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EXECUTIVE COUNCIL
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25 – 26 January 2007
Addis Ababa, ETHIOPIA

EX.CL/316 (X)

REPORT OF THE EXTRAORDINARY SESSION OF THE AU CONFERENCE OF MINISTERS OF HEALTH ON SEXUAL AND REPRODUCTIVE HEALTH IN AFRICA

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INTRODUCTORY NOTE

In an endeavor to address sexual and reproductive health issues on the continent, the African Union Commission elaborated a Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa. This policy framework was developed as a response to the call to reduce the high levels of maternal and infant morbidity and mortality in the African continent from various stakeholders. It was developed in collaboration with the African Regional Office of the International Planned Parenthood Federation (IPPF), the United Nations Population Fund (UNFPA) and other development partners.

It addresses issues that were identified at six Sub-regional consultations jointly organized by the African Union and IPPF. These consultations identified several factors that contribute to deaths among women and children on the continent. The consultations recommended the implementation of the Roadmap for the Acceleration of the Reduction of Maternal and Newborn Child morbidity and mortality as the strategy for improving reproductive health.

The Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa was adopted by the 2nd Session of the Conference of African Ministers of Health held in Gaborone in October 2005. In that Session, the Ministers called for a Special Session to discuss the issues in greater detail and come up with a concrete plan of action for integration of SRH in PHC, among other things. Mozambique offered to host this special session. The decision to convene a special session was endorsed by the Summit of Heads of State and Government in Khartoum, Sudan in January 2006. The Special Session took place from September 18-22, 2006.

The main out come of the Special Session was the Maputo Plan of Action for the Operationalisation of the Continental Sexual and Reproductive Health and Rights Policy Framework in Africa.

EX.CL/316 (X)
Annex I

Theme: **"*Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa*"**

REPORT OF THE MINISTERS' MEETING

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SPECIAL SESSION OF THE AFRICAN UNION
CONFERENCE OF MINISTERS OF HEALTH
MAPUTO, MOZAMBIQUE
18 – 22 SEPTEMBER 2006

Sp/MIN/CAMH/Rpt(I)

Theme: ***"Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa"***

REPORT OF THE MINISTERS' MEETING
21 – 22 SEPTEMBER 2006

DRAFT REPORT OF THE MINISTERS' MEETING 21 - 22 SEPTEMBER 2006

I. INTRODUCTION

1. The Special Session of the AU Conference of Ministers of Health was held at the Joaquim Chissano Conference Centre, Maputo, Mozambique, from 21 to 22 September 2006 on the theme: ***"Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa"***. A three-day experts meeting preceded the Ministerial Session. The Conference was organized to implement the decision adopted by the 2nd Session of the AU Conference of Ministers of Health held in Gaborone, Botswana in October 2005 and endorsed by the AU Summit in Khartoum, Sudan in January 2006. It was hosted by the Government of the Republic of Mozambique and organized by the African Union, in with technical support from UNFPA, IPPF and other partners; and financial support from the European Commission. The main objective of the Special Session was to adopt a costed Action Plan for the implementation of the Continental Policy Framework on Sexual and Reproductive Health and Rights.

II. ATTENDANCE

2. The Ministers' Meeting was attended by delegates from the following 46 AU Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Guinea, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Saharawi Arab Democratic Republic (SADR), Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

3. The Ministers' Meeting was also attended by Representatives of the following International and Regional Organizations, countries and NGOs: UNFPA, IPPF, WHO, ECA, UNESCO, IOM, Comite Inter-African, WAHO, Bill and Melinda Gates Foundation, David and Lucile Packard Foundation, William and Flora Hewlett Foundation, Johns Hopkins University, USAID, University of Kwazulu-Natal, DELD, AECI, Partners in Population and Development, Belgium, Family Health International, Total Health Trust, East, Central and Southern African Health Community, SADC, JICA, Oxfam GB, AGBEF (Rep. Guinea), RPMM Network, DFID, JSI/Deliver, Averting Maternal Death, John Hopkins Program for International Education on Gynecology and Obstetrics (JHPIEGO), Columbia University, AMDP, Council of Women World Leaders, Realizing Rights, Spain, Germany, Palestine, and USA.

III. OPENING CEREMONY

(i) The Chairperson of Bureau of 2nd Ministerial Conference of Health (CAMH2) Calls the Meeting to Order

4. The Opening Ceremony was presided over by Prof. Sheila Tlou, Minister of Health, Botswana and Chairperson of the Bureau of AU Conference of Ministers of Health. After welcoming the delegates and thanking Mozambique for hosting the Conference, she called upon and invited dignitaries to address the Meeting.

(ii) Welcome Remarks by the Minister of Health for Mozambique

5. In his welcoming statement, the Minister of Health of Mozambique, Hon. Prof. Paulo Ivo Garrido recognized the challenges posed by Sexual and Reproductive Health problems and urged that the continent needs to seriously address these challenges. In this regard, he called for the active participation of all stakeholders including donors and other development partners. He finally thanked his colleague Ministers of Health for their attendance and wished all the participants a pleasant stay in Maputo.

(iii) Statement by the Chairperson of AU Conference of Ministers of Health, Hon. Minister of Botswana

6. The Hon. Minister of Health of Botswana, in her capacity as Chair of the 2nd Conference of African Ministers of Health Bureau, commended the AU Commission for organizing the Special Session and thanked Government of Mozambique for offering to host the event. She recalled that the Special Session was a follow-up of the 2nd Session of the AU Conference of Ministers of Health which she had the pleasure to host in October 2005 in Gaborone, Botswana. She informed the delegates that at the Gaborone Session Ministers adopted the Continental Policy on Sexual and Reproductive Health and Rights. She noted that the objective of the Special Session was to collectively address concerns related to SRHR in Africa and its linkage to HIV/AIDS, as well as adopt an Action Plan for Implementation of the Continental Policy Framework on SRHR.

7. She expressed her appreciation to the Experts and the Secretariat for their hard work in the preceding three days to prepare and finalize the Plan of Action for the operationalization of the policy framework for Sexual and Reproductive Health and Rights. She called on Member States to take the implementation of the Continental Policy Framework seriously.

(iv) Statement by the IPPF Director General

8. Speaking on behalf of the Director General of IPPF, Mr. Tewodros Melesse, Regional Director of IPPF for the African Region, congratulated the AU and the Government of Mozambique for organizing such a successful conference. He also expressed satisfaction with the strong collaboration between the AU and the IPPF, along with other partners, in working very hard to prepare the policy framework for Sexual and Reproductive Health and Rights, as well as the Plan of Action, for its operationalization.

9. He noted that IPPF has 150 Affiliate Members in 180 countries which makes it one of the largest SRHR organizations in the World. IPPF, he added, is a strong global voice not only to those who are voiceless but also to those who, for various reasons, can not raise their voices loud. He emphasised that the Millennium Development Goals (MDGs) cannot be achieved without taking SRHR issues into account by addressing them in a holistic and integrated manner.

10. He concluded his remarks underscoring IPPF's commitment to work with the AU Commission and, in collaboration with other partners, in making "Every Child a Wanted and Loved One".

(v) Statement by H.E. Mme Peiyun PENG, People's Republic of China

11. The Chinese delegation, led by H.E. Madam Peiyun Peng, former Vice-Chair of the Standing Committee of the National People's Congress of China and currently President of the Red Cross Society of China and Chairperson of the China Population Association of the People's Republic of China, expressed her appreciation to Mozambican authorities for their hospitality and to the African Union for its leadership and vision on African problems.

12. Madam Peng said the special session of the Conference of African Union Ministers of Health on Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa was one of the priority lines of action of South-South cooperation in general and of Sino-African cooperation in particular.

13. After sharing the experience of her country on SRHR, she recalled that China, in spite of the challenges it still has to overcome, has made substantial progress in the reproductive health area. She concluded by expressing China's commitment to cooperate with Africa on political dialogue, the sharing of experiences and capacity building in the area of population development and urged the delegates to participate in the China Africa Forum due later this year.

