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PROGRESS REPORT OF THE COMMISSION ON MATERNAL NEW BORN AND CHILD HEALTH

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List of Acronyms and Abbreviations

ANC - Antenatal Care
ART - Antiretroviral
ARV - Antiretroviral
AUC - African Union Commission
CARMMA - Campaign on Accelerated Reduction of Maternal, New born and Child Mortality in Africa
CPRs - Contraceptive Prevalence Rates
DPT - Diphtheria, Pertussis and Tetanus
EAC - East African Community
ECOWAS - Economic Community of West African States
EID - Early Infant Diagnosis
EPI - Environmental Performance Index
FP - Family Planning
FGM – Female Genital Mutilation
HIV - Human Immunodeficiency Virus
HPV - Human Papilloma Virus
ICPD - International Conference on Population and Development
MDGs - Millennium Development Goals
MMR - Maternal Mortality Ratio
MNCH - Maternal New born and Child Health
MPoA - Maputo Plan of Action
M&E - Monitoring and Evaluation
PMTCT - Preventing Mother-to-child Transmission of HIV
SRH - Sexual and Reproductive Health
SRHR - Sexual and Reproductive Health and Rights
SADC - Southern African Development Community
RECs - Regional Economic Communities
SBA - Skilled Birth Attendants
SIAs - Supplementary Immunization Activities
UNFPA - United Nations Population Fund
UNGASS - United Nations General Assembly Special Session
WHO - World Health Organization

FOREWORD

Despite the progress recorded, Africa is still confronted with formidable challenges as the continent strives towards the attainment of the MDGs especially MDGs 4 and 5 by 2015. The substantial progress made in most African Union Member States in improving Maternal, New born and Child Health (MNCH) is a clear testimony to the fact that the factors underpinning the said challenges are known as well as the interventions to be undertaken as a counter measure. What remains is the political will to galvanize our efforts for a sustained and accelerated push in the right direction.

The Continental Policy Framework on Sexual and Reproductive Health and Rights and the Maputo Plan of Action for its implementation, remain key tools for Africa to attain MDGs 4 and 5. The Campaign on Accelerated Reduction of Maternal, New born and Child Mortality in Africa (CARMMA) serves as a critical advocacy platform for improvement of maternal, new born and child health in Africa. CARMMA has motivated significant national ownership, having been launched by 37 AU Member States. It is our sincere hope that within the next eighteen (18) months, all AU Member states will have successfully launched CARMMA.

Maternal, New born and Child Health issues has also engaged the attention of the African Union Heads of State and Government who following their Kampala 2010 summit (theme: Maternal, New born and Child Health) identified key actions to be undertaken including the directive that Africa's state of Maternal, New born and Child Health be reported on, annually up to the year 2015, corresponding to the time we shall report on the MDGs.

This first report, therefore, seeks to facilitate the presentation of progress thus far while highlighting persistent challenges and recommending remedial action.

Africa through the CARMMA also advocates for recognizing preventable maternal mortality and morbidity as a pressing human-rights issue that violates a woman's rights to health, life, education, dignity, and information. Our response to maternal morbidity and mortality should include implementing specific legal and ethical obligations on Member States, such as the establishment of effective mechanisms of accountability (i.e. maternal death audits or reviews). Monitoring of our interventions should not just be about discussing figures, but also realize that there are faces behind all those numbers. We should also reinforce equity, by insisting on disaggregated data on maternal mortality and morbidity rates to see if vulnerable groups are benefiting from health programmes.

I wish to appreciate all the development partners that have continued to support MNCH programmes and interventions on the continent, especially by those partners that have contributed to the development of this Report.

Maternal, New born and Child morbidity and mortality are limiting Africa's development. Let's act now to improve MNCH in Africa. I look forward to the day when *No Woman in Africa will Die while Giving Life*! and no child should die of hunger, disease and neglect.

H.E. Advocate Bience Gawanas
Commissioner for Social Affairs
African Union Commission

EXECUTIVE SUMMARY

The improvement in the status of maternal, new born and child health in Africa, despite some recorded progress still falls short of the targets of the Millennium Development Goals (MDGs). Continental and national leadership have repeatedly expressed commitment to the implementation of policies and programmes to address identified challenges and facilitate a positive change in the status.

The AU Summit of Heads of State and Government, in Kampala 2010 adopted key actions to improve MNCH amongst other things, they directed that annual status reports of MNCH be submitted to the Assembly. The African Union Commission (AUC) has continued to promote the implementation of the Continental Policy Framework on Sexual and Reproductive Health as well as the Maputo Plan of Action (MPoA) for its implementation. The Campaign for Accelerated Reduction in Maternal (New born and Child) Mortality in Africa (CARMMA) has continued to be adopted, launched and implemented by Members States. The total number of Member States that have launched the Campaign stands at 37, surpassing the targets set for 7 Members states per year in 2009.

Nevertheless, the continent continues to contribute the highest proportion of under-five deaths with 1 in 8 children dying before their 5^{th} birthday, notwithstanding the fact that progress has been recorded. Under-nutrition, hunger and mortality from preventable illness remain a challenge not only to health status (especially of children) but socio-economic development of the Member states and the continent as a whole. The immunization status on the continent has recorded significant progress with 85% drop in measles deaths between 2001 and 2010, specifically for the regions outside North Africa, though stock outs of routine vaccines in key countries in 2011 threaten to reverse the gains made.

Increased political will and national investment is required to boost immunization coverage in Africa. While immunization coverage in Africa is at its highest level in history, the burden of vaccine preventable deaths is borne most by the African continent, accounting for almost half of the global burden. Every year, millions of children in Africa die from preventable diseases because they do not have access to life-saving vaccines against the major killers of children, including pentavalent, pneumococcal, rotavirus and meningitis vaccines. Immunization is one of the most important investments in the health of the people and children of Africa, enabling them to lead productive, prosperous, and healthy lives.

Africa is still home to a large proportion of HIV positive women of reproductive age group/pregnant women as well as HIV+ children. However, access to Prevention of Mother-to-Child Transmission (PMTCT) services is reported at less than 50% on the average for the priority countries on the continent while access to ART services for HIV positive children is reported at 26% (2009).The evidence presents Africa as the continent with both the highest disease burden and the highest gaps in access to care.

Maternal deaths have reduced globally as well as on the African continent but not sufficiently to make a significant push towards the MDG targets. Access to and utilization of quality reproductive health services such as family planning, antenatal care and skilled delivery at birth are reportedly low. Integration of HIV and Sexual and Reproductive Health services is largely weak across the continent with the loss of the benefits accruable through appropriate constellation of services.

Resource allocation to the health sector remains inadequate to facilitate the delivery of quality services that amongst others would promote good health, which is fundamental to the development of the critical human capital required to stimulate economic development.

Poor linkages and collaboration between the ministries of health and the social determinants ministries such as the ministries of water resources, the environment and the ministry of agriculture is a crucial factor that if not addressed will weaken Africa's progress in meeting the MDG targets and as well fuel the death toll of Africa's women and children due to preventable disease. Social determinants such as clean water while not covered in the health budget impact very heavily on health. Synergy and collaboration between these ministries in areas of responsibility over lap will maximize available resources and thus provide for better health for the population particularly the most at risk children and women living in rural communities where services are most lacking.

Concrete steps must therefore be taken to scale up the evidence based, cost-effective interventions that have been proven to work. The health sector must be adequately funded by AU Member States as a real sector which is fundamental in driving the engine of socio-economic and human development.

Background

1. Globally, more than half a million women die each year due to pregnancy and childbirth related causes. Ninety nine (99) per cent of these deaths occur in developing countries, of which 50 per cent occur in Africa (specifically outside the North African region). For every death, at least another 20 women suffer illnesses or injuries related to childbirth or pregnancy. The lifetime risk of dying during pregnancy and childbirth in Africa (excluding North Africa) is 1 in 22 women, compared with about 1 in 8000 women in the developed world. Eighty per cent (80%) of those deaths could be prevented by simple, low-cost treatments and quality obstetrics care.

2. The African Union Commission (AUC) recognizes fully that the status of women, of which maternal health is a potent proximate indicator, is central to social and human development, a key determinant of equitable and sustainable economic growth and development. The AUC firmly believes that sustained economic growth, peace and stability would not be realized without addressing persistent gender inequalities, social exclusion and poor health outcomes on the continent.

