. Additionally, HIV/AIDS has been a top priority for many countries in the region with diversion of resources to the pandemic in contexts where there is a general lack of understanding that HIV/AIDS should be a critical part of successful SRH strategies.

None of the governments represented in this review have specifically developed a national action plan for the MPoA

None of the governments represented in this review have specifically developed a national action plan for the MPoA, and indeed the MPoA does not require those that already have strategies to start afresh, but encourages a review of existing national plans against the Maputo Plan of Action to identify any gaps. However, even though comprehensive policies on SRH exist and strategies for implementation have been developed, operationalising for implementation has been very slow for a variety of reasons including inadequate financial and human resources, the lack of political will on the part of some governments, and the lack of organisation within government structures, which prevents the efficient use of financial resources when they are made available. In addition, core areas of SRH were often found fragmented across departments in the 3 focal study countries (Botswana, Nigeria and Senegal); thus, it is not always clear where the responsibility for the implementation of SRHR as a national programme lies.

If African countries are to meet the scale of demand for knowledge, skills, information and services needed to achieve universal access to SRHR by 2015, there is an urgent need for greater and more targeted investment in SRHR. However, it is evident that the problem of resources for health in general and SRH in particular is not always due to financial shortage. Countries might instead be burdened with institutional constraints such as staffing attitudes to SRH, inadequate capacity with regard all core SRH issues and, in some cases, challenges in spending money allocated to health due to the lack of an organised framework for such spending.

In addition to the advocacy action points provided in this document, this study also recommends:

- Dedicated, increased and sustainable financial resources to support all the core areas of SRH.

- Strengthening of service delivery infrastructures and service providers' capacity to provide necessary SRH care through training.
- Expanding existing programmes to under-served communities and populations.
- Working in a holistic way for SRHR through coordinated multi-sectoral approaches, and making a strong call for countries to imbibe a comprehensive approach to SRHR.
- The creation of public awareness of, and education in regard to, SRH policies and reformed laws so that individuals and communities are aware of services what is available for their use.
- Targeting parliamentarians to identify how national obligations to support SRH can be advanced since they appropriate funds.
- Developing M/E systems and accountability mechanisms to monitor progress and help ensure that SRHR services are effectively and consistently implemented, and that financial resources for SRHR are effectively utilised.
- Focusing advocacy efforts not only at central level, but a decentralized level as well.

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Appendix 1

Glossary of Terms

Civil Society
Civil society refers to the arena of un-coerced collective action around shared interest group interests, purposes and values. In theory, its institutional forms are distinct from those of the Sovereign state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organizations such as registered charities, development non-governmental organizations, community groups, women's organizations, faith-based organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions and advocacy groups.
(Source http://www.lse.ac.uk/collections/CCS/what_is_civil_society.htm)

Gross national income (GNI)
GNI per capita (formerly GNP per capita) is the gross national income, converted to US dollars using the World Bank Atlas method, divided by the midyear population. (Source: World Bank, World Development Indicators database, Washington DC, World Bank, 2006)

Human development index (HDI)
This is a summary measure of countries' achievement in long and healthy life (life expectancy at birth – LEAB), knowledge (adult literacy plus primary, secondary and tertiary gross enrolment) and decent standard of living (GDP per capital in purchasing power parity). The levels of GDP basically reflect the level of human development in the countries.

Life expectancy at birth (male)
The average number of years that a male newborn could expect to live if, during the course of life, he were exposed to the sex- and age-specific death rates prevailing at the time of his birth for a specific year, in a given country or other specified area. (Source: World Health Organisation, The World Health Report 2006: Working Together for Health, Geneva, World Health Organisation, 2006).

Life expectancy at birth (female)
The average number of years that a female newborn could expect to live if, during the course of life, she were exposed to the sex- and age-specific death rates prevailing at the time of her birth for a specific year, in a given country or other specified area. (Source: World Health Organisation, The World Health Report 2006: Working Together for Health, Geneva, World Health Organisation, 2006).

Literacy
The proportion of the female/male population aged 15 years and older that is literate, expressed as a percentage of the corresponding population in a given country or other specified area at a specific

point in time, usually mid-year. For statistical purposes, a person is literate if he can read, write and understand a short, simple statement about his life.

Maternal mortality ratio
The quotient between the number of maternal deaths in a given year and the number of live births reported in the same year, expressed per 100,000 live births, for a given country or other specified area. Maternal death is defined as the death of a woman while pregnant or within 42 days after termination of that pregnancy, regardless of the length and site of the pregnancy, due to any cause related to or aggravated by the pregnancy itself or its care, but not due to accidental or incidental causes.

