Sexual and Reproductive Health and Rights

CONTINENTAL POLICY FRAMEWORK

AFRICAN UNION COMMISSION

• **ACKNOWLEDGEMENT** •

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
BCC	Behaviour Change Communication
CPR	Contraceptive Prevalence Rate
ECA	Economic Commission for Africa
FGM	Female Genital Mutilation
FWCW	Fourth World Conference on Women
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICPD/PoA	ICPD Programme of Action
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IPPF/ARO	IPPF Africa Regional Office
MCH	Mother and Child Health
MCT	Mother-to-Child Transmission
MDGs	Millennium Development Goals
MOH	Ministry of Health
NEPAD	New Partnership for Africa's Development
NGO	Non-Government Organization
OECD	Organization for Economic Cooperation and Development
ODA	Official Development Assistance
PLWHA	People Living With HIV/AIDS
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNAIDS	Joint UN Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

FOREWORD

This Sexual and Reproductive Health and Rights Continental Policy Framework was developed by in response to the call for the reduction of maternal and infant morbidity and mortality in the African continent. It was developed by the African Union Commission in collaboration with the United Nations Population Fund, the African Regional Office of the International Planned Parenthood Federation, and other development partners.

It started with the conducting of studies in the six Regions of the African Union and consideration of the issues that were identified at the review meetings at Expert and Ministerial levels in each of these Regions as the major factors contributing to the unnecessary deaths of women and children on the continent.

The Continental Policy Framework calls for mainstreaming of Sexual and Reproductive Health and Rights in primary health care so as to accelerate the achievement of health-related MDGs. It addresses the commonest causes of maternal and newborn child morbidity and mortality, and identifies 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 Policy Framework also calls for strengthening of the health sector component in Poverty Reduction Strategy Papers, and Sexual and Reproductive Health and Rights in particular; by implementing the Abuja recommendation of the 2001 Summit of Heads of State and Government to increase resources to health sector thereby improve access to services. By extension the Framework calls for mainstreaming gender issues in socio-economic development programmes, by facilitating improved women's health thereby increasing their participation in national economic development. It also calls for the development of SRH Commodity Security by including SRH commodities in the Essential Drug Lists and thereby ensures that women do not die needlessly because of lack of basic medicines.

The Continental Policy Framework on Sexual and Reproductive Health and Rights was adopted by the African Ministers of Health at the 2nd African Union Conference of Health Ministers held in Gaborone, Botswana in October 2005 and endorsed by the Summit of the African Heads of State and Government in Khartoum, Sudan in January 2006.

It is our sincere hope that the effective implementation of this Policy Framework at regional and national levels will greatly reduce the high rate of maternal and child mortality and ensure that there is a better life for all.

Adv BIENCE GAWANAS
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African Union

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The African Union Commission wishes to express its appreciation to the UNFPA, the IPPF Africa Regional Office and other development partners for their technical and financial assistance in the elaboration of this Framework. The AU Commission further wishes to acknowledge the support by UNFPA in the printing and publishing of this booklet containing the Framework which will assist greatly in its wider dissemination.

Member States have also played an important role in the process through their valuable contribution in the Regional Workshops conducted to collect information, which eventually culminated, into this framework. The African Union Commission therefore wishes to acknowledge and appreciate the role they played and for the effective collaboration in making the elaboration of this Framework possible.

1. Introduction

The International Conference on Population and Development (ICPD), held in Cairo in September 1994 represented a major shift in international thinking about the relationship between population and development. The document, which was agreed by 179 governments, set a number of objectives to be implemented by 2015.

The experiences gained since the 1974 Bucharest Conference had shown the necessity to move from the narrow confines of demographic targets through contraceptive services to the wider area of sexual and reproductive health and rights, taking into serious account issues such as human rights, gender equality and informed choice.

Although some progress has been made in implementing the ICPD/ Programme of Action (PoA) as documented at various meetings (Cairo Plus 5, held in 1999 and ICPD at Ten, held in 2004), many government and international organizations' officials doubt whether the majority of developing countries would be able to achieve the Cairo objectives by 2015.

A number of constrains prevent many countries, especially in Africa, from attaining the ICPD/PoA and MDGs. Shortage of funds both from national budgets and from donor countries, the absence of an enabling legislative environment, administrative rigidity which prevents integration of reproductive health services and the lack of human and technical resources- all contribute to the slow progress in achieving the internationally agreed objectives.

Aware of the need to accelerate the implementation of the ICPD/PoA, the African Union (AU) and the International Planned Parenthood Federation, Africa Regional Office (IPPFARO), in collaboration with the United Nations Population Fund (UNFPA), sponsored sub-regional studies on the situation of reproductive health in Africa ten years after the Cairo Conference and joined their efforts to organize a number of sub-Regional consultations to discuss and recommend ways to accelerate the promotion of sexual and reproductive health and rights (SRHR) and develop a comprehensive Policy Framework for Sexual and Reproductive Health and Rights at the African Union Commission. The Department of Social Affairs has played a leading role in driving this process forward and taken an active part in many of the sub-regional meetings of experts and in ministerial meetings.

Accordingly to the six sub-regional meetings were held in Yaoundé (August 2004), Bamako (November 2004), Windhoek (February 2005), Abuja

(June 2005) and Tunis (August 2005) and in Nairobi (September 2005). The main purpose of theses meetings was to review the issues relating to the status of reproductive health and rights in Africa with emphasis on sub-regional realities and to make recommendations which will guide the preparation of a Continental Policy Framework on SRHR, which will in turn be passed to appropriate organs of the Africa Union for consideration.

Therefore, the present document is based on the deliberations of the sub-regional meetings mentioned above. It reviews the position of Africa with regard to the international consensus regarding SRHR, the progress achieved so far in implementing the ICPD/PoA, the gaps and opportunities in the areas of SRHR issues and the challenges facing Africa. This review is followed by a draft Declaration and draft Plan of Action to guide policy formulation and/or actions at the level of respective member states. The draft Action emphasizes nine areas having a strategic Focus, Priority Actions and a Check List to help in monitoring progress.

2. Africa and the International Consensus on Sexual and Reproductive Health and Rights

After a number of decades during which the international community looked at the population issue from purely a demographic perspective, the **International Conference on Population and Development (ICPD),** held in Cairo in September 1994, represented a paradigm shift in dealing with the population and development issues facing humanity at the end of the second millennium. However, despite the pre-ICPD focus on demographic targets, many voices rose in developing countries in general and in Africa in particular to advocate the view that population and health problems go beyond the perspective of "human numbers". So, in a sense, ICPD and its Programme of Action (PoA) represented a victory for such voices.

The ICPD/PoA, shifted the attention of governments, inter-government agencies and the civil society from demographic targets and couple-year protection to issues that were considered important for the achievement of a balanced development. Such issues relate among others to reproductive and sexual health, reproductive rights, women's empowerment and youth reproductive health. In addition, the ICPD/PoA called upon governments and donor agencies to adopt an integrated approach to deal with these issues rather than continuing with the old practice of fragmented actions through uncoordinated projects.