3. The SRHR Policy Framework was adopted by the AU under decision no; *EX.CL/225 (VIII),* in 2005 in response to the call for the reduction of maternal and infant morbidity and mortality in Africa. It was developed as Africa's contribution to the implementation of the Programmes of Action of the International Conference on Population and Development (ICPD) as reproductive health and the rights of women as well as men were among the key priority objectives of the ICPD. Furthermore, the continental SRHR policy framework was aimed at accelerating action on the implementation of the MDGs, particularly those related to health, including MDGs 4, 5 and 6. In 2006, the AU under Executive Council declaration no. *EX.CL/Dec.516 (XV),*adopted the Maputo Plan of Action (MPoA) for the implementation of the SRHR Policy Framework.

4. Following a successful review of the implementation of the Maputo Plan of Action in 2010, the 15th Session of the Ordinary AU Assembly whose Summit was held in Kampala, mandated the AUC (under declaration Assembly/AU/Decl.1{XV}) to report annually on the status of MNCH in Africa until 2015.

5. In furtherance of the foregoing, the AUC in collaboration with partners have developed this 1st report on the status of Maternal, New born and Child Health in Africa.

Child Health

- Substantial progress has been made towards achieving MDG 4. The number of under-five deaths worldwide has declined from more than 12 million in 1990 to 7.6 million in 2010. Nearly 21,000 children under five died every day in 2010—about 12,000 fewer a day than in 1990.

- The under-five mortality rate has dropped worldwide by 35%—from 88 deaths per 1,000 live births in 1990 to 57 in 2010. Northern Africa has reduced their under- five mortality rate by 67% however the rate of decline in under-five mortality remains insufficient to reach MDG 4 in the rest of Africa.

- Africa (excluding North Africa) still registers the highest rates of child mortality —with 1 in 8 children dying before age 5, more than 17 times the average for developed regions (1 in 143)—and Southern Asia (1 in 15). As progress on reducing under-five mortality has occurred globally the disparity between Africa and other regions has consequently been magnified.

- In Africa (excluding North Africa) the average annual rate of reduction in under-five mortality has accelerated, doubling from 1990– 2000 to 2000–2010. Six Member States (Democratic Republic of the Congo, Madagascar, Niger, Malawi, Liberia, and Sierra Leone) of the fourteen best-performing countries are in this region, as are four of the five countries with the largest absolute reductions (more than 100 deaths per 1,000 live births)

- About (50%) half of under-five deaths occur in only five countries, two of which are African Union Member states: Nigeria and Democratic Republic of the Congo.

- Over 70% of under-five deaths occur within the first year of life with the proportion of under-five deaths that occur within the first month of life (the neonatal period) has increased about 10% since 1990 to more than 40%.

- Africa (excluding North Africa) has the highest risk of death in the first month of life and has shown the least progress.

- Globally, the four major killers of children under age 5 are pneumonia (18%), diarrheal diseases (15%), preterm birth complications (12%) and birth asphyxia (9%). Under-nutrition is an underlying cause in more than a third of under-five deaths. Malaria is still a major killer in Africa, causing about 16% of under-five deaths.

Under-five Mortality

6. Current statistics on under-five mortality presents a 35% decline in the under-five mortality rate globally, from 88 deaths per 1,000 live births in 1990 to 57 in 2010. Over the same period, the total number of under-five deaths in the world has declined from more than 12 million in 1990 to 7.6 million in 2010.

7. Northern Africa has achieved MDG 4, with a 67% reduction, while the rest of Africa has achieved only about 30% reduction in under-five mortality, less than half of what is required to reach MDG 4. Nevertheless, the rest of Africa (excluding North Africa) has managed to double its average rate of reduction from 1.2% a year over 1990–2000 to 2.4% a year over 2000–2010. However, 24 of the 26 countries the world

over with under-five mortality rates above 100 deaths per 1,000 live births in 2010, are in this region. Some 70% of the world's under-five deaths in 2010 occurred in only 15 countries, and about half in only five countries which include Nigeria and Democratic Republic of the Congo.

8. Madagascar is one of fourteen countries which had reduced its under-five mortality rate by at least a half between 1990 and 2010. In absolute terms, the greatest reductions on the continent were registered in Niger, Malawi, Liberia, and Sierra Leone (surpassing 100 deaths per 1,000 live births during the period). Moreover, in Africa (excluding North Africa), the declining rate has doubled in the region with the greatest burden of under-five deaths.

9. Despite substantial progress in reducing under-five deaths, children from rural and poorer households remain disproportionately affected. Statistics indicate that children in rural areas are about 1.7 times as likely to die before their 5^{th} birthday compared to those in urban areas and that children from the poorest 20% of households are nearly twice as likely to die before their 5th birthday compared to children in the richest 20% of households. Similarly, mother's education remains a powerful determinant of inequity. Children of educated mothers—even mothers with only primary education—are more likely to survive than children of mothers with no education.

Neonatal Mortality

10. Neonatal mortality, deaths in the first month of birth, is of interest because the health interventions needed to address the major causes of neonatal deaths generally differ from those needed to address other under-five deaths. Over the last two decades almost all regions have seen slower declines in neonatal mortality than in under-five mortality. Globally, neonatal mortality has declined by 28% only from 32 deaths per 1,000 live births in 1990 to 23 in 2010—an average of 1.7% a year, much slower than for under-five mortality (2.2% per year) and for maternal mortality (2.3% per year). The fastest reduction was in Northern Africa (55%) with the rest of Africa recording the slowest reduction.

11. Between 1990–2010, the share of neonatal deaths among under-five deaths has increased from about 37% to slightly above 40%, worldwide. The largest increases have again been registered in Northern Africa (37%). The rest of Africa, which accounts for more than a third of global neonatal deaths, has the highest neonatal mortality rate (35 deaths per 1,000 live births in 2010) and has shown the least progress in reducing that rate over the last two decades.

Child Under-nutrition and Hunger

12. Global leadership has been understandably occupied with one economic crisis after another, while a hunger and malnutrition crisis affecting millions of children appears to have apparently gone unchecked. As the global community experiences years of financial turmoil, pervasive long-term malnutrition is slowly eroding the foundations of the global economy by destroying the potential of millions of children.

13. Malnutrition is an underlying cause of death for 2.6 million children each year, and it leaves millions more with lifelong physical and mental impairments. Worldwide, more than 170 million children do not have the opportunity to reach their full potential because of poor nutrition in the earliest months of life.

14. Much of a child's future – and in fact much of a nation's future – is determined by the quality of nutrition in the first 1,000 days. The period from the start of a mother's pregnancy through her child's second birthday is a critical window when a child's brain and body are developing rapidly and good nutrition is essential to lay the foundation for a healthy and productive future. If children do not get the right nutrients during this period, the damage is often irreversible. Childhood malnutrition can lessen productivity – stunted children are predicted to earn an average of 20% less when they become adults.

15. Progress on reducing malnutrition has been pitifully slow for 20 years. But a combination of global trends – climate change, volatile food prices, economic uncertainty and demographic shifts – is putting future progress on tackling malnutrition at risk.

Vital Statistics

Malnutrition is the underlying cause of more than 2.6 million children's deaths each year.

171 million children – 27 percent of all children globally – are stunted, meaning their bodies and minds have suffered permanent, irreversible damage due to malnutrition.

Adults who were malnourished as children earn an estimated 20 percent less on average than those who weren't.

The effects of malnutrition in developing countries can translate into losses in GDP of up to 2-3 percent annually.

Globally, the direct cost of malnutrition is estimated at $20 to $30 billion per year.

In developing countries, breastfed children are at least a 6 times more likely to survive in the early months than non-breastfed children.

If all children in the developing world received adequate complementary feeding, stunting rates at 12 months could be cut by 20 percent.

Every hour of every day, 300 children die because of malnutrition. It's an underlying cause of more than a third of children's deaths – 2.6 million every year. But it's not recorded on death certificates and, as a result, it's not effectively addressed.

16. Recent data underscores the assertion that **under nutrition is a crisis that must be addressed now.** Stunting prevalence is unacceptably high, even in countries that are making progress in reducing child mortality. Addressing child under-nutrition should be a priority for all governments and their partners, especially among children under two years of age.

17. The biggest gaps exist in unstable AU Member States experiencing political crisis. The Horn of Africa crisis continues to highlight how vulnerable children are in such disasters, which contribute to slowing down progress and reversing the gains made in child survival and maternal health. A food crisis is currently unfolding in the Sahel, threatening the survival of children and women already weakened by malnutrition as a result of recurrent and frequent droughts in the region.

Current statistics reflects the following trends

1) **Children in an alarming number of countries are not getting adequate nutrition during their first 1,000 days.** Malawi and Madagascar are the two top African Union Member States where the majority of children under age 2 are being fed according to recommended standards.

