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MAPUTO PLAN OF ACTION 2016 - 2030

THE AFRICAN UNION COMMISSION

Universal Access to Comprehensive Sexual and Reproductive Health Services In Africa

MAPUTO PLAN OF ACTION 2016-2030

FOR

THE OPERATIONALISATION OF THE CONTINENTAL POLICY FRAMEWORK FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Introduction

1. Recognizing that African countries made significant progress in achieving the MDG targets of improving maternal, newborn and child health and ensuring universal access to sexual and reproductive health services, although fell short of meeting these targets, the Continental Policy Framework on Sexual and Reproductive Health and Rights adopted by the 2nd Ordinary Session of the Conference of African Ministers of Health in Gaborone, Botswana, in October 2005 and endorsed by AU Heads of State in January 2006, remains relevant as the framework for achieving universal access to sexual and reproductive health, the demographic dividend, the aspirations of the Agenda 2063 and the development goals as set out in the Sustainable Development Goals.

2. At Gaborone, the AU Health Ministers further called for the development of a concrete and costed Plan of Action for implementing the Continental Policy Framework. This decision was endorsed by the Summit of the Heads of State and Government in Khartoum, Sudan, in January 2006 and resulted in the development of the Maputo Plan of Action (MPoA) 2007 - 2010 whose implementation was extended by the 15th Ordinary Session of the Assembly to 2015 to coincide with the end line of the Millennium Development Goals.

3. The MPoA 2007 - 2015 expired in 2015 at a time when the African Union's plan for Africa's structural transformation in the next fifty years "Agenda 2063: The Africa We Want" and its 10 year implementation plan are in place to influence and accelerate further Africa's transformation and development beyond 2015. A comprehensive review of the MPoA 2007 - 2015 implementation, achievements, challenges and gaps has been conducted to inform the continental SRHR policy direction post 2015. The assessment of the plan was done in the context of the seven aspirations and six main strategic pillars of Agenda 2063 and the Common African Position respectively.

4. In addition, the revised Maputo Plan of Action 2016 - 2030 on sexual and reproductive health remains consistent with Africa's Agenda 2063 which calls for a Prosperous Africa based on inclusive growth and sustainable development; an Integrated Continent, Politically United, based on the ideals of Pan Africanism; an Africa of Good Governance, Respect for Human Rights, Justice and the Rule of Law; a Peaceful and Secure Africa; an Africa with a strong Cultural Identity, Values and Ethics; An Africa with people-driven development, especially relying on the potential offered by its women and youth; and Africa as a Strong, Resilient and Influential Global Player and Partner.

5. These aspirations show strong convergence with the six pillars of the Common African Position on the post-2015 development agenda and will ride on the ten strategic interventions of the Continental Policy Framework on Sexual and Reproductive Health and Rights which are: increasing resources to SRHR

programmes, translating the International Conference on Population and Development (ICPD) and Beijing plus 20 commitments into national legislation, and SRHR policies including continuing to reduce maternal mortality and morbidity, infant and child mortality by ending all preventable deaths of mothers, newborns and children, ensuring combating HIV/AIDS, expanding contraceptive use, reducing levels of unsafe abortion, ending early and forced child marriage, eradicating female genital mutilation and preventing gender-based violence and ensuring access of adolescents and youth to SRH.

6. This revised Maputo Plan of Action 2016 - 2030 for the operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework follows the review of the Maputo Plan of Action 2007 - 2015 and seeks to take the continent forward towards the goal of universal access to comprehensive sexual and reproductive health services in Africa beyond 2015. It is a long term plan for the period up to 2030, built on nine action areas: political commitment, leadership and governance; health legislation; health financing/investments; health services strengthening/human resource development; partnerships and collaborations; information and education; accountability/monitoring and evaluation; investment in the vulnerable and marginalized populations and improved adolescent and youth SRHR. The plan is premised on SRHR in its fullest context as defined at ICPD/MPoA 1994 and ICPD+20, taking into account the life cycle approach. These elements of SRHR include Adolescent Sexual and Reproductive Health (ASRH); maternal health and newborn care; safe abortion care; family planning; prevention and management of sexually transmitted infections including HIV/AIDS; prevention and management of infertility; prevention and management of cancers of the reproductive system; addressing mid-life concerns of men and women; health and development; the reduction of gender-based violence; interpersonal communication and counseling; and health education.

