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

Sp/EXP/CAMH/ /Rpt(I)

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

**REPORT OF THE EXPERTS’ MEETING
18 – 20 SEPTEMBER 2006**

Abbreviations in Annexure 1

DRAFT REPORT OF THE EXPERTS' MEETING
18 - 20 SEPTEMBER 2006

I. INTRODUCTION

1. The Experts Meeting of the Special Session of the AU Conference of Ministers of Health was held at the Joaquim Chissano Conference Centre, Maputo, Mozambique, from 18 to 20 September 2006 on the theme: ***“Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa”***. The Conference was organized in implementation of the decision adopted by the 2nd Session of the AU Conference of Ministers of Health which was held in Gaborone, Botswana in October 2005. The conference was hosted by the Government of the Republic of Mozambique and organized by the African Union, in close collaboration with the UNFPA, IPPF and other partners, with the financial support of the European Commission. The main objective of the Special Session was to adopt a comprehensive approach to the delivery of universal sexual and reproductive health and rights, and HIV/AIDS services in Africa. The Special Session was also aimed at endorsing a costed Action Plan for the implementation of the Continental Policy Framework on Sexual and Reproductive Health and rights in Africa.

II. ATTENDANCE

2. The Experts Meeting was attended by delegates from the following 48 AU Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sahrawi Arab Democratic Republic (SADR), Sao Tome & Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia and Zimbabwe.

3. The Experts Meeting was also attended by Representatives of the following International and Regional Organizations, and NGOs: UNFPA, IPPF/AFRO, WHO, ECA, UNESCO, UNICEF, UNAIDS, World Bank, IOM, Inter-African Committee, WAHO, CEN-SAD, Gate Institute, Bill Gate and Melinda Gates Foundation, Packard Foundation, European Union Commission, USAID, EDCTP, University of KwaZulu-Natal, DELD, AECI, Partners in Population and Development, Belgium, Family Health, Total Health Trust, East, Central and Southern African Health Community, SADC, JICA-J, Oxfam GB, AGBEF (Rep. Guinea), RPMM Network, DFID, JSI/Deliver, Averting Maternal Death, Johns Hopkins University/Johns Hopkins Program for International Education on

Gynecology and Obstetrics (JHU/JHPIEGO), Columbia University, AMDP, Council of Women World Lead, Realizing Rights, IPAS, Pathfinder International, Management Sciences for Health, Reproductive Health Supplies Coalition, Spain, Germany, Palestine, Spain, USA and the African Union Commission and NEPAD Programme.

III. OPENING CEREMONY

4. The Opening Ceremony of the Experts Meeting was addressed by the following officials and Dignitaries:

- (i) **Welcome Remarks by Mrs. Kabo Mompoti, Chief Health Officer, Ministry of Health, Botswana and Chairperson of the AU Conference of Ministers of Health**

5. Mrs. Kabo Mompoti, Chief Health Officer, Department of Public Health, Botswana Ministry of Health welcomed the participants and expressed appreciation to the Government of Mozambique for hosting this very important Conference, and recognized the role of the AU Commission in organizing the Meeting. She then called the Meeting to order and invited the representative of the Government of Mozambique to welcome participants. .

- (ii) **Welcome Remarks by Dr. Mouzinho Saide, Director of Health Services, Ministry of Health, Mozambique**

6. The Mozambique Director for Health Services welcomed the delegates to the Special Session on Sexual and Reproductive Health and Rights. He noted that the Conference would provide an opportunity for consideration of challenges relating to promotion of sexual and reproductive health and rights in Africa, and finding effective means of tackling them. He recognized the Development Partners that supported the convening of the Special Session, particularly UNFPA, WHO, USAID and others. He commended the role played by the Mozambique Inter-Ministerial Committee during the preparatory process. He indicated that it was Mozambique's priority to see that the delegates have a pleasant stay in Maputo, and that they are availed adequate services. He concluded by expressing hope for a successful Meeting.

- (iii) **Statement by Amb. John K. Shinkaiye, Chief of Staff, AU Commission on behalf of the Commissioner for Social Affairs**

7. This statement was read by Ambassador John Shinkaiye, Chief of Staff for the Bureau of the AU Commission Chairperson on behalf of Advocate Bience Gawanas. In the statement the Commissioner for Social Affairs thanked the government and people of the Republic of Mozambique for hosting the Special Session of the AU Conference of Ministers of Health dedicated to Sexual and Reproductive Health and conveyed warm greetings from H.E. Prof. Alpha Konaré, the Chairperson of the AU Commission to all delegates.

8. Amb. Shinkaiye went on to recognize that health, especially sexual and reproductive health, is central to socioeconomic development because the reproductive choices that people make over time shape the age structure of the population. He further acknowledged the impact of the HIV/AIDS pandemic on political, social and economic development in Africa in the face of pervasive poverty and identified the mainstreaming of Sexual and Reproductive Health and Rights (SRHR) and its linking with HIV/AIDS in health care delivery as a logical approach to the achievement of MDGs.

9. He mentioned that the African Union developed a Continental Sexual and Reproductive Health Policy Framework which was adopted by the 2nd Session of the AU Conference of Ministers of Health held in Gaborone in October 2005 and endorsed by the Summit of AU Heads of State and Government in Khartoum, Sudan in January 2006 in order to address the disease burden associated with sexual and reproductive health.

10. The Chief of Staff concluded by assuring the delegates that the African Union was on their side and would support all their efforts in the area of sexual and reproductive health.