2) **Economic growth is not enough to fight malnutrition.** Political will and effective strategies are needed to reduce malnutrition and prevent stunting. A number of relatively poor countries are doing an admirable job of tackling this problem, while other countries with greater resources are not doing so well. Countries that are performing better on child nutrition than their national wealth might suggest include Senegal and Tunisia.

3) **Community health workers are key to success.** Community health workers have a vital role to play in promoting good nutrition in the first 1,000 days. In impoverished communities in the developing world where malnutrition is most common, doctors and hospitals are often unavailable, too far away, or too expensive. Community health workers meet critical needs in these communities by screening children for malnutrition, treating diarrhoea, promoting breastfeeding, distributing vitamins and micronutrients, and counselling mothers about balanced diet, hygiene and sanitation. The "lifesaving six" interventions (iron folate, breastfeeding, complementary feeding, vitamin A, zinc and hygiene) can all be delivered in remote, impoverished places by well-trained and well-equipped community health workers. In Malawi, health workers have contributed to broad-scale success in fighting malnutrition and saving lives.

18. One great opportunity but also potentially a threat is the increased facility birth coverage. Several AU Member States; Malawi, Uganda, Rwanda, and Ghana have had major increases in facility births in the last few years, while quality of care has not have kept pace, though.

Child Immunization

19. Preventive health interventions are the most cost effective and efficient method to sustainably improve health of populations. African Union Member States, in collaboration with development partners, are accelerating the roll-out of existing and

new vaccines against the major killers of children, including pentavalent, pneumococcal, rotavirus and meningitis vaccines. Through increased routine immunization coverage and large-scale immunization campaigns, African countries outside the North African region made the most progress with an 85 per cent drop in measles deaths between 2000 and 2010.

20. However, some previously polio-free countries in west and central Africa experienced a resurgence of poliovirus transmission in 2008-2009. Contributing factors include the inability to achieve optimal coverage during SIAs against a background of low routine immunization coverage, disconnection between required activities and available resources, and limited ownership, financing and accountability by national and sub-national authorities.

21. By the end of 2011, for example, 13 African countries introduced the pneumococcal vaccine against pneumococcal disease, one of the main causes of pneumonia, meningitis, and sepsis, and 2 countries rolled out the rotavirus vaccine, which protects against the most deadly forms of diarrhoea. By 2015, an additional 15 African countries would have introduced the pneumococcal vaccine and 17 more countries will introduce the rotavirus vaccine. These vaccines will have great impact, not only on lives saved, but also in terms of healthy lives lived.

22. Having great impact in their own right, new vaccines also bring opportunities to re-energize and strengthen integrated interventions, such as Vitamin A supplementation, bed net distribution, and family planning information; and to advance commitments to improve child and maternal health more broadly, such as the 2010 Kampala Declaration, the 2006 Maputo Plan of Action and the Campaign on Accelerated Reduction of Maternal, Neonatal, and Childhood Mortality in Africa (CARMMA).

23. Member States are also preparing for the introduction of additional vaccines that protect against diseases that take their greatest toll on women and children, including those against Human Papilloma Virus (HPV), the main cause of cervical cancer and rubella. Other promising new vaccines are on the horizon against malaria and dengue fever, while AIDS vaccine research continues to show promise.

24. The successful introduction of vaccines in Africa will require renewed commitment from African Union leaders to build on immunization platforms in their countries to advance universal coverage.

25. Since 2000, African countries successfully immunized 207million children and for the period 2012-2015, it is projected that an additional 95 million children in Africa will be immunized. The huge increase in spending on immunization and the related improvements in programme performance can be tracked predominantly to donor and national funding increases, as 38 of 46 countries in the African Region established line items for immunization in their national budgets, 12 countries bought all of their own vaccines and 19 countries that received support from the GAVI Alliance developed financial sustainability plans. Strong political will, implementation and financial commitment are all critical for ensuring continued progress and sustainability, as is

working in partnership with regional and in-country stakeholders such as civil society. Against this backdrop is the key issue of stock outs of traditional vaccines in key countries in West and Central Africa in 2011, which can threaten the gains made in increasing immunization coverage and also access to other health interventions.

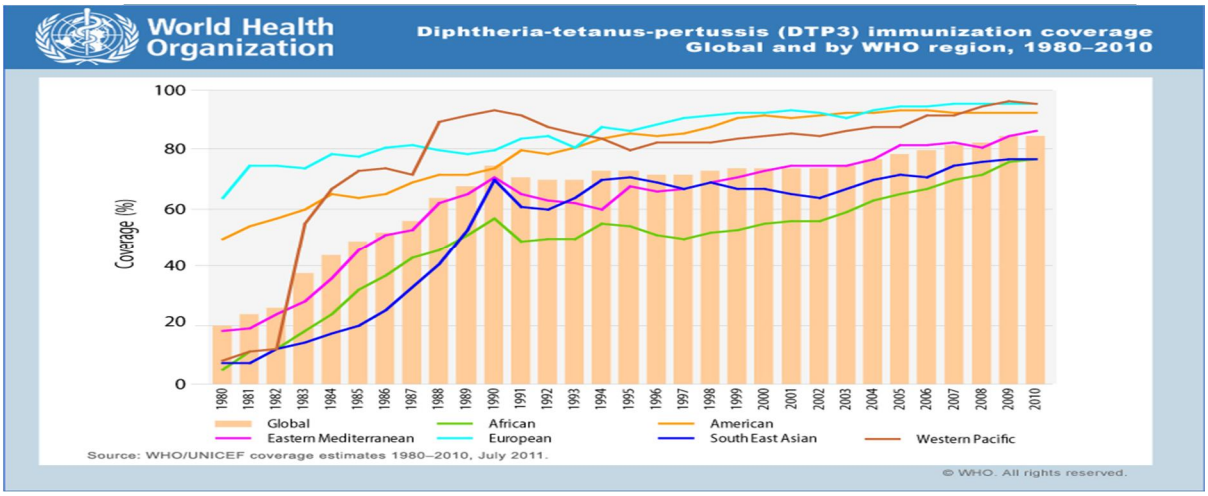
26. Concomitant with this scale up is addressing the technical challenges of introducing vaccines and monitoring and evaluating their impact over time. These include, for example, strengthening health systems and national health regulatory authorities, addressing cold chain capacity constraints with diverse and evolving product profiles (e.g. assessing needs, preparation and installation, upgrades, financing, etc.), strategic integration across EPI schedules and other health interventions, and improving data quality and surveillance.

27. While immunization coverage in Africa is on the rise,, over 20% of children on the African continent are still not protected against life-threatening illnesses. Every year, millions of children in Africa die from preventable diseases because they do not have access to life-saving vaccines. Higher coverage rates will mean that everybody, even those who are not immunized, can benefit from the miracle of vaccines through the phenomenon of herd immunity: the more children are immunized in a population, the lower the disease rate will be for all.

28. Furthermore, immunization and vaccines are considered to be one of public health's "best buys," reducing morbidity and mortality and having important long-term individual- and population-level gains, such as healthcare savings and care-related productivity gains and improved cognitive development. It has been shown, for instance, that increasing the coverage of six vaccines to 90% can reduce treatment costs and prevent lost productivity of parents or caregivers. In addition, vaccination of children with DPT (diphtheria, pertussis and tetanus), polio, tuberculosis and measles vaccines by the age of two shows improved cognition, leading to raised test scores and higher future productivity and raised earnings.

29. While vaccine coverage rates in Africa are rising (see **Figure 1**), the burden of vaccine preventable deaths is borne most by the African continent, accounting for almost half of the global burden (**Figure 2**).