(vi) Statement by Mrs. Joy Phumaphi, Assistant Director General of WHO

14. The Assistant Director General of WHO expressed how privileged she felt to address the Special Session. She also said she was disturbed that such a meeting was taking place at a time when the world was experiencing the worst crisis of reproductive health of our time. She informed the delegates that focusing on reproductive health was an essential element for attaining the MDGs.

15. She further noted that most people have no access to services for prevention of unwanted pregnancies or STIs, including HIV/AIDS, especially children under 15 years old. She lamented that so many women die in childbirth due to inequities; moreover, HIV/AIDS prevention services may be available but not utilized properly.

16. She also emphasised the importance of the meeting in solving these challenges. In this connection, she indicated WHO's commitment to support the AU's initiative in promoting SRHR, particularly in the implementation of the Plan of Action which provides a unique opportunity to guide actions, ensure comprehensive approaches, including addressing poverty, and ensuring sustainable development.

17. Finally she underlined the need to mobilize the media to promote SRHR; strengthening partnerships, and increasing global leadership. To this effect, she reiterated that the AU can always count on WHO's cooperation and collaboration.

(vii) Statement by the UNFPA Executive Director

18. The UNFPA Executive Director said that universal access to sexual and reproductive health services was more than a goal that was agreed upon by 179 governments in Cairo at the 1994 International Conference on Population and Development, and reaffirmed by leaders at the 2005 World Summit. She added that

universal access to sexual and reproductive health services was more than an effective means to reduce poverty, empower women and foster gender equality; to combat HIV/AIDS, improve maternal health and reduce child mortality; and to ensure sustainable development. It is more than an effective strategy to achieve the Millennium Development Goals.

19. She emphasised that sexual and reproductive health was human right, the right to health. Therefore, denying any person their human rights is to challenge their very humanity. The key to success is strong national reproductive health plans backed by domestic resources. She also said that the feminisation of the AIDS pandemic should be reversed by linking HIV and family planning, and integrating HIV/AIDS in maternal and newborn health programmes. She pointed out that prevention is particularly important for young people and called for comprehensive and expanded youth-friendly services. Young people should be given a chance to lead in this struggle to meet their needs for realizing their human rights.

20. She explained that if all individuals are to be able to exercise their human right to sexual and reproductive health, it is critical that a reliable and consistent supply of reproductive health commodities is ensured. She concluded by reiterating UNFPA's support in developing national capacity for the costing, development, implementation of and leveraging and mobilizing funds for national reproductive health plans.

(viii) **Statement by Advocate Bience Gawanas, Commissioner for Social Affairs**, **African Union Commission**

21. After welcoming the delegates to the Special Session of Ministers of Health on Sexual and Reproductive Health and Rights, the Commissioner commended the Ministers for their presence, especially since they have been particularly busy lately. She recalled the theme of the Special Session: "***Access to Comprehensive Sexual and Reproductive Health Services in Africa***". She then thanked H.E. the President, H.E. the Prime Minister, Government and People of Mozambique for hosting the Special Session, and for the welcome and hospitality accorded to the delegates. She particularly thanked the Minister of Health of Mozambique and his team for successfully coordinating the convening of the conference. She informed participants that the AU Commissioners had, in fact, been elected into office here in Maputo in 2003.

22. The Commissioner then expressed her appreciation to the collaborators including UNFPA, IPPF, EU, WHO and Bill and Melinda Gates Foundation for their support, which enabled the realization and success of the Conference. Speaking as an African woman she urged participants to ensure that women are at the centre of policies in order to promote their human rights.

23. She again commended the Ministers of Health for deciding to meet and plan on how to operationalize the decision of Heads of State and Government, adopted in Khartoum, Sudan, in January 2006. She called for a comprehensive, integrated, harmonized and well-coordinated approach in the implementation of the outcome of the Special Session. She called on partners and other stakeholders to provide the needed support. She concluded her statement by wishing the Ministers successful deliberations.

(ix) **Keynote address by H.E. the Prime Minister of the Republic of Mozambique H.E Dr. Luisa Dias DIOGO**

24. The Ministerial Conference was officially opened by Mozambican Prime Minister Dr Luisa Dias Diogo. In her keynote address, Dr Diogo said that her country was honoured to host the Special Session and extended a warm welcome to all delegates. She went on to say that her country has integrated SRH in their programmes and acknowledged the threat posed by the HIV/AIDS pandemic. She echoed the feeling of ministers at the conference that universal access to sexual and reproductive health (SRH) is important for the development of Africa, especially in the context of the need to achieve the MDGs.

25. She advocated for a holistic approach to SRH and called for more efforts by African countries to achieve the Abuja declaration goal of allocating 15 % of national budgets to health. She concluded by expressing her hope that the meeting would contribute to harmonization of strategies in order to achieve the MDGs.

Vote of Thanks by the First Vice-Chair of the AU Conference of Ministers of Health

26. The Vote of Thanks was delivered by Hon. Wilfred Machape Deputy Minister of Health of Kenya, and 1st Vice Chairperson of the AU Conference of Ministers of Health on behalf of all Ministers of Health. He conveyed the appreciation of the Ministers for the hospitality extended to them by the government of Mozambique and commended the President of the Republic of Mozambique for the peace and stability prevailing in the country. He emphasised that peace was essential for achieving the objectives and theme of the Special Session.

27. He thanked the Prime Minister for finding time in her busy schedule to grace the occasion. He noted that a Mozambican had been selected as Africa's only candidate for the post of Director-General of WHO and called on all Member States of the Continent to collectively support this candidate. He commended the Guest Speakers and Officials for their enlightening and touching speeches. He concluded by thanking all whose contributions had made the Conference possible and a success.

IV. PROCEDURAL MATTERS

(a) Adoption of the Agenda

28. The agenda was adopted as presented.

(b) Organization of Work

29. The Programme of Work was adopted without amendment and the following working hours were adopted:

Morning	:	09.00	-	13.00 hrs.
Afternoon	:	15.00	-	18.00 hrs.

V. ROUNDTABLE ON "*PROGRAMME APPROACHES FOR THE LINKING OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND HIV/AIDS SERVICES" -*

30. The Roundtable was chaired by the AU Commissioner for Social Affairs, H.E. Advocate Bience Gawanas with the following presenters:, theDeputy Minister of Health of Kenya representing the Minister; the Minister of Health of Lesotho representing the SADC Ministers of Health; Executive Director of of UNFPA; IPPF Director Technical Knowledge and Support representing the Executive Director and Secretary General of the Ministry of Public Health, Cameroon representing the Minister.

31. A summary of the discussions on the theme of the Roundtable is presented below.

SPEAKERS:

***Deputy Minister of Health, Kenya, Dr. Wilfred Machape on* Linking of Sexual and Reproductive Health and Rights and HIV/AIDS Services in Kenya**

30. The Hon. Deputy Minister of Health presented the demographic indicators for Kenya as concerns the total population, mortality rates, family planning (FP) and contraceptive utilization, and HIV prevalence rates. He noted that contraceptive usage had increased steadily between 1978 and 1998 and then stagnated and that the total fertility rate (TFR) had declined from 8 to 4.9 in 20 years but now showed an increasing trend. The enabling factors for integration in Kenya include: a supportive policy environment with emphasis on the essential package of health at all life cycle stages but which showed a gender bias towards women. Reporting structures are in place; HIV/AIDS control already exists as a component with the RH Strategy; and relevant service provision guidelines exist.

31. On the progress to date, the Deputy Minister emphasised significant integration of FP and Voluntary Counseling and Testing (VCT); comprehensive post-rape care, and prevention of maternal to child transmission (PMTCT) of HIV. Among the challenges faced, he noted the following: inadequate resources, acceptability and ownership by services providers, weak health systems including shortage of staff; deep-rooted vertical projects' mentality by managers and lack of adequate knowledge on both RH and FP;

32. For the way forward, the Deputy Minister indicated the following: PMTCT to be delivered country-wide as a routine antenatal (ANC) service; rapid preparation of more VCT centres to be integrated into RH services; finalization of key pilot studies; assurance of RH and HIV/AIDS commodities security through budgetary allocations, and mobilization of communities to increase demand for both RH and HIV services.