Percent using family planning (modern methods)
The percent of married (or currently in union) women of reproductive age (15-49) who currently use modern contraception.

Total fertility rate
The expected average number of children that would be born to a woman in her lifetime, if during the course of her childbearing years, she were to experience the age-specific fertility rates prevailing in a given year or period, for a given country or other specified area. (Source: United Nations, World Population Prospects: Te 2004 Revision, New York, Department of Economic and Social Affairs, Population Division, United Nations, 2005)

Unmet need for contraception
This generally refers to fecund women and men who desire to limit or space their births but are not using any contraception.

Appendix 2

List of IPPFAR-Membership Associations participating in the Study

Association Rwandaise pour le bien être Familial (ARBEF). B.P 1580 Kigali, Rwanda Tel: +250 576127; Fax: +250 572828 Email: Arbef @rwanda1.com

Association Sénégalaise pour le Bien-Etre Familial. No. 5 Route du Front de Terre, BP 6084, DAKAR. Tel. 824 2561/62 Fax: 002218245272 asbefdk@sentoo.sn

Botswana Family Welfare Association (BOFWA) Private Bag 00100, Gaborone, Botswana. Tel: +267 3900489 Fax: +267 3901222 bofwa@info.bwwww.fgae.org

Burkina Faso, Association Burkinabe pour le Bien-Etre Familial (ABBEF), BP 535, OUAGADOUGOU, Tél. : (226) 50 30 75 10/ 50 31 05 98, Fax : 22650317511, abbef@fasonet.bf

Cameroon National Association for Family Welfare, BP 11994, YAOUNDE, Tel. /Fax: (237) 223 62 30. Fax: 237 2236230 camnafaw@ippf.org camnafaw@yahoo.fr

Family Guidance Association of Ethiopia (FGAE), P O Box 5716, Addis Ababa, Ethiopia Tel: +251 115 51 411; Fax: +251 115 51 2192. fgaeed@ethionet.org www.fgae.org

Family Planning Association of Uganda (FPAU). P.O. Box 10746, Kampala, Uganda Telephone: +256 -414-540665/58 fpau@fpau.org www.fpau.org & fpau.or.ug

Planned Parenthood Association of Ghana (PPAG). P.O. Box 5756 Accra – North Ghana, Tel: +233 - 21- 310369 Fax: +233 – 21 – 304567 ppag@africaonline.com.gh www.ppag-gh.org

Planned Parenthood Federation of Nigeria (PPFN), 4 Baltic Crescent, MAITAMA, ABUJA, Nigeria. Tel: +234 (9) 7809438, +234 8033048146, ppfn@ippf.org; www.ppfn.org

Appendix 3:
Checklist of Selected Indicators for the Maputo Plan of Action: Countries Summary

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
Socio-economic Indicators											
		Gross Domestic Product (GDP) per capita(PPPUS$)	1,128	2,480	1,213	1,792	2,299	1,454	1,206	1,055	12,387
		GDP growth	0.8	2.0	1.3	1.2	0.6	3.2	0.1	1.5	4.8
		Foreign Direct Investment (FDI) Net	2.0	1.0	0.4	0.7	0.1	2.9	0.4	2.4	2.7
		Total debt service (% of GDP)	9.0	2.7	0.9	2.3	4.7	2.0	1.1	0.8	0.5
		% population living below $2 per day	92	79	72	56	51	-	88	78	56
		Human Development Index (HDI)	0.470	0.553	0.370	0.499	0.532	0.505	0.452	0.406	0.654
		Relative HDI rank	158	135	176	156	144	154	161	169	124
		Gender related development index	0.456	0.549	0.364	0.492	0.524	0.501	0.450	0.393	0.639
		Population (mid 2008) million	148.1	23.9	12.7	15.2	18.5	29.2	9.6	79.1	1.8
		Total fertility rate (TFR)	5.9	4.3	5.3	6.2	4.7	6.7	6.0	5.3	2.9
		Life expectancy at birth (LEAB) – total (years)	47	58	62	51	52	48	47	49	49
		LEAB – Male (years)	46	57	60	49	51	47	47	48	50
		LEAB – Female (years)	47	59	64	52	52	48	48	51	49
		Adult literacy rate (%)	69.1	57.9	39.3	23.6	67.9	66.8	64.9	35.9	81.2
		Net primary school enrolment – male	73	66	69	51	-	-	72	64	84
		Net primary school enrolment – female (%)	64	65	67	40	-	-	75	59	84
Integration of SRH services into primary health care											
	1.1.1	Has integrated SRHR/HIV/AIDS/STIs and Malaria policy documents and national plan	YES	YES	YES	YES	YES	YES	YES	YES	YES
	1.1.2	Has policies and legal frameworks in place to ensure access to	YES	YES	YES	YES	YES	YES	YES	YES	YES