Figure 1: ***Historic trends in DPT3 Coverage by WHO Region***



Source: http://www.who.int/gho/en/

Figure 2: ***Africa's Vaccine Preventable Disease Burden***

Total and vaccine preventable diseases cause specific deaths, children under age 5, by WHO region, 2008

	All cause	Pneumococcal diseases	Rotavirus diarrhea	Hib	Pertussis	Measles	Tetanus
AFR	4,202,000	247,000	217,000	94,000	84,000	25,000	27,000
AMR	284,000	13,000	8,000	1,000	2,000	-	1,000
EMR	1,237,000	68,000	90,000	32,000	19,000	7,000	14,000
EUR	148,000	7,000	3,000	3,000	-	-	-
SEAR	2,390,000	107,000	127,000	52,000	90,000	84,000	17,000
WPR	534,000	33,000	8,000	17,000	1,000	2,000	4,000
Total	8,795,000	476,000	453,000	199,000	195,000	118,000	63,000

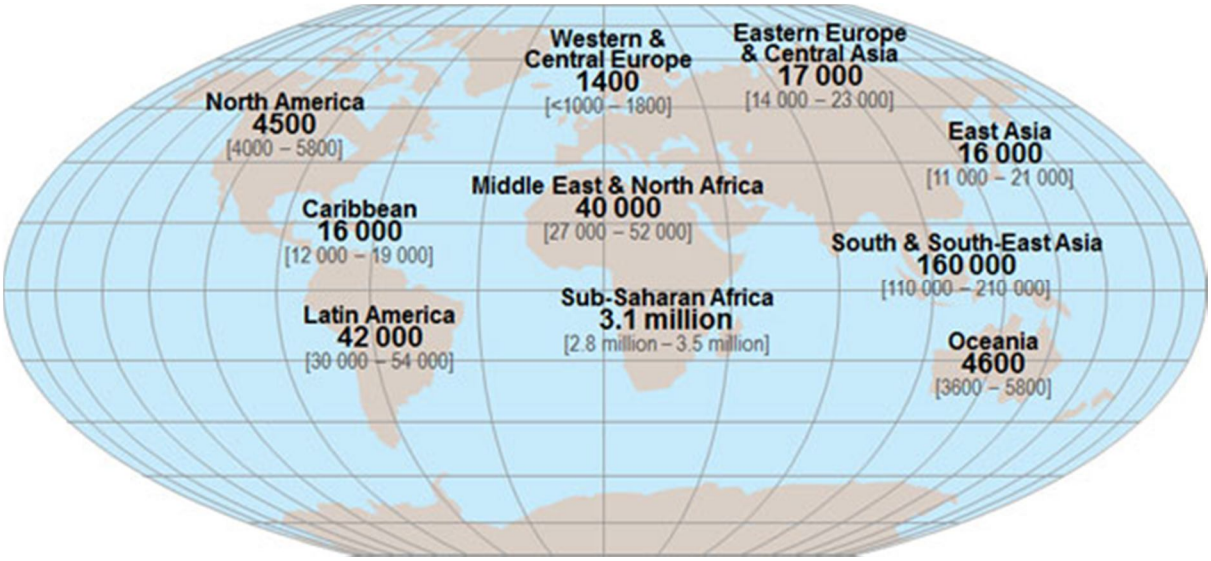
Number rounded to thousand

Source: http://www.who.int/immunization_monitoring/burden/estimates_burden/en/index.html

Status of Paediatric HIV

30. Africa (excluding North Africa) is the region with the largest number of pregnant women living with HIV. In the year 2010, there were 1.36 million pregnant women living with HIV as well as 3.1 million children (aged 0 – 14 years) living with HIV in Africa of which 360,000 were newly infected. The primary means through which children acquire HIV is from their HIV-infected mothers during pregnancy, birth or breastfeeding.

Figure 3: ***Children under 15 years living with HIV globally, 2010***



Total: 3.4 million (3.0 million - 3.8 million)

Source: WHO, UNAIDS and UNICEF, *Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011.*

Prevention of Mother to Child Transmission (PMTCT)

31. Without any intervention, the rate of infection of children is estimated at 40%. With efficacious interventions the risk of mother-to-child HIV transmission can be reduced to 5%. Providing antiretroviral prophylaxis to pregnant women living with HIV has prevented more than 350, 000 children globally from acquiring HIV infection since 1995 and eighty-six per cent of these children live in Africa (excluding North Africa). However, such interventions are still not widely accessible or available in some resource-limited countries where the burden of HIV is highest.

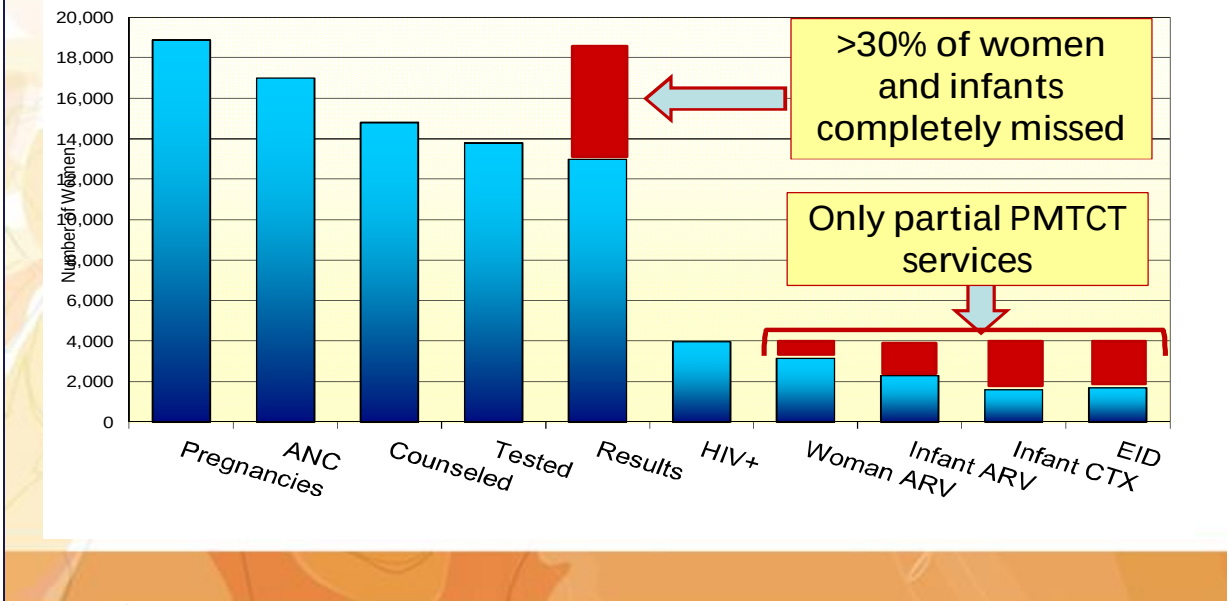
32. There is evidence that it is possible to virtually eliminate paediatric HIV and keep mothers and infants alive through four main strategies: Reduction of HIV incidence among women; reduction of unmet need for family planning to zero among all women; reduction of the vertical transmission rate to <5%; 90% reduction in HIV-related maternal deaths up to 12 months post-partum and 90% reduction in HIV attributable deaths among infants and children under five. These strategies, outlined in the Global Plan to Eliminate New HIV Infections in Children by 2015 and Keep their Mothers Alive, have been signed onto by most of the countries in the region.

33. Among the major challenges in preventing the vertical transmission of HIV is the lack of ability to follow women through the continuum of care. The most effective PMTCT services are those that interact with the pregnant mother throughout her pregnancy and for months after giving birth to her infant. At each step of this “PMTCT cascade”, there are missed opportunities to prevent mother- to- child transmission of HIV infection. However, no country in the region is able to track women through the PMTCT cascade to understand how many women are being reached with the complete

set of necessary services. Using the available data in the region, the PMTCT cascade shown below illustrates the multiple points where women fail to receive services.

34. Significant challenges remain to preventing new HIV infections among children and to scaling up the provision of treatment for pregnant women, but there are also opportunities for the region to overcome these challenges.

Figure 4:Typical PMTCT Cascade



Source: EGPAF

Early Infant Diagnosis (EID)

35. In 2010, only 28% of infants born to HIV positive mothers were tested for HIV within the first two months of life. Improved follow-up of women in PMTCT programs, particularly in the post natal period, is vital to ensure all infants are tested for HIV and linked to treatment services if needed. Often, even if infants and young children are coming at the health facilities for immunization and others services, the HIV status of their mothers is not always checked, leaving the HIV exposure status of the child unknown. Leveraging child health services with a high uptake (such as immunization programs) can help get children diagnosed and onto appropriate ARV treatment. However, many health facilities lack the appropriate tools to identify HIV exposed infants, and the healthcare providers are insufficiently trained and have inadequate clinical mentoring to provide appropriate diagnosis of HIV infection in children.

36. The turn-around time from blood collection to the time the HIV result is back to the health facility and shared with the parents/caregiver so that treatment can be initiated for infants and young children who are found HIV infected, is still too long in many countries in Africa. Many countries have put systems in place to reduce turn-

around time for infant diagnosis but access to early infant testing with appropriate follow up is still low.