33. During the discussion that ensued, the Deputy Minister was commended for sharing the Kenyan experience which was a lesson other countries could emulate.

***Minister of Health of Lesotho and SADC Ministers Chairperson, Dr. M. Phooko,* on the Audit Report on Reproductive health and Related Mortality and Morbidity in the SADC region**

34. The Chairperson of the SADC Ministers of Health, Minister of Health of Lesotho, Hon. Dr M Phooko, made a presentation on the SADC Sexual and Reproductive Health Strategy. This Strategy is informed by the Audit Report of reproductive health-related morbidity and mortality. The Honourable Minister started by providing a brief summary of the regional situation on sexual and reproductive health challenges. In terms of maternal morbidity and mortality, the SADC region has mortality ratios ranging between 124 (South Africa) and 1,300 (Angola) per 100,000 live births except for Mauritius which is 45/100 000 live births. Most countries report high rates of ante-natal care (ANC) for one visit (over 90%), while reaching less than 50% coverage for 4 antenatal visits. Service coverage for prevention of mother to child transmission of HIV (PMTCT) is poor despite high ANC attendance reflecting lack of integration of services and challenges related to the uptake of services. Birth delivery with skilled attendance ranges from 42% in Angola to 99% in Mauritius.

35. In order to address the challenges outlined above, the SADC Ministers of Health approved the SADC Strategy on Sexual and Reproductive Health, which covers the period 2006 to 2015. The Strategy identifies key priority issues and outlines strategies and activities directed at i) Improving SRH services which will address direct causes of maternal mortality; ii). Strengthening health systems; iii) providing skilled human resources iv) mobilizing resources; v) strengthening government commitment; vi) establishing SRH databases; vii) developing and harmonising policies and strategies; viii) integrating SRH services; ix) mobilizing and involving communities; x) strengthening partnerships; and xi) creating platforms for sharing experiences. The Hon. Minister reiterated the need for the region to strengthen collaboration with relevant stakeholders in the implementation of the Strategy.

Thoraya Ahmed Obaid, UNFPA Executive Director and UN Under Secretary General on *" Making RH /HIV Integration a Reality: The Moment for Leadership"*

36. Ms Thoraya Obaid expressed how deeply honoured she was to address African Ministers of Health as a group for the first time. She thanked the African Union Commission and the Government of Mozambique for making this possible. She went on to recognize all the other dignitaries present. She said that the promotion of sexual and reproductive health and rights was the mandate of the UNFPA, and universal access to services was a target of the ICPD/PoA. AU Member States and UNFPA were therefore all committed to saving lives through sexual and reproductive health and rights services. The Continental Policy Framework for the Promotion of Sexual and Reproductive Health was a welcome development for which she commended the AU Commission Chairperson and Commissioner for Social Affairs.

37. She quoted the former President of the Republic of South Africa, Dr. Nelson Mandela who said that "to deny any person his human rights is to challenge the person's humanity'; emphasizing that access to sexual and reproductive health service was a human right. She said that the SRH Policy Framework was a foundation for the delivery of SRHR services, but the real work was the implementation of the Plan of Action adopted at national levels. She noted that there were many challenges including the

mobilization of the necessary resources. She assured the meeting the support of UNFPA in their efforts and urged other development partners to lend support to the efforts of African countries. There was no time to waste.

38. She welcomed the integration of HIV in SRHR but stressed that with no cure in sight, prevention, especially among young people should be given special attention. She urged that space be given to young people to lead the strategy for prevention of HIV infection. She said that a strong Africa requires a health people and progress for women is progress for all. Every woman should be free from unsafe abortion and obstetric fistula by having access to services that protect women. She shared appalling statistics on maternal and newborn health and gender-based violence. She noted that about 50% of the pregnant women had no skilled attendance at child birth, an issue that should be given adequate attention.

39. Ms Obaid said that now that a vaccine against the human papillovirus that causes cancer of the cervix was available, it should be accessible to all. The UNFPA, WHO, UNICEF, UNAIDS and other partners had defined indicators for monitoring progress in the delivery of SRHR services. She emphasized the need to strengthen youth SRHR programmes. Community leaders, including parliamentarians, must be sensitized to the importance of SRHR services.

IPPF Director Technical Knowledge and Support on
Repositioning Family Planning in the 21st century.

40. In her presentation, Dr. Nono Princess Simelela; Director, Technical Knowledge and Support, IPPF highlighted the current challenges to repositioning family planning such as inequity in access especially for vulnerable populations, poverty and competing demands on the health sector. This has resulted in high unmet need for many health interventions, including SRH/FP. Yet SRH/FP is central and key to achievement of the Millennium Development Goals, including eradication of extreme poverty.

41. Therefore, in order to reposition SRH/FP, there is need to address unmet needs (especially for contraceptive commodities); integrate and scale up services; and strengthen coordination, monitoring and evaluation systems. There is also need to respond to the urgent needs of vulnerable and marginalized populations. Even more importantly, there is need to embrace the life cycle approach to planning, policy and tools development, resource mobilization and health services provision for each life stage under a global partnership of “Alliance for Life.” This would ensure that the interventions are comprehensive and meet all the preventive and therapeutic needs at a given life stage (birth to 6 months, 6 months – 5 years; 6 – 12 years; 13 – 19 years; 20 – 35 years and beyond 35 years). This should be pursued as an inter-generational contract for the different life stages, with each generation securing the health and well-being of the other so that “*we realize an African Society in which every child is a wanted child, every person enjoys good health and men, women and youth live free of HIV/AIDS*.”

42. In the discussion that followed, the proposal to consider the needs in life stages was appreciatively recognized as offering ways by which the specific needs of each age group could be addressed more effectively.

Secretary General of the Ministry of Public Health, Cameroon on *Harmful Traditional Practices to Sexual and Reproductive Health and Rights.*

43. In his intervention, on behalf of the Minister of Public Health of Cameroon, Prof. Angwafo reflected that "Harmful traditional practices are a threat to our survival let alone our development". He pointed out the various types of harmful practices which have their roots in our cultures, traditions, and attitudes of men and women towards sex, sexual behaviour and male-female roles.

44. He urged that "An all-out effort to educate, to legislate on gender and family issues is the one continental struggle that should destroy the shackles of these harmful traditional practices". He proposed that various stakeholders be involved, for example, chiefs and opinion leaders, in the fight against harmful traditional practices. He further urged that re-setting of the African mind-set to the right to total health for all its children, especially female children, is a pre-requisite to Africa's salvation, development and survival.

45. Finally, he suggested that a holistic approach in operational research, as well as encouraging inter-ministerial, inter-sectoral collaboration in the elimination of harmful traditional practices, be adopted.

46. In the discussion that followed, participants commended the presenter and underscored the need for eradicating harmful practices in the context of the Continental Policy Framework for Sexual and Reproductive Health and Rights as well as the Plan of Action being considered at that time.

VI. CONSIDERATION OF THE ACTION PLAN FOR THE OPERATIONALISATION OF THE CONTINENTAL POLICY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

47. This topic was presented to the Ministers of Health by H.E. Bience Gawanas, Commissioner for Social Affairs at the African Union. She provided the background to the Plan of Action noting that it was meant to operationalize the Continental Policy Framework on Sexual and Reproductive Health and Rights adopted in Gaborone, Botswana and endorsed by Heads of States in Khartoum in January 2006.

48. She observed that the Plan was premised on SRH in its fullest context as defined at ICPD/PoA 1994 taking into account the life cycle approach. These elements of SRHR includes Adolescent Sexual and Reproductive Health (ASRH); Safe Motherhood and Newborn care; Abortion Care; Family Planning; Prevention and Management of Sexually Transmitted Infections including STI/HIV/AIDS; Prevention and Management of Infertility; Prevention and Management of Cancers of the Reproductive System; Addressing Mid-Life Concerns of Boys, Girls, Men and Women; Health and Development; the Reduction of Gender-based Violence; Interpersonal Communication and Counseling; and Health Education.