7. In addition to the Sexual and Reproductive Health Continental Policy Framework, the Plan of Action 2016 - 2030 takes into account the findings from the review findings of 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 and also drawn from issues in Agenda 2063 and its 10 year implementation plan, Sustainable Development Goals (SDGs), Rio+20, ICPD+20 and the Global Strategy for Women's, Children's and Adolescent's Health.

8. While recognizing the need for an emphasis on SRH, the revised Plan recognizes that this must be built into and on an effective health system with sufficient infrastructural, 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 commitments.

9. The revised Plan learns from best practices and high impact 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 to ensure no body is left behind. It recognizes the importance of creating an enabling environment and of community and women's empowerment and the role of men in access to SRH services.

10. The revised Plan is broad and flexible to allow for adaptation at the country level, recognizing the unique circumstances of AU member states. 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 nine 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.

Rationale

11. Though Extreme poverty has declined significantly over the last two decade, the number of people living in extreme poverty remains unacceptably high despite the attainment of the first Millennium Development Goal target—to cut the 1990 poverty rate in half by 2015—five years ahead of schedule, in 2010. Globally, the number of people living in extreme poverty has declined by more than half, falling from 1.9 billion in 1990 to 836 million in 2015[1]. In 1990, nearly half of the population in the developing world lived on less than $1.25 a day; that proportion dropped to 14 per cent in 2015[1]. Poverty rate in Africa south of the Sahara remains dropped by 28% but still remain very high at 41%.[1]

12. Competing priorities for resources on the part of governments and inability of international donors to fulfill their commitments has led to a corresponding inadequate funding for improved access to SRHR services[2]. An average of 10.5% instead of the expected 15% Abuja commitment of public expenditure is currently allocated to health on the continent[3].

13. Maternal, neonatal and under-five mortality ratios remain high at 510 per 100,000 live births[1], 28 per 1,000 live births[3] and 86 per 1,000 live births respectively[1]. Some reproductive and child health indicators although improved, still fall short of

[1] The Millennium Development Goal Report 2015
[2] Resource flows project, 2006. Financial resources flows for population activities in 2004. *UNFPA/UNAIDS/Netherlands Interdisciplinary Demographic Institute.*
[3] MPoA Review Report, 2015

the expected targets. Skilled attendance at birth is more than 25% below the expected 80%, whilst contraceptive prevalence rate and unmet need for family planning remain at 28% and 24% respectively[1]. Only 12% of pregnant women who need emergency obstetric services are receiving them. Immunization rate is 10% below the expected target of 90%, whilst stunting remains high at 34%[3].

14. Malaria, HIV and Tuberculosis still affect significant number of women and children on the continent despite improvements seen over the years. Sub-Saharan Africa had both the largest share of people living with HIV and the largest increase in the number of people receiving ART. Yet, the region is also home to 78 per cent of the people living with HIV in developing regions who are not receiving ART. Eighty per cent of global malaria deaths occur in just 17 countries, mostly in Africa, whilst lack of effective strategies (for example a post-exposure vaccine or treatment for latent TB infection) to prevent the reactivation of disease in the 2 billion-plus people who are estimated to have been infected by *mycobacterium tuberculosis* limits the impact of current efforts to control TB incidence[4]

15. Also, gender inequalities remain deeply entrenched in the region. Women continue to face discrimination in access to work, economic assets and participation in private and public decision-making and are also more likely to live in poverty than men. About three quarters of working-age men participate in the labour force, compared to only half of working-age women, whilst women earn 24 per cent less than men[4].