This draft Policy Framework is to provide a model for the harmonization of national, sub-regional and continental efforts to promote "**reproductive health**" and "**reproductive rights**" as one of priority flagship programmes of the African Union Commission. Sexual and Reproductive Health and Rights are here defined as they were stated in the ICPD/ PoA.

Reproductive Health

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of

family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".

In line with the above definition of reproductive health, reproductive health care is defined as *"The constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."* (ICPD/ PoA. Chapter VII. sect. A. Paragraph 7.2)

Reproductive Rights

"Bearing in mind the definition of reproductive health above, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community-supported policies and programmes in the area of reproductive health, including family planning. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls, and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries. Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed"(Chapter .VII sect. A, Paragraph. 7.3).

This holistic approach was reinforced through the deliberations and recommendations of the **Fourth World Conference on Women (FWCW),** held in Beijing in September 1995, which put emphasis on gender equity and equality and on reproductive rights and a rights-based approach to reproductive health.

The follow-up conferences: Cairo + 5 (1999), Cairo at Ten (2004) and Beijing + 5 (2000) while they reinforced the messages of ICPD and FWCW, they also drew the attention of stakeholders (governments, UN Agencies, regional institutions and NGOs) that based on the achievements so far, there is a risk of not implementing the objectives of these conferences if reproductive health is not fully integrated in the various health strategies at various levels.

In order to consolidate the recommendations of the major UN conferences held in the 1990s, the Heads of State held the **Millennium Summit** in September 2000 and adopted the **Millennium Declaration** which was agreed by 189 countries and which led to the adoption by the UN of the **Millennium Development Goals (MDGs)** to be achieved by 2015.

The eight MDGs are:

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

Of the eight MDGs, the three highlighted above - improve maternal health, reduce child mortality and combat HIV/AIDS, Malaria and other diseases are directly linked to reproductive health, while the other four are closely related to health, including reproductive health.

However, the MDGs do not explicitly articulate the most important objective of the ICPD/PoA - universal access to reproductive health services by 2015. This led the UN Secretary General Kofi Annan to state at the Fifth Asian and Pacific Population Conference in Bangkok in December 2002 that "*The Millennium Development Goals, particularly the eradication of poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed".* This "lacuna" has been addressed by setting up a Reproductive Health Task Force advising the UN Secretary General with regard to the implementation of the MDGs.

In order to create a "mechanism" for implementing the MDGs, the UN General Assembly adopted at its Fifty-sixth Session in September 2001 a "Road Map towards the implementation of the United Nations Millennium Declaration". The Road Map contains both targets and indicators for each MDG and these will be partly used in developing the NEPAD's Implementation Plan.

Africa and ICPD: 10 Years After

In 2003 the UN Economic Commission for Africa (ECA) and the United Nations Population Fund (UNFPA) conducted two ICPD at Ten surveys to assess the degree of implementation of the ICPD/PoA by the African Governments. The surveys showed that most African countries have given priority to the implementation of comprehensive reproductive health programmes and that some progress has been achieved in several areas relating to the Cairo Programme of Action and to the MDGs.

However, a number of operational constraints have prevented the implementation of the ICPD/PoA. In a number of countries, the vertical organizational health systems, often inherited from the colonial era, constitute a major obstacle for a more integrated approach.

On the policy level, a number of countries have integrated population issues into the development, implementation and evaluation of various development programmes and in some cases in the Poverty Reduction Strategy Papers (PRSPs). In addition, a number of governments have integrated reproductive health services into their health care services. In the area of reducing maternal and child mortality, many governments introduced emergency obstetric care, assisted delivery, extension of immunization campaigns and programmes dealing with the complications resulting from unsafe abortion.

In the area of combating HIV/AIDS, following ICPD, the majority of African governments increased commitment to deal with this epidemic. This has been demonstrated through the fact that close to half of the African countries have established coordinating bodies, many of them at the level of the Presidents' office.

However, despite such a progress, only a small number of African countries have succeeded in the implementation of the ICPD objectives. A report presented at the ICPD at Ten meeting held in London in 2004 concluded that eight countries only made significant progress, seven made moderate progress and five made little or no progress.

3. Sexual and Reproductive Health and Rights in Africa: Issues and Challenges

The six Sub-Regional meetings held so far identified issues and challenges relating to the following areas of reproductive health:

Issues:

- **Demographic Situation**

Although there are some sub-regional variations, the continent is characterized by high birth and death rates. On average, there are 38 births and 14 deaths per 1,000 people respectively leading to a rate of natural increase of 2.4%. The number of births per 1,000 people ranges from a low of 16 in Mauritius to 51 in Malawi while the number of deaths per 1,000 people ranges from 4 in Algeria and Libya to 29 in Sierra Leone. The highest natural rate of increase is registered in Niger and Comoros (3.5%) while the lowest is registered in Botswana (0.1%). (Population Reference Bureau: 2004 World population Data Sheet).

The sub-regional meetings discussed the issue of high Total Fertility Rates (TFR), which is estimated at 5.1 with the lowest rate in Mauritius (1.9) and the highest in Niger (8). As far as the total population in Africa is concerned, it is now estimated at 885 million and is expected to reach 1,323 million in 2025 and 1,941 million in 2050. The projected population change between 2004 and 2050 is 119% in Africa in general and 132% in Sub-Saharan Africa.

- **Maternal Mortality and morbidity**

All the Sub-Regional meetings raised the issue of the high mortality rate that ravages a number of African countries. While the average is around 400 maternal deaths per 100,000 live births, this number is above 900 in certain countries.

The lifetime risk of death from maternal causes is 1 in 16 in Sub-Saharan Africa. WHO estimates that the major causes of maternal mortality are: bleeding after delivery, followed by infection, unsafe abortion, high blood pressure and obstructed labour. One of the contributing factors to maternal mortality in Africa is the lack of skilled personnel during delivery. While skilled health workers attended 33% of deliveries in 1985, the percentage increased to 41% by 2000 but remains far short on the demand for skilled attendants for prenatal, childbirth and postnatal care.

- **Infant And Child Mortality**

In general, infant and child mortality rates have declined in many African countries, (infant mortality declined from 99 per 1,000 live births in the period 1990-95 to 88.5 in 2000-2004). The same trend has been witnessed with regard to child mortality from 163.6 in 1990-95 to 148.4 in 2000-2004. However, the region continues to have some of the highest mortality rates in the world. The average rate for infant mortality ranges between 16 and 177 per 1,000 live births (respectively in Mauritius and Sierra Leone) while the average is 89 (Africa) and 96 in Sub-Africa. As for under five mortality rates, it ranges from 52 per 1,000 live births among the richest fifth of the population of Ghana to 282 per 1,000 live births among the poorest fifth of the population of Niger.

It is estimated that 45 African countries have not met the goal of bringing child mortality rate to less than 70 death per 1,000 live births set for the year 2000.