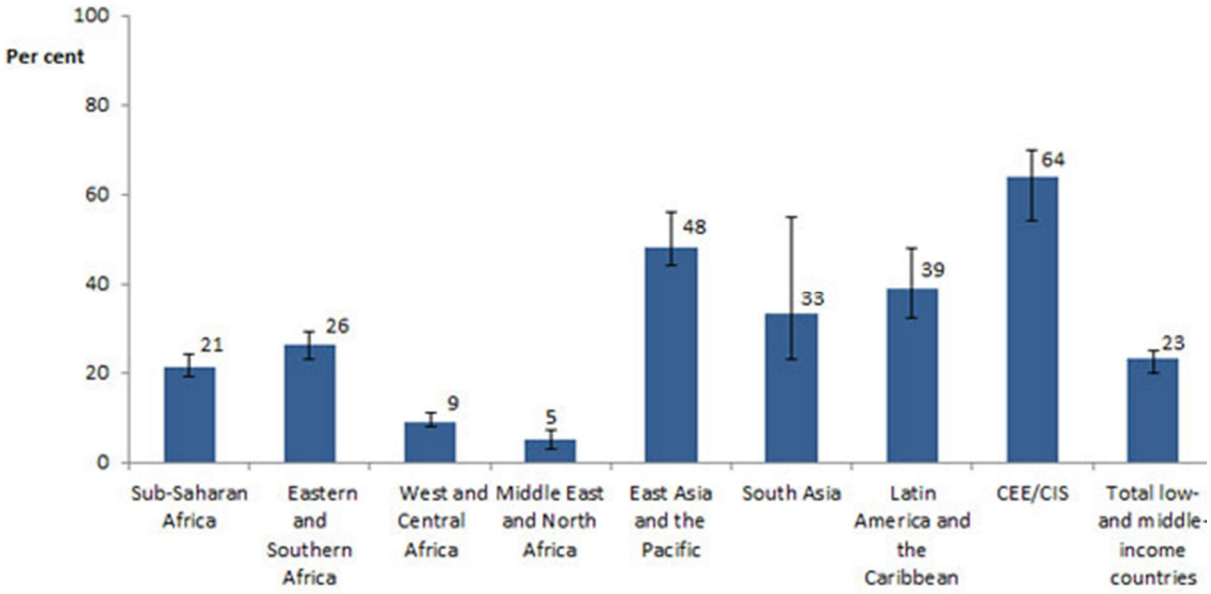
37. Stock out of HIV test kits and materials used in early infant diagnosis are still reported in several countries in Africa. Equipment is also often broken and the repair process takes too long, seriously handicapping EID efforts and consequently delaying the early initiation of lifesaving treatment for infants and young children who are HIV infected.

Paediatric Care and Treatment

38. Among the estimated 1.49 million infants born to mothers living with HIV globally, only 42% received antiretroviral medicine to prevent HIV transmission from their mothers in 2010.

39. Children account for 1 in 6 new infections globally while as of December 2009, 90% of children living with HIV are in Africa and without diagnosis and treatment, half of them will die before their second birthday., only 26% of HIV-infected children in Africa (outside North Africa) were receiving antiretroviral treatment, a proportion far lower than the 51% coverage of antiretroviral therapy among adults. While the number of children receiving ART increased from about 75 000 in 2005 to 450 000 in 2010, more than 2 million still needed treatment in 2010. It is evident that less progress has been made in scaling-up paediatric HIV diagnosis, care, support and treatment.

Figure 5: ***Percentage of children under 15 years old receiving antiretroviral therapy, 2010***



Note: The lines on the bars show the uncertainty bounds for the estimates.

Source: *UNICEF calculations based on data reported in Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011 (WHO, UNAIDS, UNICEF), Geneva 2011. Regions were recalculated according to UNICEF classification of regions.*

ART initiation for HIV infected children and retention in care

40. HIV-infected infants have an exceptionally high mortality – approximately 30% will die by their first birthday without access to HIV care and treatment and by 2 years, over 50% HIV infected children will die in absence of treatment. Unfortunately, access to treatment among infants is even lower than that among older children.

41. Paediatric formulations of ARV drugs are not always available, leading to inaccurate dosing, with over dosage or under dosage of infants and young children, further compromising the health of these vulnerable populations.

42. In addition, an HIV infected infant and young child always needs an adult to administer the ART. This is challenging because many of these children are orphans and live with relatives who have their own children to take of or who have other duties. Strong and appropriate counselling is needed to support caregivers and families in providing treatment for children.

Status of Reproductive (and Maternal) Health

43. Despite the increasing commitment of the African Union leadership to enhance investment and strengthen capacity, interventions to address the exceptionally high levels of unmet needs for Sexual and Reproductive Health (SRH) and safe motherhood in Africa (excluding North Africa), progress made in addressing these challenges have remained limited.

44. The 2008 estimates put the Maternal Mortality Ratio (MMR) at 260 for the World, 280 for South Asia, 590 for Africa, and when North Africa is excluded the figure for Africa reaches 640. Maternal deaths in Africa (excluding North Africa) account for more than half (59%) of global maternal deaths. The proportion of married women using modern contraception followed the same trend: 55% for the World, 45% for South/Central Asia, 23% for Africa, with the figure reducing to 17% for Africa when North Africa is excluded.

45. There are regional variations in the status of maternal deaths across Africa. Statistics suggest that the East African Community (EAC) region is trailing behind the Southern Africa Development Community (SADC) with regard to indicators of safe motherhood, family planning and adolescent SRH, but is ahead of Economic Community of West African States (ECOWAS). The EAC region's progress on maternal health and FP nearly stalled in the 1990s but regained momentum in the 2000s. In general, the countries in the region made much more progress regarding universal access to SRH (MDG 5b) than they did with regard to safe motherhood (MDG 5a). Besides, efforts to revitalize SRH programs appear to be paying off, as evidenced by faster progress towards universal access to SRH and safe motherhood in the 2000s than in the 1990s.

46. The progress recorded in these countries is largely attributable to several policy and program features. They include: government commitment demonstrated by clear strategies and committed funding; a well-developed health care infrastructure and

system focusing on enhancing access to services among disadvantaged groups; strong community outreach activities that take services closer to vulnerable and hard-to-reach communities; provision of low-cost or free maternal health and FP services; sustained training of health care personnel and task-sharing, where lower cadre personnel are trained to provide some of the services currently provided by doctors; and strong public-private partnerships. The EAC provides a valuable platform for supporting the identification, enhancement, dissemination, and scaling-up of the drivers of progress towards universal access to SRH in the region.

Levels and Trends in Maternal Deaths

47. The Maternal Mortality Ratio (MMR), which estimates the number of maternal deaths per 100,000 live births, is the ultimate indicator of the disease burden associated with high-risk pregnancies and childbirth.

48. The current mortality burden translates into a lifetime risk of maternal death during a woman's reproductive lifespan of 1 out of 35 women in the EAC, 1 out of 28 women in ECOWAS, and 1 out of 44 women in SADC. The maternal mortality burden (2008 MMR estimates) however stands at 560 for ECOWAS, 540 for the EAC, and 455 for SADC.

49. Overall, the EAC region's marker for progress towards achieving MDG 5a, which seeks to reduce maternal mortality ratios by 75% by 2015, is rated "insignificant", having registered a 19% decline. With an overall MMR decline of 70%, Eritrea is the only country in the wider Eastern Africa region that is on track to achieving MDG 5a. Rwanda and Ethiopia have made good progress that could see them achieve MDG 5a by 2015.
Six Member States (Djibouti, Kenya, Sudan, Tanzania, Burundi and Somalia.) of the Eastern Africa region's 10 countries made no progress or insignificant progress between 1990 and 2008. Besides, MMRs increased in several countries during the 1990s.