16. It is generally recognized that health, especially sexual and reproductive health and rights (SRHR) is a precondition for and an outcome and indicator of all aspects of sustainable development and that the goals of sustainable development can only be achieved in the absence of preventable maternal, newborn and child morbidity and mortality. Over the years Africa has made significant strides to achieve universal access to SRHR, although progress has been slow and uneven. However, more remains to be done, hence the introduction of the SDGs 3 and 5

Overarching goal

17. The ultimate goal of this Plan of Action is for African Governments, civil society, the private sector and all multisector development partners to join forces and redouble efforts so that together, the effective implementation of the continental policy framework on SRHR is achieved in order to end preventable maternal, newborn, child and adolescent deaths, expand contraceptive use, reduce levels of unsafe abortion, end child marriage, eradicate harmful traditional practices including female genital mutilation and prevent gender-based violence and ensure access of adolescents and youth to SRH by 2030 in all countries in

[4] The Millennium Development Goal Report 2015

Africa. This will contribute to a prosperous Africa based on inclusive growth and sustainable development and an Africa whose development is people-driven, especially relying on the potential offered by its women and youth. In addition, the plan will contribute to the attainment of the SRHR targets set out in the SDGs and the global strategy on Women's, Children's and Adolescent's Health.

18. Key strategies for operationalizing the SRHR policy framework include:

i. **Improving political commitment, leadership and good governance** – This will entail adoption and ownership of the MPoA 2016 - 2030 at the continental, regional and national levels, prioritizing Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) into continental, regional and national development plans, budgets and Policy Reduction Strategic Plans (PRSPs) and holding political leaders accountable for attainment of milestones set out in global and regional declarations, policy frameworks and development agendas targeting RMNCAH.

ii. **Instituting health legislation and policies for improved access to RMNCAH services** – This will involve removal of legal, regulatory and policy barriers limiting adolescent and young people's access to SRH commodities, programmes and services; streamlining legislative frameworks, policies and operational strategies that govern partnerships and collaborations in the health sector; enacting, reviewing and enforcing laws that prevent early and forced marriages and ensure access to safe abortions to the full extent of national laws and policies.

iii. **Increasing health financing and investments by**: improving domestic resource mobilization for RMNCAH through innovative health financing mechanisms and putting in place social protection mechanisms; identifying and instituting budget lines and budgetary allocations for essential and cost-effective RMNCAH interventions and programmes and encouraging and supporting member states to invest in health infrastructure, local manufacturing of medicines, health equipment and consumables.

iv. **Ensuring gender equality, women and girls empowerment and respect of human rights by**: protecting the rights of women, men, adolescents and youth to have control over and decide freely and responsibly on matters related to sexual and reproductive health, free from coercion, discrimination and violence; eradicating female genital mutilation/cutting and other harmful practices, and eliminating all forms of discrimination and violence against girls; ending gender-based violence; and promote social values of equality, non-discrimination, and non-violent conflict resolution.

v. **Improving SRHR information, education and communication through**: the institution of effective behaviour change communication and information sharing mechanisms that promotes RMNCAH; targeting adolescents and youth (both in and

out of school) with age-appropriate and culturally sensitive comprehensive education on sexual and reproductive health that involves parents and communities; promotion and facilitation of communication among health care providers including peer educators at various levels; widely disseminating information on RMNCAH; and promoting community mobilization for and participation in RMNCAH, with a special focus on the involvement of men.

vi. **Investing in SRHR needs of adolescents, youth and other vulnerable and marginalized populations** (including children, orphans, the elderly, youth, people with disabilities, rural populations, displaced persons and migrants) by improving access to and uptake of quality RMNCAH information and services for youth, including HPV vaccination and family planning through provision of quality youth-friendly adolescent SRH services; providing young people with age-appropriate and culturally sensitive comprehensive sexuality education and referrals to SRH services; preventing child marriage and other harmful traditional practices; investing to improving the SRH status of the poor; and empowering and supporting community-led efforts to address their RMNCAH challenges and advance inclusion. In addition, effective emergency response would be ensured in humanitarian and fragile settings while continuing routine services deliveries for women, children and adolescents.

vii. **Optimizing the functioning of health system and improving human resource for RMNCAH by ensuring universal health coverage through**:: Strengthening primary health care systems by linking comprehensive, quality RMNCAH, HIV/AIDS, Malaria/TB services at all levels of the health system; Strengthening referral systems for integrated RMNCAH, HIV/AIDS/STI and Malaria/TB services; ensuring availability of the widest range of drugs/medicines and commodities for RMNCAH; expanding access to high-impact health interventions such as immunization; skilled attendance at birth and quality care including EmONC for mothers, newborns and children and access to contraception; addressing the rising burden of reproductive cancers; improving efforts to end vertical transmission of HIV; ending malaria transmission; achieving excellence in human resources capacity development, training, retention and recruitment and strengthening emergency preparedness capacities at all levels of the health system in accordance with the International Health Regulations.