- **Contraceptive Use**

All the sub-regional studies reveal the phenomenon of low contraceptive prevalence in most countries. While the world average relating all methods (traditional and modern) is 59%, this average is 28% in Africa (21% in Sub-Saharan Africa) in terms of modern contraceptives. (Source: Population Reference Bureau: 2004 World population data sheet).

There are, however, some stark variations. The highest use of modern contraceptive is to be found in Mauritius (76%), Egypt (57%) and South Africa (55%) while the lowest is registered in Chad (2%) and DRC, Guinea, Guinea-Bissau and Rwanda (4%).

In general, Africa continues to have the world's lowest contraceptive prevalence rate. While the prevalence is low, the proportion of married women who need contraceptives but who are not using any methods is estimated to be 24% in sub-Saharan Africa and 18% in Northern Africa. However, this estimate is conservative as it deals only with married women.

- **Unsafe Abortion**

All the sub-regional meetings reported high frequency of abortion. It was reported by the Central Africa meeting to reach 28% for the sub-region as a whole while the West Africa meeting estimated that abortion resulted in 13% of maternal death and as many as 40% in some countries such as Eritrea.

• STDS And HIV/AIDS

All the sub-regional meetings draw attention to the unprecedented spread of HIV/AIDS. In the case of Central Africa, the prevalence rate ranges from 2% in Madagascar to 38% in Swaziland.

Despite the current political will and donors support for curative programmes, only 11% of those infected with AIDS in Africa have access to anti-retroviral therapy (as opposed to 62% in Latin America and 14% in Asia).

About twice as many young women as men are infected with HIV in sub-Saharan Africa. In 2001, it was estimated that 6% to 11% of young women were living with HIV/AIDS, compared 3% to 6% of young men.

• Adolescent Reproductive Health

Adolescents and young people aged 15-19, who represent 20.3 % of the African population, are at risk of early and unwanted pregnancy leading to unsafe abortion, sexually transmitted diseases and dropping out of school.

In the majority of countries, young people lack relevant information on sexual and reproductive health and rights. The UN Population Division estimates that of the African girls who were sexually active by the age 20, 51% had initiated sexual activity before marriage. The corresponding proportion for males is 90%. As a result, the contribution to fertility of adolescents aged 15-19 is around 107 per 1,000 women 15-19 years old (ranging from 7 in Libya and Tunisia to 233 in Niger). In some sub-regions, the proportion of girls aged 15-19 with at least one child varies from 10% in the Congo to over 30% in the Cameroon.

• Female Genital Mutilation (FGM)

Despite research revealing the harmful effects of this practice including physical pain, mental anguish and injuries and sometimes deaths during the procedure and during childbirth, there is a legal and legislative vacuum that needs to be addressed. The percentage of FGM ranges from 10% in the Democratic Republic of Congo to 89 % in Eritrea. It is also widely practiced in most ECOWAS and some African Arab countries. A frequency of 80 – 90% in common in these countries.

In 2003, the Afro-Arab Expert Consultation for the Prevention of Female Genital Mutilation issued the Cairo Declaration, which calls on all concerned Governments to adopt and implement appropriate laws to eradicate this "obsolete tradition not required by religion". Despite campaigns by some First

Ladies, efforts by The Inter-Africa Committee on Harmful Traditional Practices, and despite prohibition by some Governments, progress is painfully slow.

- **Sexual And Domestic Violence**

While sexual and domestic violence is widespread in most African countries, the phenomenon is still poorly reported due to socio-cultural reasons and to the legal vacuum surrounding this issue.

- **Health Budget Allocation**

Some sub-regional meetings decried the low budgetary allocations to health in general and to RH in particular. The inadequate budgetary allocation has its own impact on the promotion of health in general and on ensuring reproductive health in particular.

Challenges:

In view of the various SRHR issues identified by the Sub-Regional consultations, the participants identified the following challenges that Africa has to face if the African countries are to successfully implement the ICPD Programme of Action as well as MDGs. These challenges relate to areas such as policy and legislation, infrastructures, services, human resource development and partnership.

Policy:

While all African countries have subscribed to the ICPD/PoA and renewed their commitment on the occasion of Cairo Plus 5 and Cairo at Ten, as well as in a number of regional instruments, especially those developed by the OUA and AU, many policies and laws fall far short of the expectations of all the stakeholders. One of the difficulties faced in the area of policy formulation is the absence of adequate human and technical capacity to monitor progress in the implementation of the ICPD objectives. This deficiency includes the areas of data collection and analysis and the absence of indicators and benchmarks and the quasi absence of SRH management information systems in many countries. It is therefore necessary to amend laws in order to match the commitments made, especially in the areas of SRHR, HIV/AIDS and adolescent and young people SRH. In addition, there is a need to build the capacity of health care providers for the successful implementation of these commitments.

Funding

Despite the commitments made by donors at the Cairo Conference, the level of Official Development Assistance (ODA) in general and the level of ODA devoted to health, the actual funding decreased between 1995 and 2001. It was only in 2002 that the decreasing trend of ODA has been checked and its amount returned to the pre-ICPD figure in 2003.

Infrastructures:

Due to low budget allocations to health, in general and to reproductive health, in particular, the existing infrastructures, including facilities and equipment are not able to cope with the rising SRH demands, especially in remote and rural areas where the majority of the population lives.

Services:

While the major ICPD /PoA components were agreed, their integration into the pre-existing services was not carried out in a systematic manner and this has rendered difficult the task of assessing progress in implementing the Cairo recommendations.

Human Resource Development:

In the absence of adequate financial resources, many countries have failed to train staff in the additional areas of SRH which resulted from the Cairo agenda.

Partnership:

Despite the positive discourse on partnership and cooperation, no systematic cooperation plans were put in place to exchange experiences and lessons learned and to set up a programme of South-South collaboration, be it in the field of training, contraceptive supplies or joint procurement.

OAU/AU's Response to Reproductive Health Challenges: Gaps and Opportunities

The Constitutive Act of the African Union (AU), which entered into effect in May 2001, referred to health matters by stating in its Article 3(n) that the AU will work toward "the eradication of preventive diseases and the promotion of good health". In addition, Article 13(h) relating to the AU Institutions states that the Executive Council is responsible for the coordination and policy decision –making in education, culture, health and human resource development.

In order to tackle the issue of African development on amore solid basis, the African Heads of State adopted, in July 2001, the New Partnership for Africa's Development (NEPAD), which represents a strategic development framework for African countries in meeting the socio-economic challenges facing the continent. This Framework was ratified by the African Union Summit in July 2002.

However, the NEPAD Programme of Action did not sufficiently cover the other issues of sexual and reproductive health and rights despite the fact that almost all African countries subscribed to the recommendations of the ICPD and FWCW. The April 2003 meeting of the African Health Ministers held in Tripoli, Libya recognized this gap. The Ministers called for the inclusion of maternal and infant mortality reduction into the NEPAD health sector strategy document and drew the attention to the fact that the NEPAD Framework did not make adequate case for sexual and reproductive health and rights. It is the recognition of this gap that led the African Union in collaboration with the International Planned Parenthood Federation, Africa Regional Office (IPPFARO) and United Nations Fund for Population (UNFPA) to organize a number of sub-Regional consultations with the view to developing recommendations and Draft Policy Framework for reproductive health and rights to be considered by the competent authorities of the African Union.