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
		comprehensive HIV/AIDS/STI and malaria prevention, care and treatment options for pregnant women, mothers, infants, families and PLWHA									
	1.1.3a	Strategies dealing with GBV developed and implemented	NO	YES	YES	YES	YES	YES	YES	YES	Communication strategy
	1.1.3b	Country has laws dealing with GBV in place	NO	YES	YES	YES	YES	YES, in constitution	YES	YES	NO. Bill pending
	1.1.4a	Has programmes to address HTP	YES		YES	YES	YES	YES	NO	YES	Not an issue
	1.1.4b	Has research report(s) on HTP and FGM			YES	YES	YES	YES	NO	YES	NO
	1.1.5	Has curricula for health workers and legal service providers that incorporate health related components of GBV	YES	YES	NO	YES	On course	No information	YES	----	NO
	1.1.6	Has policies that ensure access to condoms especially for PLWHA	YES	YES	YES	YES	YES	YES	YES	YES	NO
	1.1.7	Policies on public private partnership on SRHR developed and implemented	YES	YES	YES	YES	NO		YES	In process	NO
	1.1.8	Has multi-sectoral plans supporting SRHR	YES	YES	YES	YES	YES	YES	YES	---	YES
	1.3.1	% of Service Delivery Points (SDPs) offering routine HIV counseling and testing in STI, family planning and maternal and newborn and reproductive cancer services		no data	No data	90%			YES	---	
	1.3.2	% SDPs offering integrated comprehensive HIV prevention, management and treatment		no data	No data	100%, but only for prevention	not available		YES	---	
	1.3.3	% SDPs offering STI, PEP and EC services for GBV victims		no data	No data	No data		Scanty	YES	---	

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
	1.3.4	% SDPs offering infertility management services		no data	No data	100% but only for prevention	not available	less than 2%	YES	---	
	1.3.6	Has specific SRH policies/services for mobile populations and IDPs	NO		NO	No data	YES	YES	YES	YES	YES: services NO policy
	1.3.7	Has programme that ensures partnership with, support from and inclusion of men in SRHR services	YES	YES	YES	No data	YES	YES	YES	---	YES
	1.3.8	Has policies/plans around screening and management of cancers of the Reproductive system for both men and women	In pipeline	YES	YES	YES	YES	Scanty; less than 5%	YES	YES	YES
	1.3.9	Has services for mid-life concerns of both men and women	NO	YES	YES	YES	YES	Scanty	YES	---	NO
	1.3.10a	% of population under nourished (2002-2004)	9	11	20	15	26	19	33	46	32
Repositioning family planning											
	3.1.1	Proportion of SRH budget allocated to family planning	No data	No data	No data				No data	---	No data
	3.1.2	Supportive legislation, protocols and guidelines for family planning	YES	YES	YES	YES		YES	YES	YES	YES
	3.3.1a	% of men with FP knowledge	89.5	98.9	--	91.2	-	-	98.0	90.7	
	3.3.1b	% of women with FP knowledge	76.7	97.5	90.7	89.5	89.6	-	94.5	86.0	
	3.3.3a	Contraceptive prevalence rate (CPR) %	12	17	14	12	26	24	17	15	44
	3.3.3c	Unmet need for FP %	17	34	29	32	20	41	38	34	-
Youth-friendly SRHR services											
	4.1.1	Has developed policies to support SRH services for young people	YES	YES	YES	YES	YES	YES	YES	YES	YES
	4.1.2	Celebrates day of SRHR Services for young people			NO	YES	NO		YES	YES	YES
	4.2.1	Has IEC/BCC strategies that	YES	YES	YES	YES	YES	YES	YES	YES	YES