viii. **Improving partnerships and multi-sectoral collaborations for RMNCAH by**: Collaborating with development partners to fulfil their pledge to devote 0.7% of their GNP to development; working with partners to develop operational and financing frameworks that take into consideration specific RMNCAH characteristics and priorities of the continent, sub-regions and countries; developing policies that promote involvement of civil society, private sector and communities in RMNCAH service delivery within national programmes; and strengthening South-South, North-

South, triangular partnerships and Diaspora cooperation in achieving SRHR goals. In addition, the health sector needs to work in an integrated and coordinated manner.

ix. **Ensuring accountability and strengthening monitoring and evaluation, research and innovation by**: Establishing strong evidence–based integrated national monitoring and evaluation frameworks; implementing or strengthen MCDSR systems; developing a foundation for baseline data that can be used to track progress; developing/strengthening civil registration and vital statistics systems; strengthening national health information systems to collect and publish key age/sex disaggregated RMNCAH data; investment in research and innovation to address key health and social development priorities among others and strengthening the monitoring and evaluation system for the Plan of Action.

Priority Target Groups

19. Reproductive Health encompasses the whole life cycle of an individual from birth to old age, as such SRH services shall be provided along the continuum of care to all who need them. Emphasis will be on women of reproductive age, newborns, children, adolescents and youth both in rural and urban areas, mobile, rural, urban and cross-border populations, displaced persons and other marginalized groups.

Expected Outcomes

20. This Plan of Action will provide a framework from which countries can draw inspiration. This will not require the creation of new strategies but simply the incorporation of elements of this strategy into the existing ones. The implementation of this Plan of Action will bring about improvements in the health status of women, children and young people and hence greater family savings and stronger economies in Africa. The outputs and outcomes of the plans detailed in table 1 not only reflect the unique RMNCAH issues on the continent but are also consistent with the Agenda 2063 10 year Implementation Plan, the SDGs and the UNGS 2016 – 2030.

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21. Investing in RMNCAH enable individuals and couples to have healthy sexual lives, free from HIV and other sexually transmitted infections; to have the number of children they want and when they want them, to deliver their babies safely and have healthy newborns. Although significant progress has been made in the last decade, Africa lags far behind other world regions on measures of sexual and reproductive health.

22. About 58% of women who want to avoid pregnancy are not using any effective methods of contraception and account for a disproportionate 93% of unintended pregnancies[5]. Seventy-six percent of the poorest people in Africa do not have access to health facilities for antenatal care (4+) and delivery, whilst 78% of women and newborns who need care for medical complications of pregnancy and delivery and complications during and soon after delivery do not get them. Also, 73% of pregnant women living with HIV do not receive antiretroviral medicines that would protect their health and prevent mother –to-child transmission of HIV[6]. These unmet needs would form the basis for computing the cost under the unmet need scenario (see Table 3).

23. It was estimated at the end of 2014 that the total cost of reproductive health care in Africa would be $17.2billion annually. This consisted of $3.2billion if all needs of women's contraceptives are met, $11.2 billion for pregnancy related care, $3.1billion for HIV care for mother and newborn up to six weeks post-delivery for those living with HIV and $0.7billion for STI care covering four major curable STIs (Chlamydia, gonorrhoea, syphilis, trichomoniasis)[7].

24. The total cost of RMNCAH health in Africa is made up of direct and indirect costs. The direct cost consists of cost of drugs/supplies and personnel or health worker cost. The indirect costs include many types of program support, such as staff supervision and training, information and education on family planning, construction and maintenance of facilities, development and maintenance of commodity supply systems, and other programme and management functions[6]. The direct and indirect costs of providing current levels of care, improved care for current users and 100% of RMNCAH needs were computed and averaged. The direct cost constituted nearly 40%, whilst indirect cost constituted nearly 60%. For family planning, personnel cost constituted 36% of direct costs, whilst for the other RMNCAH care, personnel cost constituted 64% of direct cost[6].