As pointed out earlier, the objectives of the sub-Regional meetings are as follows:

- To make an inventory of the Sexual and Reproductive Health and Rights (SRH&R)–related implications of the various international conferences on population, gender and development;
- To define critical reproductive health challenges in Africa;
- To determine the place of SRH in the NEPAD Plan of Action;
- To recommend a comprehensive SRH component for incorporation into the NEPAD Framework;
- To advocate for the full institutionalization of SRH within the African Union structures.

4. Policy Statement

On the basis of the review of progress made by the African countries in implementing the objectives of the ICPD/PoA, of the current situation of reproductive health and in view of the continuing Sexual and Reproductive Health and Rights challenges facing Africa, the African Union Commission believes that it is time to act towards mainstreaming reproductive health programmes on the continent. This mainstreaming and harmonization of reproductive health issues into national, sub-Regional and continental development initiatives will surely speed up the process of implementing the ICPD/PoA and Millennium Development Goals (MDGs) and will contribute generally to the alleviation of poverty in Africa since development is measured not in terms of quantitative growth in GDP but in terms of the quality of life enjoyed and the overall well-being of the population of a given country.

While all African countries have expressed concern over the worsening situation of SRHR in their respective countries, there is still a lot to be done to translate these commitments into action. Among others there is lack of harmonization, coordination and standards for monitoring and evaluation of efforts towards promoting sexual and reproductive health and rights on the continent. Moreover, there are also some legislative bottlenecks that need to be amended in order to facilitate actions in the RH programme. This policy framework is elaborated to assist member states fill this gap in the promotion of reproductive health and rights.

Due to the fact that policy formulation at the central level is only the beginning of socio-cultural change and that some of the socio-cultural values are deeply rooted in the mind of people, and in order to obtain the largest possible adherence to the new enabling legislation, it is imperative that all relevant institutions and representatives of the community participate in the discussions leading to this policy review and formulation. It is also important to sensitize authorities at the district and local levels to the need to implement the new policies and regulations.

However, all good legislation, regulations and programmes would remain alien to the community if they were not part of the policy-making and planning process and if messages are not communicated in their own African languages and dialects. In this regard, the implementing agencies of the Policy Framework should develop glossaries of various SRHR terms with translation into local languages in order to increase people's awareness about issues relating to their health.

Concerning the adoption, adaptation or integration of SRHR Policy Framework into the health programmes of the various African countries, it is imperative to put a special emphasis on a number of areas which are strategic in terms of their contribution to achieving the ICPD objectives and the MDGs and to providing an enabling environment for a healthy and decent life. These areas relate to core policy concerns, including maternal mortality, infant and child mortality, family planning services, unsafe abortion, STDs and HIV/AIDS, adolescent reproductive health, female genital mutilation and gender-based violence.

With regard to maternal mortality and morbidity, some progress has been achieved in many countries. However, in order to reduce maternal mortality by two-thirds by 2015, a systematic focus should be put on eliminating the major five women killers: post-partum haemorrhage, infection, unsafe abortion, high blood pressure and obstructed labour which account respectively for 25%, 15%, 13%, 12% and 8% of maternal mortality. A priority action is to increase the number of emergency obstetric services closer to the community. As the means are lacking to establish emergency obstetric facilities in all health structures, it is imperative that the public, private and NGO sectors collaborate with local communities to plan for emergency transportation to the nearest relevant health facility when required.

Africa still lags behind with regard to reducing infant and child morbidity and mortality. At a time when lives are ravaged by the HIV/AIDS epidemic, it is imperative to save the lives of infants and children under five. While the phenomenon of the under-five mortality is linked to a number of factors accounting for poverty, some priority actions can be taken in the short term: intensifying immunization of all infants under one year of age against measles and the generalized immunization of all children against other diseases.

Despite the efforts that governments and the civil society have exerted over the last forty years to expand family planning services, the contraceptive prevalence rate is still very low (average of 21%) in Africa. This is so despite the fact that the majority of African governments consider that the population growth in their countries is high and despite the fact the couples that would like to have access to contraceptives do not have access to family planning services. Indeed, an unmet family planning need is around 24% and the lack of access to services leads to unsafe sex, unwanted pregnancy and unsafe abortion, which often results in death. The supply of family planning methods should be one of the priorities of any minimum SRH package due to its impact on many other components of reproductive health. The successful experience of community-based services by NGOs should be replicated and scaled up and authorities across the African countries should facilitate the tasks of NGOs in this regard due to the cost effectiveness of NGO interventions.

The issue of abortion is certainly a sensitive one for a number of people. However, the solution is not to bury one's head in the sand and to hope the phenomenon will disappear. While programmes should aim at eliminating the reasons leading to abortion, it is important also to deal with the issue of unsafe abortion squarely. Policy makers and opinion leaders must encourage a healthy and unemotional debate about the issue and about the ravages caused by unsafe abortion. Positive legislative change must be envisaged despite the ideological clouds surrounding this issue. In the final analysis, one has to recognize that unsafe abortion is the third cause of maternal death and ill-health. One cannot achieve the goal of reducing maternal mortality and morbidity without dealing with unsafe abortion.

The HIV/AIDS epidemic has hit Africa harder than any other continent. No family or community has been able to escape this modern plague. The success of some countries in dealing with this problem is an indication that it is possible to start tackling the issue. In this area more than any other, the exchange of experiences among African countries is of a primordial importance. This is one area where the new Policy Framework can be an important instrument to encourage such an exchange. In addition, a special effort is required by all African countries to expand the supply and use of anti-retroviral medicines.

Young people have been always regarded as the future of the continent. Yet, when it comes to their reproductive health a number of taboos blur the vision of society. Facts are strong-headed and they speak for themselves: 90% young men and 50% of young women have had sexual activities before they reach the age of twenty. However, neither families nor schools prepare them in terms of their sexual and reproductive health and rights. The result is that 20% of births are attributed to adolescents aged 15-19. Dealing with the issue of adolescent reproductive health is easy neither for families nor for schools. In fact, a number of African NGOs embarked on successful experiments relating to Youth Friendly Services where young people participated in the design and implementation of relevant SRHR programmes. This is one area where governments should encourage as well as provide meaningful support to young people's NGOs to promote health sexuality both in and out-of-school.

The experience of African and other developing countries since independence has shown that no success can be achieved without gender equality. And the same is even truer when it comes to SRHR. African women are exposed to poverty, ill health and illiteracy and are the victims of pregnancy-related morbidity and mortality and many of them lose their lives during delivery at the time there are giving life. It is essential to review all existing legislation and amend all provisions which discriminate against women or which restrict equality. In addition to suffering from the lack of gender equality,

women throughout the continent are suffering in silence from gender-based violence. Domestic and sexual violence should not be tolerated and laws to punish the culprits should be enacted. Women should be empowered to decry domestic violence and young girls should be enabled to grow up with self-esteem.