Figure 6: ***Progress towards reduction of maternal mortality ratios: 1990-2008, Eastern African Region***

	Regions, Regional Economic Blocks, and Countries	1990	2008	Maternal Death Lifetime risk 2008; 1 in :	MDG MMR Target by 2015	Target Annual MMR Reduction per year	Overall % Change (1990-2008)	Average Annual Change in MMR (1990-2008)	Overall Progress towards Reducing MMR
	Sub-Saharan Africa	*780*	*530*	*31*	*195*	*-23*	*-25*	*-12*	Reasonable
1	*SADC*	*380*	*455*	*44*	*95*	*-11*	*-13*	*-1*	Insignificant
2	*EAC*	*880*	*540*	*35*	*220*	*-26*	*-19*	*-13*	Insignificant
3	*ECOWAS*	*790*	*560*	*28*	*198*	*-24*	*-41*	*-17*	Reasonable
1	Eritrea	930	280	72	233	-28	-70	-36	On Track
2	Djibouti	370	300	93	93	-11	-19	-4	Insignificant
3	Uganda	670	430	35	168	-20	-36	-13	Reasonable
4	Ethiopia	990	470	40	248	-30	-53	-29	Good
5	Kenya	380	530	38	95	-11	39	8	No Progress
6	Rwanda	1100	540	35	275	-33	-51	-31	Good
7	Sudan	830	750	32	208	-25	-10	-4	Insignificant
8	Tanzania	880	790	23	220	-26	-10	-5	Insignificant
9	Burundi	1200	970	25	300	-36	-19	-13	Insignificant
10	Somalia	1100	1200	14	275	-33	9	6	No Progress

Data Source: WHO, UNFPA, The Word Bank. (2010). Trends in Maternal Mortality: 1990-2008

***The progress marker is categorized as follows: 0% No progress; 1-24% Reasonable, 50-69% Good progress; 70+% = on track*

50. It is encouraging that efforts in most EAC countries during the 2000s are reversing this trend. Despite improvements in maternal health in the 2000s progress remains slow, and the region needs to make significant and sustainable investments in maternal health for member countries to come close to meeting MDG 5a.

51. It is encouraging to note that, compared with the other RECs, the EAC region is making the most progress towards achieving MDG 5a, which seeks to reduce maternal mortality ratios by 75% by 2015. The region recorded an overall 41% reduction in the average MMR from 790 in 1990 to 560 in 2008. None of the ECOWAS countries is on track to achieving MDG 5a, with only Cape Verde having made good progress towards this end.

52. Mauritius has the lowest MMR in the SADC region (36 deaths per 100,000 live births), as well as in Africa (excluding North Africa). None of the countries in the SADC region is considered on track to achieving MDG 5a. However, Mauritius is clearly making very good progress. It is followed by Namibia, with a maternal death rate of 180 per 100,000 live births, and Botswana, with a rate of 190.

53. Overall, the SADC region's reduction in MMR is 13% and if this trend continues, it is unlikely that countries in the region will get close to the MDG target by 2015. The fact that MMRs increased in countries that had achieved relatively low levels of mortality raises major concerns about the sustainability of progress in improving women's health and calls for more concerted efforts to sustain programs.

Causes of Maternal Deaths

54. WHO estimates that the leading causes of maternal mortality in Africa (excluding North Africa) are maternal haemorrhage (34%), hypertensive disorders (19%), maternal sepsis (9%), abortion (9%), and other maternal conditions (11%). However, data from other sources give higher proportions of maternal deaths due to abortion.

55. The 2008 WHO data indicate that unsafe abortions account for 12% maternal deaths in Southern Africa and Western Africa, and 18% in Eastern Africa. It is estimated that there were 2.4 million unsafe abortions in Eastern Africa in 2008, and that unsafe abortions account for 13,000 maternal deaths in the region every year. In the same period, there were about 1.8 million abortions in Western Africa, with about 28 unsafe abortions out of every 1,000 women of reproductive age. In comparison, there were about 120,000 unsafe abortions in Southern Africa in 2008. Unsafe abortions also cause other long-term maternal disabilities, which do not even get documented.

Maternal morbidity

56. Maternal morbidity is defined as a severe, life-threatening complication as a result of childbirth. Complications of childbearing include obstetric fistula, anaemia, infertility, damaged pelvic structure, chronic infection, depression and impaired productivity. Women who suffer from maternal morbidity may face long-term physical, psychological, social and economic consequences which again may lead household and marital problems, social isolation, shortened life spans and suicide.

57. The leading causes of maternal morbidity and mortality in many developing countries, particularly in sub-Saharan Africa, are pregnancy and birth related complications. In Africa, for every woman who dies during childbirth, another 20 are estimated to suffer from debilitating diseases. These complications are a result of several complex and often synergistic factors linked to, among many others, age at first marriage which leads to early pregnancy before full maturity of female reproductive organs which increases the risk for complicated labour including fistula and rapture of the uterus.

58. Obstetric fistula is a result of prolonged or obstructed labour resulting in tissue damage and the uncontrollable passage of urine and faeces into the vagina. Women with fistula are often deserted by their family, friends, and are unable to undertake their daily activities. Obstetric fistula disproportionately affects young and poor women, as well as women living in rural areas and those whose growth is stunted due to poor nutrition or childhood illness. Women who have undergone female genital mutilation

(FGM) are also more likely to experience prolonged or obstructed labour and develop obstetric fistula.

59. Measuring maternal morbidity is difficult, yet is a necessary component of monitoring progress made in maternal health in Africa. The exact number of women living with obstetric fistula is unknown, but is estimated by UNFPA to be over 2 million worldwide, with 100,000 women at risk of obstetric fistula each year. Surveys show that one per cent of women in Ethiopia and 4.7 per cent of women in Malawi who have ever given birth have experienced obstetric fistula. However, due to underreporting and social stigma, these numbers are believed to be an underestimate of the true extent of the problem.

Availability of Skilled Birth Attendants

60. It is estimated that almost three-quarters of maternal deaths can be prevented by increasing women's access to comprehensive reproductive health services, including antenatal care, having skilled attendants during childbirth, emergency obstetric care (including post abortion care), maternal nutrition, postpartum care for mothers, and family planning.

61. The proportion of births assisted by Skilled Birth Attendants (SBA) is considered the most appropriate measure of a country's readiness to prevent maternal deaths since unskilled birth attendants are ill-equipped to provide emergency obstetric care and deal with the main causes of maternal deaths. The results create a very worrying image of the SBA situation in the EAC region. The latest data show that just over half of the deliveries (50.6%) in the EAC region were assisted by SBAs, compared to 51.3% in ECOWAS and 61.5% in SADC.

62. Deliveries assisted by SBA and Antenatal Care (ANC) are the primary interventions used to deliver services that help address maternal mortality. The SADC region has the highest proportion of births assisted by SBAs (an average of 61.5%) compared with 50.6% in EAC and 53.5% in ECOWAS.

63. It is, therefore, fitting that two of three countries that have consistently had good coverage of these interventions (Rwanda and Uganda) are also rank highest in progress aimed at lowering estimated MMRs in the EAC. In fact, the two SADC countries that have consistently had good coverage of these two interventions (Botswana and Namibia) are also among the top three countries with the lowest estimated MMRs in the region. In the same vein, the ECOWAS countries that have consistently had good coverage of these two interventions (Cape Verde, Ghana, and Gambia) also have the lowest estimated MMRs in the region.

64. There are huge disparities in access to safe motherhood services between the different socio-economic groups that should be monitored closely and addressed urgently. An analysis of these disparities shows that, overall, progress was most notable in countries that are doing better in increasing access to SBA-aided deliveries for people of relatively low socio-economic status (the less educated, poor, and rural-based).

Antenatal Care (ANC)

65. ANC provides an opportunity for monitoring pregnancies, detecting potential problems, and determining remedial measures during pregnancy and/or delivery. For example, women's nutritional status is assessed, solutions like caesarean section recommended for deliveries likely to end up in obstructed labour, tests for HIV are conducted to facilitate treatment for prevention of mother-to-child transmission, and women are provided with malaria prevention treatment and treated bed-nets.

66. Monitoring of pregnancies in the EAC region is quite impressive, with an average of at least 9 out of 10 pregnant women making one ANC visit (97.7%), the highest, compared with 91.5% for SADC and 84.1% for ECOWAS. Tanzania recorded a near-universal level of at least one ANC visit (97.7%); the remaining EAC countries also had equally impressive ANC coverage of more than 90%.

67. The proportion of women making at least four ANC visits are considerably lower than those attending at least once; with the average for the ECOWAS region at 48.8%, that for the EAC 45% and SADC 60%.

68. Notably, most of the decline occurred in the 2000s. It is important to determine whether this is a reflection of program inefficiencies or of deliberate programmatic actions to de-emphasize the number of times women should attend ANC and focus on the quality of care during the few visits they make. The near-universal coverage of at least one ANC visit in most countries shows that women generally understand the importance of having at least one medical check-up during pregnancy. The main challenge is how programs can build on this success to get more women to deliver in clinics with SBAs and to increase the coverage of those making at least four visits.

Addressing Unsafe Abortion

69. Except for South Africa, which has liberalized its abortion laws, all SADC countries had restrictive abortion laws. Considering that the removal of legal restrictions paves the way for the provision of safe abortion services that would save many women's lives, it is important for SADC countries to continue reforming their abortion laws.