25. The base year for the costing of this MPOA is 2015. The total cost of RMNCAH for 2015 was extrapolated from that at December 2014[6], adjusted for inflation (0.1%) in 2015[8]. Thus the total cost of providing 100% of RMNCAH in Africa was $17.67 billion in 2015 (Table 2). Cost estimation for the MPOA from 2016 to 2030 was computed by adjusting the cost at the base year for annual inflation (1.49% for 2016, 2.37% for 2017, 2.54 for 2018, 2.33% for 2019, 2.31% for 2020, 2.00% for 2021-2025 and 2.25% for 2026-2030)[7,8] and fertility and population changes

[5] Singh S, Darroch JE, Ashford LS. Adding it up. The Costs and benefits of Investing in Sexual and Reproductive Health. December 2014
[6] Singh S, Darroch JE, Ashford LS. Adding it up. Investing in Sexual and Reproductive Health in Sub-Saharan Africa. December 2014
[7] http://www.statista.com/statistics/244983/projected-inflation-rate-in-the-united-states/
[8] http://www.tradingeconomics.com/united-states/inflation-cpi

(based on the UN medium variant projections carried out in 2015)[9]. According to the projections, Africa's population will i increase by 493million in 2030 people from 1.186 billion people in 2015, based on the prevailing fertility changes within the period 2015-2030. This implies that there will be an average annual increase of 33million people per year. It is however estimated that to provide all women in the region with a total package of care that includes modern family planning services; maternal and newborn care and HIV/STI care $18 per person will be required[7]. This implies the adjustment for population increases based on the UN medium variant projections will be $0.59 billion per year.

26. The cost estimates for this MPOA reflect the requirements for RMNCAH Care under two scenarios: (1) the cost when all women's RMNCAH care needs are provided (2) the cost required to provide the unmet RMNCAH care needs of women on the continent. After all adjustments are made, a total of $318billion would be required from 2016 to 2030 to meet the RMNCAH needs on the continent (Table 2) whilst $182billion will be required to cover the unmet RMNCAH needs on the continent (Table 3). These estimates should be reviewed and further updated on the basis of the experience gained in the implementation of the programmes and new evidence. However, what is most important is that national plans include detailed definitions of interventions appropriate to meeting national needs for sexual and reproductive health and that investments reflect and improve national capacity for their implementation and monitoring.

27. The principles of the current analysis, however, should be adhered to, including that: plans should be geared to achieving universal access to sexual and reproductive health by 2030, increased investment and action to improve human resources for health , 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 Sustainable Development Goals. The current estimates are indicative of the scale of the required effort and should mobilize an appropriate response by governments, donors, civil society and the private sector.

[9] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables*. Working Paper No. ESA/P/WP.241.

Table 1: MPOA for Implementing the Continental Sexual and Reproductive Health and Rights Policy Framework 2016–2030

Strategic focus	Priority interventions	Indicators for monitoring progress
1. Improve Political Commitment, leadership and Governance for RMNCAH	1.1 Popularise MPoA 2016-2030 at the continental, regional and national levels	Presence of a costed roadmap for the reduction of maternal, new-born and child morbidity and mortality
	1.2 Integrate maternal, newborn, child and adolescent health into other health services	Existence of national health policy frameworks and plans that integrates RMNCAH, HIV/AIDS/STI and Malaria services.
	1.3 Develop Communication Strategy and Implementation Plan for the MPoA 2016-2030	Communication Strategy and Implementation plan for MPOA in place
	1.4 High political commitment and leadership for RMNCAH	# of countries achieving the continental/global RMNCAH commitments Proportion of country health budget allocated for RMNCAH Proportion of countries whose National Health accounts track RMNCAH allocations and expenditures
2. Institute health legislation in support of RMNCAH	2.1 Remove legal, regulatory and policy barriers limiting access to SRH commodities, programmes and services	Number of countries with laws and regulations that guarantee all women aged 15 - 49 years access to sexual and reproductive health care, information and education Existence of policy, regulatory or legal frameworks to support RMNCAH services for young people
	2.2 Develop and implement legal and policy frameworks that prevent child marriages	% of Member States that have national strategies and Action Plans on ending child marriage Percentage of women aged 20-24 who were married or in a union before age 18 or Prevalence of child marriage
	2.3 Implement policies, strategies and action plans to reduce unintended	# countries preparing status report on unsafe abortion