Needless to say, African leaders, governments and civil society have been aware of the shortcomings in implementing the ICPD objectives. Among others, two factors have contributed to the lack of meaningful progress: lack of resources and the weight of bureaucracy.

With regard to resources, while donors promise to increase their support to reproductive health at the Cairo Conference, in actual fact, their contributions decreased during most of the decade following Cairo. The increase in Official Development Assistance (ODA) that began in 2002 is to be applauded although most donors are still far from reaching the 0.7% of GNP to ODA, which the UN General Assembly recommended in 1970. At a time when globalization, the decreasing prices of developing countries' commodities and the increasing oil prices are creating additional problems for most African economies. Africa calls upon its donors to increase support to African countries in order for them to be able to achieve the ICPD goals and the MDGs.

Internal additional resources should also be made available to health in general and SRHR in particular. The African Heads of State already pledged that 15% of the national budget be allocated to health. Now is the time to transform this pledge into a budgetary reality.

As for good governance, the war of turf between different sectors of the administration and the lack of cost effective management have resulted in maintaining vertical SRH programmes in place and not embarking on integrating their services. In order to give impetus to such an endeavour, it is important to establish a coordination mechanism at the top government level of each member state.

5. Annexes

Annex I: Declaration

Recognising the critical linkages between population dynamics, poverty, productivity, health including sexual and reproductive health, human rights and gender and their resulting impact on sustainable development as articulated in the 1994 International Conference on Population and Development (ICPD) Programme of Action, the 1995 Beijing Platform for Action and the 2000 UN Millennium Declaration and noting that most of these agreements have not been satisfactorily implemented,

Recognising that sexual and reproductive health is an important component in its own right of health, human rights and development programmes and that it is an integral part of the Millennium Development Goals (MDGs),

Acknowledging the strong link between gender inequality, women's ill health, violence against women and the lack of access to reproductive health information and services and the need to overcome pervasive gender bias in bringing about more equitable and effective solutions to national development,

Considering the Convention on the Elimination of all Forms of Discrimination against Women (1979), the African Charter on Human and People's Rights (1981), the African Charter on the Rights and Welfare of the African Child (1990), the Dakar/Ngor Declaration on Population, Family and Sustainable Development (1992), the SADC Gender and Development Declaration (1997, 1998), the SADC Health Protocol (1999) and the Abuja, Maseru and Maputo Declarations (2001, 2003),

Acknowledging that the New Partnership for Africa's Development (NEPAD) adopted by the African Union as a development strategy, constitutes a strong and shared commitment by all States to the urgent eradication of poverty and for the achievement of sustainable growth and development,

Encouraged by the fact that the new Vision, Mission and Strategic Framework of the African Union has recognized the importance of sexual and reproductive health for the success of the African development agenda,

Concerned by the high rate of maternal mortality, the high prevalence of unsafe abortions, low contraceptive prevalence rate, the high HIV/AIDS prevalence rate,

Considering the African Union/WHO African Regional Office Roadmap to accelerate the reduction of maternal and infant mortality and morbidity and cognizant of our commitment in the Abuja Declaration of 2001 against Malaria, Tuberculosis and other related infectious diseases and the AU NEPAD Health strategy,

Concerned with the plight of adolescents and young adults who have limited access to SRH services although carrying the burden of sexually transmitted infections, including HIV and AIDS, sexual abuse and other life threatening challenges to their SRH&R,

Recognising that programmes for young people are crucial to address their vulnerability to Sexually Transmitted Infections (STIs) and Human Immune-deficiency Virus (HIV) infections, unsafe abortions and unintended pregnancies and acknowledging the benefits of investing in young people's development and health, including their sexual and reproductive health,

Alarmed at the effects of the escalating pandemic of HIV/AIDS, recognizing that investment in sexual and reproductive health programmes and services are key points for entry for HIV prevention and aware of the need to scale up prevention of maternal to child transmission of HIV infection,

Alarmed at the increasing brain drain of trained skilled health personnel and the implication for the implementation of the various health strategies adopted and for the development targets we have set ourselves,

Having reviewed the SRH status in Africa and having considered the inadequate inclusion of SRH in the NEPAD Plan of Action as a whole, and in its health component in particular;

We hereby reaffirm our strong and irrevocable commitment to work together towards the full enforcement of SHR into the AU NEPAD Health strategy and to take all the necessary key actions to speed up the development of the relevant policies for its implementation in our countries including but not limited to the following:

Work towards realising our commitment to allocate 15% of national budgets to health (Abuja Declaration, 2001);

Scale up efforts to meet the Millennium Development Goals of reducing maternal and child mortality rates;

Ensure that RH&R policies and actions follow a life-course approach that recognizes the continuum from birth through childhood, adolescence and adulthood;

Ensure that the health needs of young girls, adolescents and women past reproductive age are not neglected;

Involve adolescents in reproductive health programmes intended for them at all stages of development, implementation, monitoring and evaluation;

Scale up efforts to meet the Millennium Development Goals of halting and beginning to reverse the spread of HIV and AIDS, malaria and tuberculosis by 2015;

Increase the contraceptive prevalence rate by 30% by 2015;

Address men both in terms of their own health needs and in terms of their shared responsibility as husbands, partners and fathers;

Advocate for the inclusion of sexual and reproductive health and rights in all agreements entered into for socioeconomic development;

Strengthen partnerships for improving SRH outcomes with communities, local government, youth networks, civil society, regional economic communities, member states, United Nations agencies and other development partners;

Work with national stakeholders and regional and international partners to secure political, financial and material support for reproductive health projects and programmes;

Mainstream SRH&R, gender equity and youth empowerment initiatives within the structures of NEPAD and other relevant African institutions;

Strengthen existing structures for promoting SRH&R, gender equity and youth empowerment within the African Union;

Institute mechanisms for a harmonised, standardised database that enables better monitoring and evaluation of SRH&R policies and programmes across the sub-region;

Support the exchange of South-to-South experience, expertise and best practice in the area of SRH&R;

We endeavour to:

Undertake to harmonize existing policies into nationally relevant and specific 'road-maps' that address SRH issues in a coordinated manner with a view to facilitate mobilization of resources to ensure that the policies are underpinned by a gender analysis that is disaggregated by age and sex.

Develop strong and equitable health systems to eliminate the current gaps in access to and use of reproductive health services, especially focusing on the needs of women and young people.

Strengthen health systems to ensure universal access to basic health services including services to promote child and maternal health, support Sexual and Reproductive Health and control Tuberculosis and Malaria.

Promote SRH&R policies, including policies to facilitate access to services for HIV and AIDS prevention, mitigation, treatment and care, family planning, maternal and newborn health and prevention of unsafe abortion among adults and young people in the sub-region.