49. The Commissioner also observed that the Plan is specifically broad and flexible to allow for adaptation at the country level. It provides a core set of actions, but neither limits countries nor requires those that already have strategies to start afresh. Rather it

encourages all countries to review their plans against this action plan to identify gaps and areas for improvement.

50. She then summarized the rationale, key operational strategies and cost implications noting specifically that a total cost of US16 billion is required for the 4-year period ending in 2010.

51. With respect to the target population, the Commissioner indicated that since Reproductive Health encompasses the whole life span of an individual from conception to old age, as such SRH services shall be provided to all who need them. Emphasis will be on men and women of reproductive age, newborns, young people, rural, mobile, and cross-border populations, displaced persons and other marginalized groups. She then highlighted the main strategic action and indicators contained in the plan as presented in the matrix.

52. During the discussions following her presentation, delegates pointed out the need to include impact indicators and that poverty reduction should be incorporated in the introductory part. Issues of equity, community involvement, culture and religion as they affect reproductive health were also raised. There were also proposals on the inclusion of males and the involvement of health ministries in conflict resolution. A number of important comments were made regarding the outputs, strategic actions and indicators in the Plan. These included blood safety considerations, abstinence promotion, need to commemorate a safe motherhood and young people's day, provision of integrated VCT services and establishment of RHCS committees at national and regional levels.

53. The Maputo Plan of Action on the Operationalization of the Continental Sexual and Reproductive Health and Rights Policy Framework was then adopted with these amendments.

VII. PANEL DISCUSSION ON YOUNG WOMEN AND GIRLS' HIGHER VULNERABILITY TO HIV/AIDS

54. The Panel Discussion on Young Women and Girls' Higher Vulnerability to HIV/AIDS was chaired by Professor Sheila Tlou, Minister of Health of Botswana and Chair of the Bureau of the AU Conference of Ministers of Health. In her introduction she emphasized the concern around young women and their vulnerability. She then called upon the panelists to make their presentations.

55. Dr Aida Libombo, the Deputy Minister of Health of Mozambique, spoke on the Feminization of HIV/AIDS with a focus on Mozambique. She pointed out that young women, aged 15-24, were 2-5 times more likely to be infected by HIV. Responsible factors include poverty and low socio-economic status of women, lack of information, low education, early marriage and social norms around extramarital sex, inability to negotiate, commercial sex, STI susceptibility, domestic and sexual violence and displaced or refugee status. The recommendations she put forward to address girls' higher vulnerability include a comprehensive poverty reduction strategy, especially for vulnerable groups, streamlining of gender policies, increased access to education and other opportunities, advocacy, involvement of men, intensifying IEC and VCT, peer education, implementation of youth focused interventions, PMTCT, Integration of

HIV/AIDS within national health systems and incorporation of research into AIDS strategies.

56. Commissioner Angela Melo, Special Rapporteur on the Rights of Women, informed the Conference of Ministers that the Protocol of Human Rights and Women's Rights has now been ratified by 21 countries. Countries should then adopt them into their law and promote the rights in the protocol. SRHR is a right of women and should be delivered and women should have the rights to choose and not to be discriminated against. A change of mind is needed to achieve implementation of the plan of action. She reminded delegates of key elements of the Cairo Declaration of 1994 of International Conference on Population and Development and the need to implement its commitments. Countries need to adopt the framework policy, including legislation and develop priority programmes.

57. Ms. Diakhoumba Gassama of the AU Women Gender and Development Directorate made a presentation on Ending Young Women and Girls' Higher Vulnerability to HIV/AIDS infection in Africa: An AU Continental Campaign. She thanked the government of Mozambique and her colleagues from the Department of Social Affairs for providing her with the opportunity to address the AU Conference of Ministers of Health. She then explained that her Department was focusing on young women and girls because HIV infection rates among them are up to six times higher than their male peers due to early sexual debut and relationships with older men, namely cross-generational sex. She described how, starting with an Expert Consultation that was held in July in Addis Ababa, the Gender Directorate has been engaged in a process whereby the AU and its partners, which includes Population Services International, will build a social movement across Africa to address the issue at stake. She informed the meeting that plans were underway to launch the Campaign before the end of the year. In her brief she summarized presentations by John Berman from PSI and Adv. Joy Ngozi Eizelo from WACOL, who were unable to attend the Meeting. Their contributions dealt with understanding the higher vulnerability of young women and girls and interventions to stop cross-generational sex and sexual and gender-based violence.

58. She further noted that the Special Session in Maputo was considered not only as an opportunity to brief the Ministers on the continental advocacy initiative but also a great occasion to explore the interconnectedness between the issue of universal access to comprehensive sexual and reproductive health services and the issue of young women and girls' higher vulnerability to HIV/AIDS infection in Africa. She concluded by emphasizing that the Continental Policy Framework, its Plan of Action and the Protocol on the Rights of Women in Africa call on the Ministers of Health, experts and other delegates to assist in the integration process and contribute urgently, effectively and a timely manner to both the acceleration in the fight against HIV/AIDS and the realization of universal access to SRHR services for young women and girls.

59. In the discussion that followed, the following key points were raised:

- Cross-generational sex is a serious problem and should be taken seriously;
- There was a call for UN Body on Young Women and for support of the AU Continental Campaign for Young Women and Girls' Higher Vulnerability to HIV/AIDS;
- Victims of early marriages need psychological and material assistance;

- Abuse is strongly driven by ignorance and poverty. Interventions should therefore address poverty;
- The need to revisit traditional practices that reduce young women's and girls' vulnerability was reiterated;
- Examples should be provided of successful alternative steps for girls wishing to advance;
- The importance of operational research was underscored;
- Following awareness-raising, young women in some countries have gained confidence in negotiating for condom use;
- There is a need to address other challenges facing young educated women from standard family environments.

IX BRIEFING ON HPAI BAMAKO CONFERENCE, 28 NOV-1 DEC 2006

60. Given that this is a very important Conference which would welcome the participation of Ministers of Health, the AUC took the opportunity provided by the Special Session to brief the Ministers. The Representative of the AU-IBAR office based in Nairobi, Kenya provided the briefing. He described the Influenza A H5N1 sub-type that causes the disease in humans. He indicated that Africa was highly vulnerable to Avian Influenza. Five countries in Africa had already reported cases of Avian Influenza before the Asian epidemic, but these were of different strains. Eight African countries, including Egypt and Nigeria, have been affected by 1401 outbreaks in 2006 as of the end of August 2006. There have been 15 human cases and 6 deaths. The great risk is for a genetic mutation that can result in human-to-human transmission. He outlined the related implications if this possibility were to occur.

61. There are clinical features in birds that can lead one to suspect presence of the Avian Influenza virus. Epidemiological surveillance is an essential component of a range of control measures, including the development of a vaccine.

62. A conference on Avian Influenza is scheduled for Bamako, Mali from 6-8 December 2006 to be organised by the AU Commission. A preparatory conference prepared through international collaboration, developed a global action plan and strategy. The African action plan is based on epidemiologic principles**.** It is a 3-year action plan, covering national, regional and international interventions and 3 sectors of intervention include animal health, human health and communication and co-ordination. The key objective of the December conference is to translate decisions into action. The AU has launched a website www.avianinluenzaconference4.org

63. In the comments that followed it was proposed that Africa needs to develop a consolidated plan and send out clear messages. Support for careful planning and preparation for Africa was expressed. An offer was made to share the SADC plan with all delegates. Concern was expressed about the weak communication on Avian Influenza. The question was asked as to how countries would be able to access Tamiflu, if needed.

VII. ANY OTHER BUSINESS

(a) Messages of Support by Development Partners

(i) Dr. Francisco Songane, Director of Partnerships for Maternal, Newborn and Child Health

64. In his remarks Dr. Songane thanked the A U Commission for inviting the PMNCH to the meeting and congratulated the Commission and the Ministers for coming up with a very good document. He suggested some prioritization of the activities in the Plan of Action and the conciliation of this plan with the 2 existing frameworks, namely the Road Map for Maternal and Newborn Health and the Africa Framework for Child Survival. He also noted that the discussion on abortion was inconclusive and alerted to the fact that the health workers are facing double burden of responding to the demand for services and managing the administrative and legal consequences when they arise. He cautioned that in some instances health workers do get requests from those in authority to perform procedures like abortion when ordinary citizens do not openly have access to such services. He therefore called for re-examination of existing policies in African countries.