	pregnancies and unsafe abortion	Proportion of unsafe abortion
	2.4 Develop legal frameworks, strategies and programmes that deal with GBV	Prevalence of GBV Proportion of GBV cases prosecuted # Countries with programmes dealing with GBV
3. Gender equality, empowerment and human rights	3.1 Protect the rights of women, youth and adolescents and address sexual and gender based violence	Proportion of ever-partnered women and girls (aged 15-49) subjected to physical and/or sexual violence by a current or former intimate partner, in the last 12 months Proportion of women and girls (aged 15-49) subjected to sexual violence by persons other than an intimate partner, since age 15
	3.2 Eradicate female genital mutilation/cutting and other harmful traditional practices	Percentage of girls and women aged 15-49 years who have undergone FGM/C, by age group
4. Improve SRH information, education and communication	4.1 Target children, adolescents and youth, both in and out of school with age-appropriate and culturally sensitive comprehensive sexuality education that involves parents and communities	Percent of children, adolescents and youth, both in and out of school reached by comprehensive sexuality education programmes
	4.2 Institute effective behaviour change communication and information sharing mechanisms to promote SRH services including initiatives to reduce gender inequality	# countries implementing a comprehensive Communication Strategy for RMNCAH that integrates initiatives to reduce gender inequality, HTPs and GBV Percentage of women aged 15 to 49 years who make informed decisions regarding sexual relations, contraceptive use, and reproductive health care
	4.3 Promote community involvement and participation in RMNCAH, with a special focus on the involvement of men.	Percent of men accompanying spouses, children and adolescents for RMNCAH services

5. Invest in adolescents, youth and other vulnerable and marginalized populations	5.1 Improve access to and uptake of quality SRH services for youth and adolescents including HPV vaccination	Proportion of young people accessing SRH services Adolescent birth rate (10-14 years and 15-19 years) HIV prevalence among young people aged 15-24 years Proportion of girls vaccinated with 3 doses of HPV vaccine by age 15 years Contraceptive prevalence rate
	5.2 Ensure that all girls and boys complete free, equitable and good-quality primary and secondary education	Percentage of children/young people at the end of each level of education achieving at least a minimum proficiency level in (a) reading and (b) mathematics
	5.3 Invest in poor and marginalized and empower and address their RMNCAH challenges	Percentage of most-at-risk populations (including refugees and other displaced persons) reached with RMNCAH and HIV services
6. Optimize the functioning of health system and improve human resource for RMNCAH	6.1 Strengthen primary health care systems by linking comprehensive, quality RMNCAH, HIV/AIDS, Malaria/TB services especially at all levels of the health system	Existence of national health policy frameworks and plans that link RMNCAH, HIV/AIDS/STI and Malaria/TB services
	6.2 Strengthen referral systems for RMNCAH services	# of countries with dedicated referral systems for RMNCAH services
	6.3 Ensure the availability of the widest range of drugs/medicines and commodities for RMNCAH	Coverage of tracer interventions (child full immunization, ARV therapy, TB treatment, skilled attendance at birth)
	6.4 Expand access to high-impact health interventions such as immunization; skilled attendance at birth and quality care including EmONC for mothers and	Maternal mortality ratio per 100,000 live births Neonatal mortality rate per 1,00 live birth Stillbirth rate (and intrapartum stillbirth rate)

	newborns and children; and access to contraception	Under-5 mortality rate per 1,000 live birth Met need for family planning Percent of children receiving full immunization (as recommended by national immunization schedules) Prevalence of stunting (height for age <-2 SD) among children under five years of age Prevalence of under-five wasting Percentage of births attended by skilled health personnel Proportion of women aged 15-49 years and newborns who received a health check within 2 days after delivery Number of facilities per 500,000 providing basic and comprehensive emergency obstetric care (basic and Comprehensive)
	6.5 Address the rising burden of reproductive cancers, including breast, cervical and prostate cancers, by investing in prevention strategies including the HPV vaccine and routine screening, early treatment at the primary care, and reliable referrals to higher levels of care	Proportion of women aged 30−49 years who report they were screened for cervical cancer Existence of national reproductive cancer policy Proportion of girls vaccinated with 3 doses of HPV vaccine by age 15
	6.6 Redoubling of efforts to eliminate mother-to-child transmission of HIV	Percentage of pregnant women attending ANC who were tested for HIV and know their results (data available for "Pregnant women tested for HIV Percentage of infants born to HIV-infected mothers who