Commit to ensuring a review of national laws so that they are gender and youth friendly and in line with relevant international agreements and AU protocols to ensure full realization of the sexual and reproductive health and rights of women and adolescents in order to ensure full gender equity for all our citizens.

Create an enabling environment for increased private and public investments and partnerships in the health system to adequately address human resource development, infrastructure and commodity supplies for effective delivery of health services.

Strengthen coordination and partnership mechanisms with civil society including nongovernmental organizations, the broader community, religious organizations and the private sector covering all levels of administration (national, regional, district) in order to sustain development.

Ensure the development and use of appropriate monitoring and evaluation frameworks including those related to the universal access to sexual reproductive health that measure progress towards the achievement of internationally agreed health development goals in order to determine cost-effective programmes and achieve better health and nutritional outcomes.

Annex II: Policy Framework[1]

1 - Sexual and Reproductive Health Legislation into Primary Health Care

Considering the inadequacy of existing sexual and reproductive health and legislative frameworks member states should strengthen the existing laws, to adopt new sexual and reproductive laws taking into account African specificities and a better application of laws.

2 - Integration of Sexual and Reproductive Health Services

In view of the acuteness of sexual and reproductive health issues, including very high maternal and infant mortality and unsafe abortion rates, African countries need to integrate sexual and reproductive health services in the minimum activity package at all levels of the health pyramid, with particular emphasis on family planning and emergency obstetric and infant care.

3 - SRH Communication

It is important to note that language is a key and indispensable vehicle for effective and efficient communication, mainly in the fight against and prevention of diseases. In this regard, it is necessary to develop appropriate communication strategies sensitive to age, gender, religion and culture in all its manifestations. It is also essential to strengthen communication and advocacy systems, to mainstream local languages in behaviour change communication (BCC) strategies and programmes and to enable SRH programmes to have access to public mass media.

4 - Budgeting of SRH Activities

Considering the importance of SRH for the well-being of people and families and its impact on development and poverty alleviation, countries should fulfil their commitment of allocating at least 15% of the budget for the health sector and to provide SRH programmes with adequate resources.

5 - Mainstreaming Gender in Development Programmes

It is an established fact that there exists persistent disparities between men and women in Africa and their bearing on the use of services and access to sexual and reproductive health information is immense. It is therefore

[1] Guidelines relating to the components of this Policy Framework are to be found in Appendix III, the operational plan.

imperative to always work towards mainstreaming gender in all development programmes of respective member states

6 - Youth Sexual and Reproductive Health

Given the persistence of adolescent and youth sexual and reproductive health problems and their harmful implications, it is essential to strengthen quality youth-friendly services and their access to information likely to meet their specific needs as well as to adopt enabling legislations for their development with emphasis on rural youth.

7 - Mid-life concerns of both men and women

In the spirit of poverty reduction a continuum of care should be available to promote healthful living for both men and women. The objective is to promote healthy active living in old age thereby facilitate productivity and reduce reproductive health morbidity in both men and women by responding to concerns about menopause, andropause, sexual dysfunction and cancers involving the reproductive systems.

8 - The Fight against HIV/AIDS Pandemic

The pervasive prevalence and rapid spread of the HIV/AIDS pandemic in Africa as well as the harmful bearing of the pandemic on Africa's development is felt by all sections of African society. Though previous efforts in curving the spread of the pandemic and alleviating its negative consequences are encouraging, a lot needs to be done to register success in meeting the MDGs and also implementing commitments by African leaders. In this regard, member states should develop affordable preventive and curative services including counselling, voluntary testing, mother-to-child HIV transmission, prevention services and access to treatment for infected people, especially for the most vulnerable groups of society: women, children, the elderly and persons living with disabilities. Finally, they should sensitize those who have not yet been infected to the danger of risky behaviour.

In view of the **AUC's** commitment towards promoting health in general and reproductive health in particular, as reflected in its Vision, Mission and strategic Framework, it is imperative to build and strengthen the Commission's capacity for effective coordination, advocacy, monitoring and evaluation of sexual and reproductive health programmes and action in Africa.

9 - Strengthening of Sexual and Reproductive Health Programme of the AU

The importance of partnership has been underlined in a number of regional and international fora including the ICPD, MDGs and others. Africa has gained a considerable benefit from working hand-in-gloves with partners and will continue to do so since the challenges faced by the continent are too huge to be tackled single-handedly. More importantly the magnitude of unmet sexual and reproductive health need is very large and there is a great need to involve international partners, civil society organizations, the private sector and local communities in the resolution of sexual and reproductive health problems. It is therefore important to continue to build strong partnerships with all these bodies in order to ensure adequate funding of SRH services in Africa.

10 - Establishment of an African Maternal and Infant Mortality Advocacy Day

Considering the very high maternal and infant morbidity and mortality rates and poor contraceptive prevalence rates in the region, we resolve to establish an African Maternal and Infant Mortality Advocacy Day.

11- Establishment of an African Adolescent and Youth Health Day

Africa is a youthful continent. Young people, however, represent the majority of the victims of SRH problems. Promoting adolescent and youth SRH is the cornerstone of sustainable development process. It is therefore necessary to establish an African brainstorming and orientation day on youth and adolescent health (Resolution of the 26th African Health Ministers Meeting in April 2003, Tripoli) as well as to establish a "Youth" Unit within the African Union and sub-regional organizations.

Annex III. Operational Plan

The following Operational Plan has been developed taking into account the review of the SRHR challenges, the draft Declaration and the draft Resolutions. The plan focuses on **10 strategic areas**:

- Increasing resources to SRHR programmes,
- Translating ICPD commitments into national legislation,
- Reducing maternal mortality,
- Reducing infant and child mortality,
- Young people's SRHR,
- Combat HIV/AIDS,
- Expand contraceptive use,
- Reduce levels of unsafe abortion,
- Female genital mutilation
- Gender-based violence.

For each strategic area, a number of **priority actions** are proposed. This list is not exhaustive and can be enriched through the addition of successful actions, which have been launched throughout Africa.

Finally, selected checklists for monitoring progress are proposed. Some of these relate to internationally recognized indicators. Additional indicators may be added as per the specific conditions of every country.

Operational Plan Matrix

Strategic Focus: Increase Resources for Sexual and Reproductive Health and Rights

Major Issues:

- Low budget allocation to health in general and to Sexual and Reproductive Health and Rights, in particular.
- Many sub-Regional consultations recommended that the health allocations be increased by 15% and that allocations to SRHR are also increased. However, such an increase should not lead to vertical programmes.
- Donor countries have not fulfilled their pledge to bring their support to development to the level of 0.7% of their GNP

Strategic Focus	Priority actions	Check list for monitoring progress
1. Increase resources for Sexual and Reproductive Health and Rights	• Increase national health budget by 15% • Prioritise SRH in PRSPs to increase funding for SRH and thereby accelerate the achievement of MDGs • Set up a National SRHR Fund • Rationalize MOH expenditures with view to allocating additional funding to SRHR • Launch cost sharing schemes where appropriate • Support Civil Society NGOs to provide services • Enlist donor support through transparent accounting • Collaborate with donors to fulfil their pledge to devote 7% of their GNP to development • Request donors to harmonize their reporting requirements • Increase partnerships with both national and international stakeholders to mobilise resources for SRH	• Percentage of state budget allocated to health. • Annual health expenditure per capita. • Collaboration agreements with the private and NGO centres. • Audit Accounts published. • Propose to donors a single reporting systems on the basis of their needs • Establishment of and access to properly equipped and staffed referral facilities • Proportion of health budget allocated to contraceptives

Strategic Focus: Translation of ICPD commitments into programmes and actions.