70. In Eastern Africa, unsafe abortions are estimated to account for almost 1 out of 5 of all maternal deaths (18%), the highest rate, while the Southern Africa region has the lowest rate, being almost 1 out of 10 maternal deaths (9%). The reasons for the region's poorer abortion indicators could be partly explained by its restrictive abortion laws compared with the other regions'. The EAC countries only allow abortion in two instances: to save a woman's life, and based on a woman's physical and mental health. In Western Africa, unsafe abortions are estimated to account for almost 1 out of 8 of all maternal deaths (12%).

71. Considering that removing legal restrictions to abortion facilitates the provision and uptake of post-abortion care, and that safe abortion services can significantly reduce maternal deaths, countries that have very restrictive abortion laws should explore the possibilities of reforming their relevant policies. But having safe abortion services is not just about removing or relaxing legal barriers. It also entails addressing service-level challenges as well as stigma to ensure that women who legally qualify for safe abortion can access this service. Increasing access to FP is also cost-effective in reducing unplanned pregnancies, which drive many women to have unsafe abortions in circumstances where they cannot access safe abortion.

Improving Access and Uptake of Family Planning

72. The cornerstone of the 1994 International Conference on Population and Development (ICPD) Program of Action was to enable women and their partners to have universal access to the information and services they need to make informed and voluntary decisions about their sexuality and, therefore, plan the number and timing of their pregnancies. At the centre of interventions to achieve both MDG 5b and ICPD objectives is modern FP, which is a proven, cost-effective measure for saving the lives of women and children, preventing unwanted pregnancies, and slowing rapid population growth, the latter of which is a major obstacle to efforts to alleviate poverty at the household and national levels, preserve the environment, and adapt to the effects of climatic change.

73. The SADC region led in modern contraceptive use, with 42.2% of married women using modern FP techniques. There are also huge disparities in contraceptive use among the different socio-economic groups, but as noted with respect to safe motherhood, countries that are making relatively good overall progress in the region (Malawi, Madagascar, Zimbabwe, and Namibia) showed considerable increases in contraceptive use among the poor, the rural-based, and the least educated.

74. Fewer than 3 out of 10 married women (27.4%) in the EAC region use modern contraceptives, placing the REC behind SADC, where the use of modern contraceptives is about 4 out of 10 (42.2%). The leading country in the EAC is Rwanda, which experienced a decline in the 1990s and then experienced an unprecedented increase in the 2000s from less than 1 out of 10 women (4.3%) to about 5 out of 10 women (45.1%). Compared with SADC and the EAC, ECOWAS countries have persistently had much lower Contraceptive Prevalence Rates (CPRs), less equitable distribution of contraceptive use, and greater reliance on the largely ineffective traditional methods. Use of modern contraceptives in Western Africa almost doubled from 3.9% to 8.9% between 1993 and 2006, but the latest CPRs for modern methods were less than 10% in 8 out of the 15 ECOWAS member states. However, Cape Verde's CPR of 57.1% is exceptional in a region where the second-best level was 16.6% (Ghana) and the third 13.3% (Burkina Faso).

75. The level of unmet needs for FP shows the extent to which women who want to avoid or delay pregnancy are not using contraception and, therefore, at risk of having unwanted or unplanned pregnancies. In the SADC region, Mauritius had the lowest level

of unmet needs for FP (3.5% in 2002), followed by Namibia (6.7%), Zimbabwe (12.8%) and South Africa (13.8%).

76. The highest level of unmet needs during the 2000s was recorded in Malawi (27.6%) in 2004. The other countries had unmet need levels of between 18% and 27% (Mozambique 18.4%, Ethiopia 25%, Lesotho 23%, Swaziland 24%, DRC 24.4%, Tanzania 25.3%, and Zambia 26.5%).

77. Botswana had the highest level of unmet needs at 44.7 in 1988 followed by Uganda at 40.6% in 2006/7 (more recent data was not available). High levels of unmet demands for FP show that countries can make considerable progress towards universal access to reproductive health by enabling women with unmet needs to access and use contraception. High unmet need for family planning is a missed opportunity and provides a low lying fruit for AU Member States to rapidly increase contraceptive prevalence rate, lower fertility, reduce dependency ration and spur economic growth and thus benefit from a demographic dividend. This is the future for Africa's development.

Adolescent SRH

78. Young people's SRH is a key determinant of the economic and social development of their countries and communities. Early engagement in sex, early marriage, and low use of contraceptives are key precursors to early childbearing, high fertility, high child mortality, and low levels of female education.

79. The introduction of HPV vaccine represents a unique opportunity to deliver services to adolescents girls. Considering that HPV vaccines target a sexually transmitted infection causing cancer and are provided to adolescent girls, immunization provides opportunities for AU Member States to collaborate with numerous stakeholders in reproductive and adolescent health, education, women's empowerment and gender equity, and cancer, to advance the health of women, adolescent girls, and mothers on the continent.

80. In the EAC region, the highest age at first sexual experience was recorded at 17.8 years, highest age at marriage (19.4 years), and the lowest adolescent fertility (1 birth per 10 women) compared with the other RECs. The average level of contraceptive use among young people in the EAC region was 15.4%, which trailed SADC's 24.6%, but was better than ECOWAS' 7.6%.

81. The average age at first sexual experience in the ECOWAS region decreased slightly from 16.4 to 16.2 between 1993 and 2006, and it varied between 15.6 in Niger and 18.4 in both Ghana and Senegal. There was a slight increase from 17.4 to 18.3 in the average age at first marriage over the period, with country averages ranging between 15.5 in Niger and 19.8 in Ghana. The average ages at first sexual experience and marriage are lower in ECOWAS compared with the EAC and SADC regions.

82. Contrary to conventional thinking, the average age at first sexual experience in the SADC region increased slightly from 17.2 years to 17.4 years between 1992 and 2007, and it varied between a low of 16.1 years in Mozambique to a high of 19.3 years in Namibia. SADC recorded a slightly lower improvement in age at first sexual experience between the 1990s and 2000s (a 3.0 per cent increase) compared with the EAC's 3.6% and ECOWAS' 3.3%.

83. There had also been a slight increase in the average age at first marriage in the SADC region from 18.2 years in 1992 to 18.9 years in 2007, with country averages ranging from 17.5 years in Mozambique to an exceptionally high of 27 years in South Africa. Botswana's and Namibia's average ages of 24 at first marriage of were also quite high. The average ages at first marriage for the RECs were 18.3 years for ECOWAS, 18.9 years for SADC and 19.4 years for the EAC.

Integration of SRH and HIV

84. The need to link the responses to SRH and HIV/AIDS is considered important because HIV and SRH are closely interrelated. The potential benefits of linking SRH and HIV responses include improved access to, and uptake of, SRH and HIV/AIDS services, effective use of limited resources, improved quality of care and service effectiveness through reduced duplication of service delivery functions, as well as convenience and cost savings for clients.

85. Vast opportunities for reducing the vertical silos of SRH and HIV policies and programs continue exist in the African Union Member States. HIV prevalence rates in the EAC are quite high, making it especially critical for the region to integrate SRH and HIV services to extend the reach of both services. Yet only about 1 out of 5 women (21.5%) in Eastern Africa receives HIV counselling and testing during ANC, which is comparable to Southern Africa's 22.6%, but higher than Western Africa's 7.75%. Given the impressively high levels of at least one ANC visit in the EAC, it is evident that programs are not taking full advantage of SRH services to integrate HIV prevention and treatment services.

86. A much smaller percentage of women in ECOWAS countries (7.8%) receives HIV counselling and testing during ANC, compared with SADC (22.6%) and the EAC (25.7%). This matches the relatively low ANC coverage (at least one visit) and HIV prevalence rates in ECOWAS. The small proportion of HIV-positive women receiving ARVs to prevent mother-to-child transmission shows missed opportunities for integrating SRH and HIV. The average coverage for the ECOWAS region was 27.9%, ranging from 14.2% in Guinea to 54.7% in Niger and 57% in Cape Verde and the average coverage for the SADC region was 59.5%, although it ranged from 1.2% in Madagascar to 100% in the Seychelles.

87. Although country-level efforts to integrate SRH and HIV services are on-going (albeit at different levels), integration is generally less than optimal due to a number of challenges. These include: lack of strong coordination mechanisms; lack of clear integration strategies and policies; shortage of, and high depletion of, the health

workforce; imbalanced financial and other resources between SRH and HIV; and lack of integrated financial, procurement and M&E systems. These issues need to be addressed in order for countries and clients to take full advantage of the potential benefits of integration.