		are infected Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce the risk of mother-to-child transmission on HIV
	6.7 Renew and strengthen the fight against malaria	Proportion of children under 5 years old who slept under an ITN the previous night Proportion of children under five years old with fever in last two weeks who had a finger or heel stick Proportion of children under 5 years old with fever in last 2 weeks who received antimalarial treatment according to national policy within 24 hours from onset of fever Proportion of women who received three or more doses of Intermittent Preventive Treatment during ANC visits during their last pregnancy
	6.8 Improve recruitment, development and training, motivation and retention of the health workforce	Number of health workers per 100,000 population (Disaggregated by cadre and geographic region)
	6.9 Implement the International Health Regulations 2005	Number of countries that have fully complied with the IRG 2005
7. Improve partnerships and collaborations with private sector ,communities other extra health sectors , CSO and other partners	7.1 Increase and align external financial resources in line with global commitments	% of total RMNCAH budget mobilized from donors/development partners Number/percent of development partners with operational and financing frameworks aligned with continental, sub-regional and national RMNCAH priorities
	7.2 Develop policies that promote involvement of civil society, private sector and communities in RMNCAH service delivery within national programmes	Proportion of countries implementing policies on public private partnership on SRHR
	7.3 Strengthening South-South, North-	# Institutions in formal strategic partnerships for technical

	South, triangular partnerships and Diaspora cooperation in achieving SRHR goals(including institutionalization of technical exchange and sharing of best practices)	exchange Forum to share best practices put in place
8. Ensure accountability and strengthen monitoring and evaluation, research and innovation	8.1 Establish strong evidence–based integrated national research, innovation and monitoring and evaluation systems that incorporates population based survey	# countries with integrated national research, innovation and M&E Systems (RIME) # countries with integrated national M&E System that captures equity trends # countries with integrated national RIM&E Systems that incorporates mechanisms for tracking financial resources for RMNCAH Household surveys and service provision assessments conducted regularly
	8.2 Implement or strengthen MCDSR systems that monitor, evaluates and responds to all contributing factors to poor maternal outcomes, including those related to services delivery, access and socio-cultural/gender inequality barriers	# countries that have institutionalized MCDSR systems
	8.3 Develop/Strengthen civil registration and vital statistics systems	Percentage of children under 5 whose births have been registered with civil authority Birth [and death] registration
	8.4 Strengthen research and innovation	% of national budget allocated to health and innovation
	8.5 Strengthen the monitoring, reporting and accountability for the MPoA	Continental accountability mechanism for MPoA in place

9. Increase health financing and investments	9.1 Increase domestic resources for health by ensuring financial deepening and inclusion	General government expenditure on health as a percentage of total government expenditure Per capita government expenditure on health % of total financial needs for RMNCAH mobilised from domestic sources
	9.2 Identify and institute budget lines and budgetary allocations for essential and cost-effective SRH interventions and programmes	Existence of budget lines for essential/cost-effective interventions within the SRH/MNCAH budget
	9.3 Removal of user fees for SRH/MNCAH services and institution of innovative social protection schemes	Patient / household out of pocket expenditures of accessing or obtaining services (collected intermittently) Fraction of the population protected against catastrophic/impoverishing out-of-pocket health expenditure % of population covered by the social protection schemes including health insurance
	9.4 Encourage and support member states to invest in medical infrastructure, and local manufacturing of health equipment, medicines and consumables	Legal and policy frameworks in place for local production of health equipment, medicines and consumables Existence of systems for local production and supply of health equipment, medicines and consumables

Table 2: Resource requirements for RMNCAH in Africa (2016-2030). Total need Projection Scenarios, with programme and System adjustments (Billion $US)