- Despite the approval by most African countries of the ICPD/PoA and other SRHR instruments, there was no systematic translation of these agreements and commitments into national legislation.
- The Roadmap to accelerate reduction of maternal and newborn mortality agreed by most African countries still to be followed systematically.
- Internationally agreed SRHR protocols have not been integrated in relevant regulations and procedures.
- Weak human and technical capacity to systematically collect and analyze data with the view to developing informed policy and regulations.
- Weak monitoring and evaluation capacity.

Strategic Focus	Priority actions	Check list for monitoring progress
2. Translation of ICPD commitments into national policies and regulations.	• Harmonize national RH policies at the level of the African Union. • Mobilize political will to do so. • Review current legislation with the view to: - Amend laws and regulations that are in contradiction with commitments of ICPD/PoA and MDGs. - Sensitise relevant authorities at national, regional and district levels to the need to implement the revised and new legislation. • Building capacity in the collection, analysis, and management of information.	• Existence of a blue print for a RH policy at the level of the continent. • Review process in place. • New legislation and regulations approved • Awareness seminars and training launched • Monitoring and evaluation procedures in place.

Strategic Focus: Integration of Sexual and Reproductive Health and Rights in Relevant Health Care Services.

- Despite the call of the ICPD/PoA to integrate SRHR in all aspects of the health system, the structures of the health system still follow a vertical approach towards SRHR interventions.
- In many countries, the support given in pronouncements to SRHR has not been transformed into meaningful actions in terms of integration and increased funding.
- Only a small number of countries have reported the implementation of the ICPD objectives. Only eight African countries have made significant progress in this regard.

Strategic Focus	Priority actions	Check list for monitoring progress
3. Integration of SRHR in relevant programmes and services	Assemble all relevant data and indicators with the view to obtaining a realistic picture of the SHRR situation at national, regional and district levels and to developing a baseline survey to be used in assessing progress.	• Integration of HIV/AIDS services in RH services • Mainstreaming of gender issues in SRH • Inclusion of SRH in PRSPs • SRHR database in place.

Strategic Focus: Reduce Maternal Mortality and Morbidity.

- Maternal mortality rates in Africa are still high: an average of 400 maternal deaths per 100,000 live births. The rate reaches 900 in some countries.
- The lifetime risk of death from maternal causes is 1 in 16 in Sub-Saharan Africa.
- Lack of skilled health personnel during delivery is a contributing factor.
- Unsafe abortion is also a contributing factor.
- Lack of facilities and adequate transportation to deal with obstetric emergencies.

Strategic Focus	Priority actions	Check list for monitoring progress
4. Reduce maternal morbidity and mortality	Increase access to maternal health care services through strengthening collaboration between public, private and NGO health actors. • **Safe pregnancy and childbirth:** Train and retain skilled attendance during pregnancy, childbirth and the immediate postpartum period. • **National Confidential Enquiry into maternal Deaths (CEMD):** Setting up a mortality surveillance system to collect information on maternal mortality. • **Standard Management of Obstetric conditions**: Adhere to relevant international standards, and clinical protocols[1]. • **Health System:** Set up emergency obstetric care standards and facilities • **Referral System:** Provide emergency transportation and/or mobilize the community to plan for securing transportation in the case of life-threatening complications. • **Reproductive Health Commodity Security (RHCS) Initiative:** Include RH commodities in the Essential Drugs List to improve quality of care and reduce RH morbidity and mortality. Operationalize Roadmap for the Reduction of Maternal and Newborn morbidity and Mortality.	• Proportion of women attending health care centres for pre-natal and post-natal care. • Reduction of unwanted pregnancies and unsafe abortions. • Implementation of best practices in the care of pregnant women. • Reduction in stillbirths and neonatal mortality • Maternal mortality rate. • Proportion of births attended by skilled health personnel. • Collaboration agreements in place. • Number of newly established emergency obstetric facilities. • Number of emergency transportation equipment. • Reduction in unmet need for Family Planning. • Contraceptive Prevalence Rate • HIV Prevalence among women aged 15 – 24 years. • Condom use among population aged 15-24 years. • Caesarean section rate • RHCS implemented

[1] Refer to WHO Pregnancy, Childbirth, Newborn Care and Postnatal Care manual

Strategic Focus: Reduce the under-five mortality rate by two-thirds by 2015.

- Infant and child mortality rates still high in Africa.
- Infant mortality rates range between 16 and 177 with an average of 88.5 per 1,000 live births.
- Child mortality rates range between 52 and 282 with an average of 89 per 1,000 live births.
- 45 countries have not met the goal of less than 70 deaths per 1,000 live births set for the year 2000.

Strategic Focus	Priority actions	Check list for monitoring progress
5. Reduce the under-five mortality rate by two-thirds by 2015.	• **Safe pregnancy and childbirth:** Provide skilled attendance during pregnancy, childbirth and the immediate postpartum period. • **Infant feeding:** Promote exclusive breastfeeding during the 1st 6 months, thereafter supplemented breastfeeding plus vitamin A for the next 2 years. Promote complementary foods and feeding for under-5 children. • **Immunization:** Increase EPI coverage to over 80%; including vaccination against measles and tetanus. • **Diarrhoea:** Promote routine use of ORS, plus therapeautic zinc supplements and antibiotics for dysentery. • **Pneumonia and sepsis:** Promote integrated management of childhood pneumonia and neonatal sepsis with appropriate antibiotics at community and health facility levels. • **Malaria:** Promote use of Insecticide Treated mosquito bed Nets (ITNs), prompt treatment of malaria, during pregnancy and childhood, as well as intermittent preventive antimalarial treatment for pregnant women. • **Prevention and Care of HIV/AIDS:** Integrate the prevention and management of HIV/AIDS in SRH, including provision of PMTCT services, and treatment of opportunistic infections in ANC and childbirth routine • **Neonatal mortality rate:** Provide quality neonatal care services in all maternity units to deal with neonatal emergencies.	• Neonatal mortality rates • Prevalence of underweight children. • Under-five mortality rate. • Infant mortality rate. • Proportion of 1-year old children who have had full immunisation against communicable diseases including measles. • Safe motherhood campaign in place. • Progress in treating pneumonia, malaria and HIV/AIDS.