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
		promote abstinence and condom use				Integrated with other methods					
	4.2.3	Has IEC strategies for parent education for young people	YES	YES	YES	YES	NO	Scanty	YES	YES	NO
	4.3.1b	% young people with knowledge about condoms Female Male	 57.7 93.6	 96.4 98.9	 78.2 95.8	 85.9 97.5	 89.1 ---	 95.5 99.2	 89.5 98.0	 46.5 90.4	
	4.3.2a	% Condom use at last sex among sexually active young people Female Male	 6.2 30.1	 10.6 35.6	 3.1 32.1	 10.9 46.0	 18.6 -	 6.5 25.7	 2.1 -	 0.9 13.8	 - -
	4.3.2b	% of teens with pregnancy or have had a child	25	14	23	19	28	25	4	17	-
	4.3.3	Adolescent fertility as a percentage of total fertility	4.96	2.60	4.49	3.81	12.34	3.92	0.80	4.58	-
	4.3.4	Age of sexual debut Female Male	 16.7 20.7	 18.2 20.1	 18.7 --	 17.5 20.7	 16.5 18.6	 16.6 --	 -- 20.8	 16.5 21.2	
Unsafe abortion											
	5.1.1	Has status report on the magnitude and consequences of unsafe abortion.	YES	YES	YES	YES	On course		NON	YES	
	5.1.2	Has legislative/policy framework on abortion.	YES	YES	YES	YES	YES		NON	YES	YES
	5.1.3	Action plans to reduce unwanted pregnancies and unsafe abortion	YES	YES	YES	YES	NO		YES	YES	YES
Quality safe motherhood											
	6.1.1	Has developed Roadmaps for the reduction of maternal and newborn morbidity and mortality	YES	YES	YES	YES	YES	YES	YES	YES	YES

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
	6.1.2	Commemorate safe motherhood days	YES	YES	NO	YES	YES	YES	YES	YES	NO
	6.1.3	% Pregnant women vaccinated	40.2	50.4	66.2	40.2	53.3	50.8	22.3	28.0	
	6.2.1b	% of delivery supervised by skilled health professional	39	57	53	54	63	44	29	6	94
	6.3.1a	Maternal Mortality Ratio (MMR)	1100	560	980	700	1000	550	1300	720	380
	6.3.1b	Peri-natal mortality rate	51.6	21.2	26.4	50.4	45.2	44.2	49.1	37.7	
	6.3.2	Neonatal mortality rate	48.4	43.1	34.7	31.0	28.9	27.0	37.0	39.3	
	6.3.3	% 12-23 months-old fully immunized	11	64	35	48	49	36	69	17	73
	6.3.3b	% children under 5 that are under-weight	29	18	37	17	19	20	23	38	13
	6.3.4a	Availability of IMCI protocols		YES	YES	YES	YES	YES		YES	
	6.3.4b	IMR	100	64	61	81	74	71	86	77	
	6.3.4c	Under -5 mortality	200.7	111.2	121.3	183.7	143.6	127.6	152.4	123.5	
Resource mobilization											
	7.1.1a	Has 15% of budget allocated to health	NO	NO	NO	No data	NO	No data	YES	---	YES
	7.1.1b	Proportion of health budget allocated for SRHR	No data	No data	No data	No data	No data		No data	----	No data
	7.1.2a	Has SRHR in their national PRSP or development plans	YES	YES		YES	YES	YES	YES	YES	YES
	7.1.2b	% national health budgets allocated to SRHR	No data		No data	No data	No data		No data	---	No data
Commodity security											
	8.1.1	Has plans for RH commodity security (RHCS)YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
	8.1.4	Has RH commodities in essential medicines list	YES	YES	YES	YES	YES		YES	YES	YES
	8.2.2	Experiences stock out	NO	YES	YES	YES	YES		NO	YES	YES
Monitoring and Evaluation											
	9.1.1a	Regularly conducts censuses	NO	YES	YES	YES	YES	YES	YES	YES	YES
	9.1.1b	Regularly conducts DHS	YES	YES	YES	YES	YES	YES	YES	YES	NO

S/N	MPOA#	INDICATOR	NIG	GHN	SEN	BFSO	CMR	UGD	RWD	ETH	BTSW
	9.1.1c	Regularly conducts annual maternal death reviews	YES	YES	YES	YES	YES		YES	----	YES
	9.2.1	Mechanism and database for monitoring the POA in place	NO	NO	YES	YES	YES but not functional		YES	YES	NO
	9.3.1	Has institutionalised M&E system.	YES	YES	YES	YES	YES but not functional	YES	YES	YES	YES but not functional
	9.3.6b	Best practice web platform established	NO	NO	NO	YES	NO		YES	YES	NO