All needs met									
Description	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021-2025**	**2026-2030**	**2016-2030**
Personnel costs									
Family planning	0.46	1.06	1.67	2.29	2.93	3.60	21.31	22.39	55.25
Pregnancy & Newborn Care	2.81	2.85	2.92	2.99	3.66	4.34	25.09	26.25	68.10
HIV Care	0.44	0.45	0.46	0.47	1.08	1.70	11.62	12.48	28.26
STI Care	0.10	0.10	0.10	0.11	0.70	1.31	9.67	10.48	22.48
Total Personnel (A)	3.81	3.87	3.96	4.06	4.75	5.45	30.79	32.08	84.96
Drugs and Supplies									
Family planning	0.86	0.87	0.89	0.91	1.53	2.16	13.96	14.87	35.19
Pregnancy & Newborn Care	1.66	1.68	1.72	1.76	2.40	3.05	18.52	19.53	48.65
HIV Care	0.83	0.84	0.86	0.88	1.50	2.13	13.81	14.72	34.74
STI Care	0.19	0.19	0.19	0.20	0.80	1.41	10.16	10.99	23.94
Total drugs/supplies (B)	3.53	3.58	3.66	3.76	4.44	5.13	29.16	30.41	80.14
Programme and systems (C)	**10.33**	**10.48**	**10.73**	11.01	11.86	12.72	67.86	69.98	194.64
Grand Total (A+B+C)	**17.67**	**17.93**	**18.36**	**18.82**	**19.86**	**20.91**	**109.61**	**112.67**	**318.16**

Table 3: Resource requirements for RMNCAH in Africa (2016-2030). Unmet need Projection Scenario, with programme and System adjustments (Billion $US)

	Unmet needs								
Personnel costs	2015	2016	2017	2018	2019	2020	2021-2025	2026-2030	2016-2030
Family planning	0.27	0.86	1.47	2.09	2.73	3.39	20.24	21.29	52.06
Pregnancy & Newborn Care	2.14	2.17	2.22	2.28	2.92	3.58	21.25	22.32	56.75
HIV Care	0.34	0.34	0.35	0.36	0.96	1.58	11.02	11.86	26.47
STI Care	0.08	0.08	0.08	0.08	0.68	1.29	9.53	10.34	22.07
Total Personnel (A)	2.82	2.86	2.93	3.00	3.66	4.34	25.11	26.27	68.17
Drugs and Supplies									
Family planning	0.50	0.50	0.52	0.53	1.13	1.75	11.92	12.78	29.14
Pregnancy & Newborn Care	1.26	1.28	1.31	1.34	1.97	2.61	16.26	17.22	41.97
HIV Care	0.63	0.64	0.65	0.67	1.28	1.90	12.68	13.56	31.39
STI Care	0.14	0.14	0.15	0.15	0.75	1.36	9.91	10.72	23.18
Total drugs/supplies (B)	2.53	2.56	2.62	2.69	3.35	4.02	23.47	24.59	63.30
Programme and systems (C)	**4.24**	**4.30**	**4.40**	4.51	5.21	5.93	33.19	34.53	92.07
Grand Total (A+B+C)	9.58	9.72	9.95	10.20	11.03	11.88	63.58	65.60	181.97

ROLE OF STAKEHOLDERS

a. The African Union

28. The African Union will undertake high level advocacy to ensure political commitment and leadership of the plan, advocate for increased resources for RMNCAH, identify and share best practices. In addition, the Commission will ensure policies and strategies among member states are harmonized with continental and global instruments and put in place a monitoring, reporting and accountability mechanism for the plan under which a biennial, five-year, ten-year and end of term evaluations of progress of implementation of plan would be ensured. A data and best practice platforms will be hosted by the African Union Commission to support the monitoring, reporting and accountability mechanism.

b. Regional Economic Communities

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

c. Member States

30. Member States will domesticate and implement the Plan for the operationalization of the Continental SRHR Policy Framework. They will put in place advocacy, resource mobilization and budgetary provision as a demonstration of ownership and monitor the implementation of the plan on annual basis. They will also reach out to the civil society, private sector and other extra-health sectors (education, water and sanitation, environment, labour and employment etc.) and religious groups to participate in national programs and tackle the social determinants of health impacting the SRH outcomes.

d. Partners

31. 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

32. 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.

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