[1] Refer to WHO Pregnancy, Childbirth, Newborn Care and Postnatal Care manual

Strategic Focus	Priority actions	Check list for monitoring progress
6. Young People's SRHR • Young people aged 15-19 represent more than 20% of the African Population. • They are at risk of unwanted pregnancy and unsafe abortion. • Contribution of young women aged 15-19 to fertility is 107 per 1,000 women.	Introduce and/or strengthen sexuality education in and out-of-school activities. • Empower young women to say NO. • Enable young people to have access to SRH information, counselling and services. • Develop and expand youth friendly services ensuring they are affordable and accessible to all youth including the rural. • Involvement of the male child/youth in SRHR issues and services Advocate for legislation against harmful traditional practices and ensure its enforcement. Care, treatment and services for young people	• Sexuality education manuals in place. • Ratio of unwanted pregnancy. • Number of youth friendly services in place. • Fertility rate among women aged 15-19 years (births /1000 in the age group) • Legislation against THPs in place • Proportion of reported incidences of THPs prosecuted by year.
7. Combat HIV/ AIDS <u>Major issues:</u> • Prevalence ranges from 2 to 38%. • Only 11% of infested people have access to anti-retroviral medicines. • 6 to 11 young women and 3 to 6% young men are infected with HIV in Sub-Saharan Africa. • Care, treatment and services	• Accelerate the integration of HIV/AIDS prevention and care in SRH services at all levels of the health system. • Pay a special attention to pregnant women with the view to reducing mother-to-child HIV transmission. • Strengthen NGO capacity in dealing with HIV/AIDS prevention and care. • Increase the distribution of condoms. • Combat the negative campaigns against the condom. • Sensitise the community about the consequences of unsafe sex and integrate PEP into FP programs. • Sensitise health personnel to deal with people living with HIV/AIDS in a non-judgemental way. • Integrate HIV/AIDS management in SRH services and vice-versa. • Management of opportunistic infections	• Number of health facilities where integration has been achieved. • HIV prevalence among women in reproductive age. • Percentage of people living with HIV/AIDS. • Percentage of people with HIV using anti-retroviral medicines. • Condom use rate of the contraceptive prevalence rate. • Condom shortage. • Number of children orphaned by HIV/AIDS and those made vulnerable to HIV infection

Strategic Focus	Priority actions	Check list for monitoring progress
8. Increase family planning services and contraceptive use. Major issues: • Low contraceptive prevalence rates • High unmet need for FP estimated at 24%.	• Repeal laws and regulations that constrain the provision and expansion of family planning services. • Promote men's responsibility in family planning. • Provide as a wide a choice of family planning methods. • Develop and expand CBD programmes to increase access to services. • Include RH commodities in the Essential Medicines List to promote routine delivery.	• Legislative action to facilitate access to FP services, • Contraceptive supply logistics in place. • Distribution of male and female condoms.
9. Reduce levels of unsafe abortion. Major issues: • Frequency of up to 28% in parts of Africa. • Unsafe abortion leading in 13% - 40% of maternal death.	• Review and amend laws and regulations with the view to creating an enabling environment for preventing unsafe abortion. • Encourage a responsible debate to demystify taboos about abortion. • Train health professionals to deal with abortion in a non-judgmental manner. • Promote the expansion of post-abortion care and the use of menstrual vacuum aspiration (MVA) techniques as part of public health care package. • Provide safe abortion services to the fullest extent of national laws, and where appropriate provide legal framework for safe abortion services.	• Positive legislation in place. • Mortality rate resulting from unsafe abortion • Sensitisation programmes in place.

Strategic Focus	Priority actions	Check list for monitoring progress
10. Gender equality. Major issues: • Widespread inequality. • Commitments to equality not matched by legislative change. • Lack of data on un-equality in various fields of activities.	• Review current legislation with the view to: - Amending legislation and regulations not favourable to gender equality. - Introducing constitutional and legal provisions instituting gender equality. - Removing gender discrimination relating to education, employment and opportunities. • Disaggregate gender data in order to identify gender disparities and address them.	• Review process in place. • Amended legislation adopted.
11. Gender-Based Violence GBV). Major issues: • While the problem is widespread, no data is available. • Existence of legal vacuum regarding GBV. • Phenomenon tolerated in some socio-cultural settings.	• Integrate sensitisation about GBV into SRHR programmes and services. • Include in the training g curricula aspects relating to GBV such as detecting cases of abuse, counselling, treatment and referral). • Empower women to bring cases of GBV into the open and to the court system. • Encourage research on GBV. • Advocate for legal protection of GBV and its enforcement in full.	• Counselling services in place. • Guidelines dealing with GBV developed and distributed. • Legal profession sensitised. • Laws dealing with GBV in place.

Strategic Focus	Priority actions	Check list for monitoring progress
11. Promote male involvement in RH programmes	• Make SRH clinics male friendly • Increase availability of SRH male services • Promote male participation at ANC registration • Advocate for employers to allow men to accompany spouses to SRH clinic • Initiate and strengthen SRH education programmes at community level targeting males	• Range of SRH male services available • Male knowledge of SRH issues (Community surveys) • No. males accessing SRH services
12. Mid-life concerns of both men and women	• Integration of management of menopause, andropause and sexual dysfunction in reproductive health services. • Mass media campaigns to provide information on symptoms of menopause, andropause, sexual dysfunction and their management. • Community mobilization and sensitisation for utilization of services. • Screening for cancers of the reproductive systems for both males and females	• Information, education and communication services on symptoms and signs of menopause and andropause in place • Counselling services for management of symptoms and signs of menopause and andropause in place • Clinical services for screening and definitive treatment in place.

Annex IV. *Decision on the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa (Doc. EX.CL/225 (VIII)

The Executive Council:

1. **TAKES NOTE** of the Report of the 2nd session of the Conference of African Ministers of Health;
2. **ACKNOWLEDGES** the efforts of various UN agencies, International Organizations, other development partners, and NGOs in assisting Member States in improving maternal and newborn health.
3. **RECOGNIZES** the role of Sexual and Reproductive Health and Rights in the attainment of Millennium Development Goals (MDGs) and the International Conference on Population and Development (ICPD) goals.
4. **ENDORSES** the Continental Policy Framework for the Promotion of Sexual and Reproductive Health (SRH) and Rights in Africa ;
5. **URGES** Member States to allocate adequate resources for the improvement of maternal and newborn child health;
6. **ALSO URGES** Member States to mainstream SRH in their National Health Programmes by developing linkages between SRH, HIV/AIDS and other primary health care programmes and to draw inspiration from the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa;
7. **APPEALS** to the International Community to continue to provide assistance towards the attainment of the objectives contained in the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa;
8. **REQUESTS** the Commission, in collaboration with UNFPA, WHO, UNAIDS, UNICEF and IPPF, to advocate for the implementation of the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa and submit a progress report every two (2) years.

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* *Reservations were entered by the delegations of Djibouti, Egypt, Libya, Somalia and the Sudan.*