Health Financing

88. Inadequate financial resources and investment are key factors undermining progress towards universal access to SRH, safe motherhood services, new born and child health in Africa. However, assessing the amount of money spent on MDG's 4, 5a and 5b are hampered by lack of data since only a few countries have the capacity, or have undertaken detailed studies of subaccounts of national health accounts to examine and track these budget lines.

89. Analyses of African Union Member States' general expenditure on health and per capita government expenditure show that by 2010 only Six Member States have achieved, or nearly achieved, their commitments to spend 15% of their national budgets on health, in line with the Abuja Declaration.

90. Health spending in Africa excluding North Africa at the same time averaged $25 - $27 per capita with 32 of the 53 AU Members investing less than $20 per capita including 4 of the countries that have met the 15% benchmark.

91. In early 2012 a comparison was undertaken on the status of health financing in 2011 against 2010 to review progress towards attaining the 2001 Abuja Declaration of African Heads of States to allocate at least 15% of their national budgets to Health.

92. The comparison carried out in partnership with the Africa 15% plus campaign, focuses on highlights of any increase or decrease in percentage (%) government allocation to Health as well as actual per capita investment in health in mainly 15 Member states which since the 2001 Abuja commitments have at various times come closest to, or actually allocated up to 15% of annual budgets to health. The comparison also outlines broad trends in health financing across all member states.

93. The findings include the following:

- The number of countries meeting /surpassing only the 15% commitment increased from 6 in 2009/2010 to 8 in 2010/2011;
- More importantly, 42 out of the 54 AU Member States increased actual per capita investment in 2010/2011, however 23 of these countries invested under $30usd;
- 7 AU Member States decreased actual per capita investment in health;
- 26 AU Member States increased overall percentage allocation to health;

- 22 AU Member States decreased overall percentage allocation to health;

- There were cases with decrease in percentage (%) allocation to Health, alongside actual increase in actual per capita represents progress [i.e. less percentage (%) of a bigger budget to health, but more per person];

- There is overall progress based on dual analysis of both percentage (%) allocation to health, and actual per capita investment in health;

- The allocation to health in many cases includes external support of up to between 0.9% and 59%.

94. While there is a broad correlation between increased government allocation to health overall and better health outcomes; however mere allocation of more money to health overall does not necessarily result in good funding of SRH, safe motherhood, new born and child health. For instance, in many countries in Africa (excluding north Africa states), external donors provide most of the funding for FP and other SRH programs and commodities, which places these critical services at risk, should donor priorities shift.

95. Moreover, monitoring how much money is invested in MDG's 4 and 5 reveals that countries that are making the most progress have demonstrated sustained commitment to increasing allocations of domestic budgetary, and donor funding to these programs.

RECOMMENDATIONS

Child Health

- Strategies to improve child health and nutrition must focus on developing and utilizing cost-effective interventions that are focused on the primary causes of child illness and mortality. AU Member States must consistently develop, evaluate and scale up these interventions with higher impact on child health and survival.

    - Simple solutions delivered to children who are at risk of malnutrition and their families are already well known and well supported by nutrition experts. In 2008, the Lancet medical journal identified a package of 13 direct interventions – such as vitamin A and zinc supplements, iodized salt, as well as the fortification of food and the promotion of healthy behaviour, including hand washing, exclusive breastfeeding and complementary feeding practices– that were proven to have an impact on the nutrition and health of children and mothers;

    - Save the Children has identified six low-cost nutrition interventions with the greatest potential to save lives in a child's first 1,000 days and beyond. Universal coverage of these "lifesaving six" solutions globally could prevent more than 2 million mother and child deaths each year. The lifesaving six are: iron folate, breastfeeding, complementary

feeding, vitamin A, zinc and hygiene. This entire lifesaving package can be delivered at a cost of less than $12 per child.

- Member states should work to sustainably achieve high levels of immunization coverage anchored on effective routine immunization coverage, and the successful introduction of new vaccines against the biggest killers of children. Immunisation is one of the most important and cost-effective investments in the health of the people and children of Africa.

  - Increase national awareness-raising and information campaigns reinforcing the value and importance of immunization;

  - Scale-up immunization efforts by supporting the financing of vaccines and addressing the technical aspects of introducing these vaccines, which will have a measurable impact in reducing child mortality.

- Community-based care initiatives must be developed and scaled up, with task shifting (to auxiliary health workers) of basic but essential services being undertaken. This would involve the development of educational materials for these providers including training curricula, clinical guidelines, and standards of care.

  - ART programs driven by physicians have great difficulty reaching infants and young children in need of treatment, which is why task sharing approach is a key strategy to reach as many children in need of ART as possible. Medical doctors, nurses, social workers and lay counsellors should be supported through training and mentoring in order to build their capacity and get them to participate confidently in the provision of paediatric care and treatment. Quality parent and caregiver counselling as well as a strong linkage between health facilities and community can improve paediatric patient retention through:

    - the support that informed parent & caregiver will provide to the child on ART and influence positively the adherence to ART;

    - retracing those who miss their appointment and are more likely to be lost to follow up, using community health worker to bring them back to the health facilities.

- Health system strengthening initiatives should be implemented to enhance the function of the health system with due attention paid to the improvement of the quality of facility-based care;

- Community participation and partnerships with non-governmental entities and civil society need to be strengthened and institutionalized to create

necessary synergies and efficiency in the provision of care and promotion of health;

- Member States need to develop and implement innovative strategies, tailored to the needs of the individual Member States to address the challenges of human resources for health to enhance the training, recruitment, deployment and retention of various categories of health workers;

- Member States should promote the implementation of the African Plan for Elimination of Mother-to-Child Transmission of HIV (*attached as appendix 1).*

Maternal Health

- Reinforce efforts to prioritize and champion SRH by mobilizing political will and support (at the national, sub-national, and community levels), matched with committed and sustained financial input to implement supportive MH and FP policies. Member States that have launched CARMMA should be faithful to the execution of Country Implementation Plans;

- The institutionalization of maternal death audits would strengthen the evidence base for programme and policy development and implementation as well as motivate adequate attention to quality of care.

- Abortion laws should be reviewed appropriately to prevent maternal deaths resulting from unsafe abortions; to provide post-abortion care; and enhance access to FP to reduce unplanned pregnancies, in the context of national laws.

- Community participation, partnerships and service outreach should be reinforced with particular focus on the underserved sub-groups, including men and youth while gender issues and the empowerment of women should be consciously addressed. Information sharing on good practices and low cost, high impact interventions should be institutionalized to facilitate appropriately adaptation.

- Governments should ensure that SRH programs are well funded, and that they increasingly take over the funding responsibility of SRH commodities and related services from donors. National Health Accounts (NHAs) should contain sub-accounts for SRH and other major health issues to facilitate assessment of the extent to which financial resources for health are allocated and used in the light of the key health priorities.

- Prioritize the development and implementation of innovative policies and interventions that address barriers to access to basic MH and SRH services among the under-served and marginalized sub-populations.

Adolescent Reproductive Health

- Member States should develop and implement appropriate policies, legislation and programs that promote gender equality and reduce social exclusion, including policy barriers to young people's access to information, services and care. This includes promoting the integration and prioritization of young people into national policy planning and budgeting processes, such as poverty reduction strategies, social equality policies and frameworks, sector plans and budgets.

- Member States should seek to rapidly scale up programs that provide information and implement cost-effective interventions such as immunization with HPV vaccine to young adolescents beyond the small scale efforts that in most countries reach only a fraction of the population.

- Partnerships should be fostered among multiple government ministries (e.g finance, education, health, youth and sports, culture etc), development partners and civil society (including youth groups)at multiple levels to implement a coordinated, national response to the needs of young people.

- Institutional capacity should be built and supported to ensure sustainable and effective local and national programs including the development of standardized comprehensive sexuality education curricula and youth-friendly training curricula, as well as appropriate pre-service and in-service training of teachers, administrators, and health workers. These would facilitate youth friendly/focused services into existing sectoral interventions.

Health Financing

- Member States should strive to achieve the 15% allocation for health sector with emphasis on using domestic resources as opposed to donor funds;

- Efforts to increase status of health financing in Member States should aim at increasing per capita allocation to health;

- Governance and Accountability systems need to be strengthened within the health sector to minimize wastages, improve efficiency and deliver "more health for the money";

- In response to current challenges of international resource mobilization, Member States should explore alternative and sustainable sources of health financing;

- There should be corresponding investment in social determinants of health such as water and sanitation;

- RECs should play a key role in mobilizing their member states to strengthen commitments to expenditure on health in general, and in ensuring that

governments have specific budget lines on SRH and safe motherhood, and that they commit to taking primary responsibility to fund and manage these programs in due course.

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