(ii) Mrs. Joy Phumaphi, WHO Assistant Director General

65. The WHO Assistant Director General thanked the AU for its leadership in organizing the Special Session. She explained that the role of development partners is to provide tools for operationalization of commitments under the guidance of politicians. She pointed out that the UN had started the process of harmonization of programmes of its various Agencies, and advised that the World Bank and Civil Society Organizations should do like-wise under that umbrella. She concluded by reiterating the need to discuss how to provide coordinated support.

(iii) Ms fama Ba, Africa Director, UNFPA

66. The UNFPA Representative commended Member States for adopting the Action Plan for the Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR), and the AU for spearheading the related process. This should immediately be followed by implementation as it affects the lives of people. She reiterated the commitment of UNFPA to work with other Development Partners and to harmonize and coordinate their support. She noted the link between HIV/AIDS and SRHR and reiterated that the UNFPA would work with Development Partners to support integration.

(iv) Mr. Tewodros Melesse, IPPF Regional Director for Africa

67. The IPPF Regional Director for Africa commended the AU for spearheading the organization of the Special Session, with the collaboration of Development Partners. He thanked other partners, including the Hewlett Foundation, for their support. He recalled that this was a culmination of activities that had been undertaken for over one year. He indicated that multiple institutions and projects were diluting national efforts, and called for harmonization. He concluded by pledging that IPPF would respect national efforts.

(v) **Dr. Khama Rogo, Representative of the World Bank, on behalf of Development Partners**

68. The Representative of World Bank expressed his appreciation to the Organizers of the Special Session on behalf of the Development Partners. He advised that the finalization of the Action Plan consider: the demand side of SRHR; the tripartite stakeholders (public, private and community); as well as the multisectorality of SRHR and not just the Ministry of Health. For the way forward, he underlined the urgency for action to meet the MDGs, resource mobilization, and accountability for results as people are dying due to negligence by demoralized health workers. Better coordination, mobilization and integration should cease to be just rhetoric, particularly since they do not require a lot of resources. The disbursement of funds should also be speeded up. He finally reiterated the support of the World Bank.

(b) **REMARKS BY MEMBER STATES**

(i) **Hon. Minister of Health of Liberia**

69. After thanking the AU for organizing the Conference, the Minster of Health of Liberia recommended that SRHR be discussed at national levels, involving other Ministries and Parliament. This is because this issue is both political and cultural. He called for another Special Session involving local government and to carry the issue to the highest level.

(ii) **Hon. Minister of Health of Mauritius**

70. The Minister of Health of Mauritius seconded the proposal put forward by his colleague from Liberia, and stressed the parental responsibility of both parents, starting before the birth of offspring. He called for condemnation of traditional malpractices, an issue that is neglected in favour of retaining political power. He concluded by asking participants to say no to malpractices and to promote good practices.

(iii) **Hon. Minister of Health of South Africa**

71. The Minister of Health of South Africa focused her remarks on the Conference of the International Diabetic Federation, which will be held in South Africa, 3 – 7 December 2006. She explained that the mission of the Federation is to prevent Diabetes Mellitus, a silent but common killer. She indicated that a Special Session would be devoted to Africa. Participants would share information and contribute to the Declaration. She invited Member States to participate.

(iv) **Hon. Minister of Health of Lesotho**

72. The Minister of Health of Lesotho spoke on behalf of SADC Health Ministers who met recently to discuss the status of extreme multi-drug resistant TB (ERTB) in the region. They had shared experiences and challenges of ERTB, which exists in South Africa and most probably in other SADC countries. The main challenges include: no new TB drugs have been developed during recent decades; resistance to 1st and 2nd line drugs may entail use of old drugs with more side effects; this is a cross-border issue that should be addressed. The Minister recommended better surveillance, improved infection

control, sharing of experience and information, working with pharmaceutical companies to develop new drugs, mandating TB experts to meet urgently before the end of the year; and Member States to ensure they attend the TB WHO Meeting.

(c) BRIEFING ON THE 3RD SESSION OF THE AFRICAN UNION CONFERENCE OF MINISTERS OF HEALTH BY AU COMMISSIONER FOR SOCIAL AFFAIRS

73. The AU Commissioner for Social Affairs recalled the decision by Health Ministers in 2005 that the 2007 Session should focus on the theme: "***Strengthening of Health Systems for Equity and Development***". She announced that the Session would be held in South Africa, 9 – 13 April 2007, before the World Health Assembly. Among others, issues for discussion would include an African Health Development Plan, the question of access to health services including social protection, neglected and emerging health issues such as non-communicable diseases and communicable diseases such as polio, malaria. In this regard, the Bureau of Health Ministers Conference and other Member States would be called upon to contribute.

74. The Commissioner apologized for the inability to Launch the State of African Population Report 2006 as had been planned. This was because translation into all AU languages was not ready.

X. PRESENTATION OF THE REPORT OF THE EXPERTS MEETING

75. This item was presented by Mrs K. Mompati from Botswana who chaired the Experts Meeting. She summarized the proceedings systematically starting from the opening ceremony, procedural issues, papers presented, panel discussion and the process in which the Plan of Action was considered was and recommended to the Ministers for consideration and to be taken note of.

XI. CLOSING

76. The Closing Ceremony was presided over by the Hon. Dr. Wilfred Machape, Deputy Minister of Health of Kenya and 1st Vice Chairperson of the AU Conference of Ministers of Health. After calling the Closing Session to order, he invited the Speakers to deliver their remarks.

Closing Remarks by the Hon. Minister of Health of Mozambique,
Hon. Dr. Paulo Ivo Garrido

77. The Hon. Minister of Health of Mozambique commended his fellow Ministers for the decision they adopted in October 2005 to hold the Special Session on Access to Sexual and Reproductive Health Services. He thanked all delegates who had traveled to Maputo for the Special Session and for their contributions in making it a success. He concluded his remarks by thanking everybody for the honour bestowed on Mozambique by accepting its offer to host the Special Session and for their attendance and active participation.

Closing Remarks by the Chairperson of the AU Conference of Ministers of Health, Prof. Sheila Tlou, Minister of Health of Botswana

78. After commending the Ministers for a productive meeting, Hon. Minister Tlou recalled that the process to hold the Special Session had been initiated in Gaborone, Botswana, October 2005 during the 2nd Session of the AU Conference of Ministers of Health. She explained that the objective of the Action Plan that had been adopted was to guide and assist Member States to improve sexual and reproductive health and rights (SRHR) of their respective communities. She pointed out that abortion should not be a family planning method. Furthermore Prof, Tlou observed that countries need a carefully planned legislative instrument to promote the right of women to health. She concluded her remarks by calling on Member States to ensure that, by the time the next Session of the AU Conference of Ministers of Health is convened (South Africa, April 2006), visible action improvement of SRHR should have been realized.

Vote of Thanks by Hon, Minister of Health of the Saharawi Arab Republic, and Rapporteur of the AU Conference of Ministers of Health.

79. On behalf of fellow Ministers, the Hon. Minister of the Saharawi Arab Republic expressed his gratitude to Mozambique for hosting the Special Session and for the hospitality extended to the delegates. He recalled that the participants had worked hard for five days in excellent conditions to come out with the recommendations included in the Action Plan. He thanked the Secretariat, interpreters and support staff for their input. He then commended the Government of Mozambique for its contribution to the fight against apartheid and its leadership in the promotion of development in Africa. Finally, he thanked the President, Prime Minister and Minister of Health of Mozambique for excellently hosting the Special Session.

80. Following the Vote of Thanks, the Hon. Deputy Minister of Health of Kenya declared the Special Session on SRHR closed.

EX.CL/316 (X)
Annex II

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

AFRICAN UNION
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SPECIAL SESSION THE AFRICAN UNION
CONFERENCE OF MINISTERS OF HEALTH
MAPUTO, MOZAMBIQUE
18–22 SEPTEMBER 2006

Sp/MIN/CAMH/5(I)

Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

RATIONALE

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

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

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

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

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

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

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

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

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

OVERARCHING GOAL

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

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

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

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

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

iv. Addressing unsafe abortion;

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

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

18. The strategy includes the crosscutting issues to:

i. Increase domestic resources for sexual and reproductive health and rights including the addressing of the human resource crisis;
ii. Include males as an essential partner of SRHR programmes;

iii. Adopt a multisectoral approach to SRHR;

iv. Foster community involvement and participation;

v. Strengthen SRH commodity security with emphasis on family planning and emergency obstetric care and referral;

vi. Put in place operational research for evidence based action and effective monitoring tools to track progress made on the implementation of this Plan of Action;

vii. Integration of nutrition in STI/HIV/AIDS, and SRHR especially for pregnant women, and children by incorporating nutrition in the school curriculum and fortification of food institutionalisation.

viii. Involvement of families and communities;

ix. Involvement of the Ministries of Health in conflict resolution;

x. Rural-urban service delivery equity.

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

PRIORITY TARGET GROUPS

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

EXPECTED OUTCOME

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

COSTING THE PLAN OF ACTION

22. Preliminary cost estimates have been made for the direct service delivery costs required to make progressive advancement to universal access to reproductive health services by 2015 (including family planning, safe motherhood including emergency obstetric care, newborn health and sexually transmitted infection interventions). The resource needs for STI/HIV/AIDS prevention efforts related to sexual and reproductive health were also calculated. These totals were then adjusted to address human resource issues and to strengthen the health system (See Annex 1). The resulting total resource requirements amount to $28 billion over the period 2007-2010. More than half of this total is devoted to investments in the health system that support direct service provision. This PoA will mainly be financed through domestic resources. The resource needs for STI/HIV/AIDS prevention efforts related to sexual and reproductive health were also calculated. The resulting total SRH and HIV prevention resource requirements amount to $28 billion over the period 2007-2010. More than half of this total is devoted to investments in the health system that support direct service provision. This PoA will mainly be financed through domestic resources.

23. What is most important is that cost estimates of national plans be undertaken that include detailed definitions of interventions appropriate to meeting national needs for sexual and reproductive health and that investments reflect and improve national capacity for their implementation and monitoring. The principles of the current analysis, however, should be adhered to in national costing exercises (See Annex). The current estimates are indicative of the scale of the required effort and should mobilize an appropriate response by governments, donors, civil society and the private sector.

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

Outputs	Strategic actions	Indicators for monitoring progress
1. HIV, STI, Malaria and SRH services integrated into primary health care		
1.1 Advocacy/policy	1.1.1 Integrate SRHR, HIV/AIDS/STI and malaria in key national health policy documents and plans	1.1.1 # Countries with integrated SRHR/HIV/AIDS/STI and Malaria policy documents and national plans
	1.1.2 Develop policies and legal frameworks for STI/HIV/AIDS prevention to support the provision of appropriate and comprehensive HIV/AIDS/STI and malaria prevention, care and treatment options for all including pregnant women, mothers, infants, families and PLWHA	1.1.2 # Countries with 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
	1.1.3 Develop and/or implement strategies to address Gender Based Violence (GBV) in collaboration with other relevant stakeholders	1.1.3a # Countries with strategies dealing with GBV developed and implemented. 1.1.3b Laws dealing with GBV in place
	1.1.4 Conduct Research and Develop and/or implement strategies to address early marriages and harmful traditional practices (HTP) such as Female Genital Mutilation (FGM)	1.1.4a # Countries with programmes to address HTP 1.1.4b # Countries conducting with research reports on HTP and FGM
	1.1.5 Incorporate health management of GBV in the training curricula of health workers and providers of legal services.	1.1.5 # Countries with curricula for health workers and legal service providers that incorporate health related components of GBV
	1.1.6 Develop policies to ensure access to condoms especially among PLWHA	1.1.6 # Countries with policies that ensure access to condoms especially for PLWHA
	1.1.7 Develop policies that promote involvement of civil society and private sector in SRHR service delivery within national programmes	1.1.7 # Countries with policies on public private partnership on SRHR developed and implemented

Outputs	Strategic actions	Indicators for monitoring progress
	1.1.8 Advocate for multi-sectoral effort to create a supportive environment for promotion of national SRHR policies and programmes	1.1.8 # Countries with multi-sectoral plans supporting SRHR
1.2 Capacity building	1.2.1 Conduct comprehensive assessments of health care delivery systems to assess management, infrastructure and resource needs for effective integration of STI/HIV/AIDS into SRHR services	1.2.1 # SDPs providing integrated STI/HIV/AIDS and SRHR services
	Review training curricula for service providers to incorporate integration of SRH with STI/HIV/AIDS and nutrition.	1.2.2 # Training institutions integrating STI/HIV/AIDS and nutrition with SRHR in their curricula
	1.2.3 Provide pre- and in-service training for health service providers in the provision of integrated SRHR STI/HIV/AIDS and malaria services	1.2.3 # Providers trained in integrated STI/HIV/AIDS, malaria and SRHR
	1.2.4 Refurbish structures and reorganise service provision to ensure effective provision of integrated services	1.2.4 # SDPs providing integrated services
	1.2.5 Develop a Human Resource plan for training various cadres for local consumption, distribution, utilisation, and retention of health workers at all levels	1.2.5b Proportion of health workers per population
1.3 Services	1.3.1a Ensure access to routine HIV counselling and testing in STI, family planning and maternal and newborn and reproductive cancer services	1.3.1 % Service Delivery Points (SDPs) offering routine HIV counselling and testing in STI, family planning and maternal and newborn and reproductive cancer services
	1.3.2 Integrate comprehensive HIV/STI prevention, management and treatment with SRHR, including dual protection	1.3.2 % SDPs offering integrated comprehensive HIV prevention, management and treatment
	1.3.3 Ensure access to services that address gender-based violence including management of sexual abuse, emergency contraception and HIV post-exposure prophylaxis and STI treatment in an integrated and co-ordinated manner	1.3.3 % SDPs offering STI, PEP and EC services for GBV victims
	1.3.4 Ensure integration of services for prevention and management of infertility	1.3.4 Prevalence of childlessness

Outputs	Strategic actions	Indicators for monitoring progress
	1.3.5 Provide appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services	1.3.5 Availability of appropriate information on the provision of integrated STI/HIV/AIDS and SRHR services
	1.3.6 Provide services for the SRH needs of all persons including vulnerable groups and mobile populations especially migrant women, IDPs and those in conflict situations	1.3.6 Coverage for SRH services by target group
	1.3.7 Develop and implement programmes that ensure partnership with support from and inclusion of men in SRHR services.	1.3.7 % Men with favourable attitude to SRHR (FP, assisted delivery)
	1.3.8 Provide screening and management services for cancers of the reproductive system	1.3.8 Proportion of SDPs offering screening and management services for cancers of the Reproductive system for both men and women
	1.3.9 Provide services for the management of mid-life concerns of both men and women, menopause and andropause	1.3.9 Proportion of SDPs offering services for mid-life concerns of both men and women
	1.3.10 Integrate nutrition education and food supplementation programmes with SRHR and HIV/AIDS/STI services and training	1.3.10a Prevalence of underweight by age group 1.3.10b Prevalence of anaemia in pregnancy
	1.3.11 Develop and implement strategies for ensuring blood safety	1.3.11 # SDPs with blood screening facilities
2. Strengthened community-based STI/HIV/AIDS/STI and SRHR services		
	2.1.1 Build capacity of community structures and referral networks to provide a continuum of STI/HIV/AIDS services within SRHR SDPs	2.1.1 Sexual and Reproductive Health coverage statistics

Outputs	Strategic actions	Indicators for monitoring progress
	2.1.2 Build capacity of all categories of SRHR service providers (including nurses, traditional birth attendants [TBAs], community-based distributors [CBDs], etc.) to facilitate effective integration of STI/HIV/AIDS into SRHR service delivery	2.1.2 # Countries with integrated STI/HIV/AIDS into SRHR service delivery
	2.1.3 Build capacity and empower communities to effectively partner with SRHR/STI/HIV/AIDS SDPs for enhanced community-based responses	2.1.3 # SDPs with community partnerships
	2.1.4 Develop and implement behaviour change communication strategy for community mobilisation and education on health promotion and utilisation of integrated SRH with STI/HIV/AIDS, malaria and nutrition.	2.1.4i # countries with comprehensive BCC strategy 2.1.4ii Knowledge for integration of SRH with STI/HIV/AIDS, malaria and nutrition. Services
3. Family planning repositioned as key strategy for attainment of MDGs		
3.1 Advocacy/ policy	3.1.1 Mobilise political will and leadership for provision of quality family planning services	3.1.1 Proportion of SRH budget allocated to family planning
	2.1.2 Develop and/or implement gender and culture sensitive policies/legislation to ensure universal access to quality FP services	3.1.2 Supportive legislation, protocols and guidelines for family planning
3.2 Capacity building	3.2.1 Develop or implement structures and systems for increasing access to FP	3.2.1 # Countries with functional structures for FP service delivery
	3.2.2 Train health care providers for the delivery of a comprehensive range of FP services	3.2.2 Proportion of health workers trained in FP
3.3 Service delivery	3.3.1 Develop gender and culture appropriate information to enhance FP knowledge in the target populations	3.3.1 Knowledge levels for FP for both men and women

Outputs	Strategic actions	Indicators for monitoring progress
	3.3.2 Develop systems to increase coverage for FP services, including community based distribution and alternative models of service delivery	3.3.2 Proportion of SDPs offering range of FP services
	2.3.3 Integrate and provide FP as a component of Maternal, New born and Child Health service package	2.3.3a CPR 2.3.3b Couple Year Protection (CYP) 2.3.3c Unmet need for FP 2.3.3d % Clients accessing FP through community based mechanisms and alternative models
4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing		
4.1 Advocacy/ policy	4.1.1 Strengthen implementation and/or advocacy for policies that support the provision of SRHR services addressing the needs of young people	4.1.1 # Countries that have developed policies to support SRH services for young people
	4.1.2 Cerebrate a day for the SRHR Services for young people	4.1.2 # Countries cerebrating day of SRHR Services for young people
4.2 Capacity building	4.2.1 Develop and implement information and communication strategies that support both abstinence and condom use as effective strategies to prevent HIV/AIDS/STI and unplanned pregnancies and link information to service delivery	4.2.1 # Countries with IEC/BCC strategies that promote abstinence and condom use
	4.2.2 Build capacity of SDPs and all levels of service providers to provide a comprehensive, gender sensitive package of care for young people	4.2.2 # Countries with youth-friendly health services within their training curricula
	4.2.3 Develop and implement IEC strategies for parents and educators to communicate to young people.	4.2.3 # Countries with IEC strategies for parent education for young people.
4.3 Service delivery	4.3.1 Assess and establish/ strengthen youth-friendly services at SDPs	4.3.1a # Youth-friendly SDPs per population 4.3.1b % Young people with knowledge about both abstinence and condom use

Outputs	Strategic actions	Indicators for monitoring progress
	4.3.2 Integrate provision of youth friendly services including promotion of abstinence and dual protection methods within existing services	4.3.2a % Condom use among young people 4.3.2bTeenage pregnancy rate
5. Incidence of unsafe abortion reduced		
5.1 Advocacy/policy	5.1.1 Compile and disseminate data on the magnitude and consequences of unsafe abortion,	5.1.1 # Countries with status report on the magnitude and consequences of unsafe abortion.
	5.1.2 Enact policies and legal frameworks to reduce incidence of unsafe abortion	5.1.2 # Countries with legislative/policy framework on abortion.
	5.1.3 Prepare and implement national plans of action to reduce incidence of unwanted pregnancies and unsafe abortion	5.1.3 # Countries with action plans to reduce unwanted pregnancies and unsafe abortion
5.2 Capacity building	5.2.1 Train service providers in the provision of comprehensive safe abortion care services where national law allows	5.2.1 # Service providers trained in safe abortion care
	5.2.2 Refurbish and equip facilities for provision of comprehensive abortion care services	5.2.2 Proportion of SDPs providing PAC services
5.3 Service delivery	5.3.1 Provide safe abortion services to the fullest extent of the law	5.3.1a # Facilities providing safe abortion care 5.3.1b Abortion related MMR
	5.3.2 Educate communities on available safe abortion services as allowed by national laws	5.3.2 # Countries with community awareness programmes on abortion issues.
	5.3.3 Train health providers in prevention and management of unsafe abortion	5.3.3 # Countries with critical mass of trained providers in place
6. Access to quality Safe Motherhood and child survival services increased		

Outputs	Strategic actions	Indicators for monitoring progress
6.1 Advocacy	6.1.1 Develop and/or roll out the Road Map for the reduction of maternal and newborn morbidity and mortality	6.1.1 # Countries that have developed Roadmaps for the reduction of maternal and newborn morbidity and mortality
	6.1.2 Observe a Safe Motherhood Day	6.1.2 # Countries that commemorate safe motherhood days
	6.1.3 Intensify maternal and neonatal tetanus vaccination campaigns	6.1.3 # Pregnant women and children vaccinated
6.2 Capacity Building	6.2.1 Develop and implement national strategies for rapid production, deployment and retention of midwives, including harmonisation and accreditation of curriculum at regional level	6.2.1a # Midwives per population 6.2.1b Coverage for supervised delivery
	6.2.2 Incorporate Emergency Obstetric Care in pre-service training of health care providers	6.2.2 # Countries that have pre-service curricula incorporating EmOC for all appropriate cadres
	6.2.3 Develop systems for rapid transport for women with obstetric and gynaecological complications including strengthening the referral system	6.2.3 # Countries with functional referral system from community to health facility
	6.2.4 Strengthen the production of mid-level staff production	6.2.4 # Mid level staff per population
	6.2.5 South-South Staff exchange	6.2.5. # Countries exchanging staff
6.3 Services	6.3.1 Scale up safe motherhood services through the implementation of the Road Map for the reduction of maternal and newborn morbidity and mortality	6.3.1a Maternal Mortality Ration (MMR) 6.3.1b Peri-natal mortality rate 6.3.1c # Facilities per 500,000 population providing basic and comprehensive EmOC
	6.3.2 Scale up neonatal care services including the creation of neonatal resuscitation care in maternity units	6.3.2 Neonatal mortality rate

Outputs	Strategic actions	Indicators for monitoring progress
	6.3.3 Increase coverage of child survival services (expanded programme for immunization [EPI], oral rehydration solutions [ORS]), early initiation of breast feeding, and other appropriate nutritional intervention, 1st week consultations	6.3.3a Immunization coverage at one year 6.3.3b Prevalence of under-weight children
	6.3.4 Adopt integrated management of childhood illnesses (IMCI)	6.3.4a Availability of IMCI protocols 6.3.4b IMR 6.3.4c U-5 mortality
	6.3.5 Develop a mechanism for provision of adequate safe blood supply	6.3.5 Proportion of EmOC sites with access to adequate supply of safe blood.
	6. 3.6 Integrate STI/HIV/AIDS, malaria and nutrition services into obstetric care	6.3.6a Prevalence of newborn HIV infections 6.3.6b Proportion of malaria cases managed with 24 hours.
7. Resources for SRHR increased		
7.1 Advocacy/poly	7.1.1 Implement the Abuja Heads of State Declaration on national budgetary allocation for health to at least 15% of the total national budget, with an appropriate proportion of that for SRHR	7.1.1 # Countries with 15% of budget allocated to health 7.1.1b Proportion of health budget allocated for SRHR
	7.1.2 Advocate for prioritisation of SRHR in national poverty reduction strategy papers (PRSPs) and other national development plans	7.1.2a # Countries with SRHR in their national PRSP or development plans 7.1.2b % National health budgets allocated to SRHR
	7.1.3 Advocate for increased support to SRHR programmes from donors and development partners	7.1.3 % Total SRHR budget, mobilized from donors/development partners.
7.2 Capacity building	7.2.1 Develop partnerships with local & international institutions, private sector and civil society organizations (CSO/) for technical and financial support, and for advancing the implementation of the Plan of Action.	7.2.1 # Partnerships formed with each sector.
	7.1.2 Institutionalise National Health Accounts (NHA)	7.1.2 # Countries with updated NHAs
	7.1.3 Develop and implement human resource strategy to orient and train, deploy and retain health system workers	7.1.3 Cadre of staff per 100,000 population

Outputs	Strategic actions	Indicators for monitoring progress
8. SRH commodity security strategies for all SRH components achieved		
8.1 Advocacy	8.1.1 Develop national/regional strategies and action plans for forecasting, procurement and distribution of RH commodities	8.1.1 # Countries with plans for RHCS
	8.1.2 Establish a national and/or regional RHCS committee	8.1.2 # Countries/regions with national/regional RHCS committees
	8.1.3 Develop national and where appropriate regional RHCS strategy and action plans	8.1.3 Regional/national RH commodity security strategy and action plan(s) in place
	8.1.4 Revise essential medicines lists to include reproductive health commodities	8.1.4 # Countries with RH commodities in essential medicines list
	8.1.5 Establish a budget line for SRH commodities	8.1.5a % Health budget allocated to RH commodities 8.1.5b # Countries with a national budget line for SRH commodity security
8.2 *Capacity building*	8.2.1 Develop and implement logistics management system (LMS) for RHCS	8.2.1 # Countries maintaining and regularly updating statistics on commodities' stocks and flows
	8.2.2 Train relevant staff in LMS for RHCS	8.2.2 # Countries experiencing stockout
	8.2.3 Establish effective commodity management system for the full range of commodities	8.2.3 # Countries with commodity management systems in place
	8.2.4 Develop capacity for bulk purchasing through pooling of purchase orders at national and regional levels	8.2.4 # Countries with integrated systems of bulk purchasing and supply
	8.2.5 Provide training in commodity management	8.2.5 # Persons trained in management logistic systems
9. Monitoring, evaluation and coordination mechanism for the Plan of Action established		

Outputs	Strategic actions	Indicators for monitoring progress
9.1 Advocacy/policy	9.1.1 Advocate for allocation of national resources for conducting regular censuses, DHS, and annual maternal death reviews	9.1.1 # Countries that regularly conduct censuses, DHS & annual maternal death reviews
9.2 Capacity building	9.2.1 Establish a continental monitoring and tracking system to aggregate, analyse and disseminate data received from the national level	9.2.1 Continental mechanism and database for monitoring the POA in place
9.3 Data collection and utilization	9.3.1 Institutionalise M&E at the public administration and NGOs levels and allocate adequate human and financial resources to support it.	9.3.1 # Countries with institutionalised M&E systems.
	9.3.2 Collect, analyse and disseminate minimum national level information required for a continental database	9.3.2 # Countries that make timely submission of information to the continental database
	9.3.3 Support operational research for evidence based action	9.3.3 # Countries utilizing operational research in their planning.
	9. 3.4 Collaborate with UN and donor agencies in harmonizing data collection systems to ensure consistency	9.3.4 Harmonized data collection system in place
	9.3.5 Put in place coordination mechanisms to monitor and evaluate the efficient allocation of resources and implementation of laws	9.3.5 # Countries able to monitor & evaluate allocation of resources and implementation of laws
	9.3.6 Institutionalise exchange and sharing of best practices including south-south technical exchanges	9.3.6a # Institutions in formal strategic partnerships for technical exchange 9.3.6b Best practice web platform established and maintained
	9.3.7 Develop and/or implement coordination and supervisory structure and mechanism for implementation of SRHR at regional and national levels.	9.3.7a # Countries with functional coordination structure and mechanism established 9.3.7b Regional coordination structure and mechanism established.

ROLE OF STAKEHOLDERS

(a) The African Union

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

(b) Regional Economic Communities

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

(c) Member States

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

(d) Partners

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

CONCLUSION

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

Annex: 1

METHODOLOGY AND RESULTS OF COSTING OF SRHR SERVICES

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

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

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

iv. SRH-related prevention interventions were estimated by specifying the share of the UNAIDS-identified prevention activities that relate to SRHR. For example, all condom distribution and STI management, substantial shares of youth-based and special population interventions and small shares of harm exposure and blood safety interventions (in the latter case, proxied by an

estimate of the proportion of transfusions needed for maternal hemorrhage) are included. These analyses, based on UNAIDS data, produce estimates for SRH-related prevention interventions increasing from $2.2 to $3.6 billion over the same period. Additional resources would be needed for the remaining proportions of prevention, treatment, care and support services.

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

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

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

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

ix. The resulting totals for SRH and STI/HIV/AIDS prevention correspond to per capita expenditures increasing from $6.03 to $8.14 (of the $34 per capita recognized by the AU as needed for health) during this period. In comparison, in 2005 expenditures for SRH are estimated at roughly $2 per capita. These are cost-estimates prepared by experts, based on the assumptions we have stated.

Annex Table 1:
Resource requirements for Reproductive, Maternal, Newborn Health Direct Service Delivery in Africa (2007-2010)
Medium Variant and Unmet Need Met Projection Scenarios, with and without System adjustments (millions $US)

	2007	2008	2009	2010	2007-2010
MEDIUM VARIANT					
Personnel costs					
Family Planning	29.2	31.5	33.8	36.2	130.6
ANC and normal delivery	281.5	308.2	335.1	362.0	1,286.7
Added maternal/newborn*	156.0	178.1	198.5	217.8	750.5
STI	55.4	61.9	68.5	75.2	261.1
Total Personnel	**522.2**	**579.7**	**635.9**	**691.2**	**2,429.0**
Drug/supply costs					
Family Planning**	85.5	92.3	99.3	106.5	383.6
ANC and normal delivery	360.6	381.3	402.0	422.5	1,566.4
Added maternal/newborn*	216.7	252.3	286.2	319.2	1,074.4
STI	23.6	26.3	29.1	32.0	111.0
Total Drugs/supplies	**686.3**	**752.2**	**816.6**	**880.2**	**3,135.4**
Grand total (w salary adj.)	**1,730.7**	**1,911.5**	**2,088.4**	**2,262.7**	**7,993.3**
GRAND TOTAL (w system costs)	**3,530.5**	**3,899.5**	**4,260.3**	**4,616.0**	**16,306.4**
UNMET NEED					
Personnel costs					
Family Planning	30.4	33.3	36.3	39.5	139.5
ANC and normal delivery	279.4	303.5	327.4	350.9	1,261.3
Added maternal/newborn	155.0	175.8	194.7	212.2	737.7
STI	55.4	61.9	68.5	75.2	261.1
Total Personnel	**520.2**	**574.6**	**627**	**677.8**	**2,399.6**
Drug/supply costs					
Family Planning	88.3	97.2	106.4	116.0	407.9
ANC and normal delivery	358.0	375.8	393.1	410.0	1,536.9
Added maternal/newborn	215.3	248.9	280.6	310.8	1,055.6
STI	23.6	26.3	29.1	32.0	111.0
Total Drugs/supplies	**685.1**	**748.2**	**809.2**	**868.8**	**3,111.4**
Grand total (w salary adj.)	1,725.6	1,897.4	2,063.2	2,224.4	7,910.7
GRAND TOTAL (w system costs)	**3,520.2**	**3,870.8**	**4,208.9**	**4,537.8**	**16,137.7**

*** Added maternal/newborn interventions include Emergency Obstetric Care, newborn health and additional maternal conditions.**
**** Additional condom costs for STI/HIV AIDS are not included**

2007

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African Union

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