(iv) **Keynote address by the Guest of Honour, Dr. Aida Libombo, Hon. Deputy Minister of Health, Mozambique**

11. Hon. Dr. A. Libombo, Deputy Minister of Health, Mozambique welcomed the delegates and indicated that her country felt honoured to host such an important Meeting. She commended the AU for organizing the Special Session, a culmination of various meetings on promotion of the reproductive health in Africa, particularly of girls and women. She recalled the 2nd Session of the AU Conference of Ministers of Health which was held in Gaborone, Botswana in 2005 and called for integration of sexual and reproductive health into health policies, aimed at achieving the Millennium Development Goals (MDGs). This would also lead to poverty reduction. The 2nd Session also recommended that the Special Meeting on Sexual and Reproductive Health be held.

12. The Hon. Minister explained that, to reduce the disease burden, it was necessary to reposition health programmes, particularly the components of sexual and reproductive health including HIV/AIDS, abortion, family planning and neonatal care. On the impact of HIV/AIDS in Mozambique, she noted the special vulnerability of youths, particularly girls. This was, among others, due to gender-based and sexual violence, and related consequences. Addressing this challenge should therefore be incorporated into policies as a priority. She emphasized that access to health during pregnancy and delivery was a fundamental human right and as such, should be universally available. This would save the lives of many babies and mothers, and reduce poverty. She noted some improvement in the area of financing, and partnerships with the community. She advised that the Action Plan to be developed for promotion of

sexual and reproductive health and rights should be based on an integrated approach.

13. Hon. Dr. Libombo then thanked the Development Partners which had contributed to the realization of this Conference. She concluded her statement by wishing participants fruitful deliberations and a pleasant stay in Maputo.

14. Following the Keynote Statement, the Chief Health Officer of Botswana assured the Guest of Honour that the Experts would work hard and come out with a constructive outcome. She then thanked the Guest of Honour for gracing the Opening Ceremony of the Experts Meeting.

(v) **Message from the European Union**

15. After the opening the Representative of EC thanked the AU Commission for the invitation to the Conference and underscored the support of the EC for Africa. He noted that the EC and the AU Commissioners would meet in Addis Ababa next month where they would, among others, address Sexual and Reproductive Health. The Representative explained that the International Conference on Population and Development (ICPD) was a turning point for EU support. SRHR is a priority for the EU. He also emphasized that Sexual and Reproductive Health and Rights (SRHR) are critical determinants of poverty and the achievement of the MDGs.

16. The new European Consensus notes that budget or sector support is the preferred aid tool; that donors coordinate their aid more effectively; and that good governance is a key issue in European development policy.

17. The EU had provided aid for policies and actions of SRHR for NGO-driven projects in poorest countries and has a call for proposals on how to improve SRHR for refugees and displaced persons. The representative informed the Meeting that the Reproductive Health Supplies Coalition was a partnership between organizations and donors and urged more African countries to join the coalition. He also noted that Europe will support integration of HIV and SHRH prevention supplies, gender equality as part of SHRH and research on microbicides, and had hosted a high level symposium on sexual violence in conflicts and beyond. The EC Representative concluded his statement by calling for global prioritization of SRHR, and indicated that the Special Session was a leading step in this direction

IV. PROCEDURAL MATTERS

(a) Adoption of the Agenda

18. The agenda was adopted as presented.

(b) Organization of Work

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

Morning : 09.00 - 13.00 hrs.
Afternoon : 14.00 - 18.00 hrs.

V. PRESENTATION ON THE OVERVIEW OF THE THEME “UNIVERSAL ACCESS TO COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN AFRICA”

20. This item was presented by the Head of Health, Nutrition and Population of the AU Commission. He observed that among the many challenges Africa faces is the high disease burden which contributes to the high prevalence of poverty and hunger in the continent and noted that sexual and reproductive health conditions, including complications of childbirth contribute a significant proportion of disease in Africa especially among women.

21. The presenter went on to highlight that among the strategies adopted to reduce this disease burden is the delivery of Primary Health Care whose components include Sexual and Reproductive Health to reduce maternal and child morbidity and mortality.

22. He then sited the following as the main challenges that Africa faces in her effort to scale-up SRHR services. These include inadequate access to essential medicines because the cost of medicines is very high as they are mostly imported, and there are protective mechanisms to prevent local manufacture, limited public funding and lack of integrated health systems and Shortage of health workers and Less effective use of available resources

23. Finally he outlined the opportunities which Africa can build on in order to arrest the disease burden associated with sexual and reproductive health which include Sharing of Best Practices, Investment in Sexual and Reproductive Health, elimination of Harmful Traditional Practices, Repositioning of Family Planning and Ensuring Reproductive Health Commodity Security.

24. The presenter concluded by indicating that the objective of the meeting was to develop an Action Plan for the operationalisation of the SRHR Policy Framework to accelerate the achievement of universal access to SRH services which was critical for the achievement of the Millennium Development Goals.

SUMMARY OF TECHNICAL DISCUSSIONS

VI. PRESENTATION OF WORKING DOCUMENTS

(a) Best Practices in Sexual and Reproductive Health and Rights (SRHR) Service delivery

25. The presentation was made by the Representative of AU Commission. Best practice was defined as a process-oriented concept that was associated with optimum outcomes and not protocols for the guidance on the delivery of services. It was successful with use of these protocols in the prevailing situations. The paper presented 2 examples, one on delivery of safe motherhood services on the Sri Lankan model, and the other of successful mainstreaming of HIV/AIDS in national development on the Botswana model.

26. Sri Lanka was taken as an example in view of its similarity with many African countries in that it had a population of 19.7 million, a per capita Gross National Income (GNI) of \$4,000, external debt of 105% and was experiencing wide spread conflict at the time of the review. Despite these challenges, Sri Lanka had achieved significant improvements in maternal and child care resulting in indicators that were approaching those of developed countries. For example life expectancy at birth increased from 43 years in 1946 to 70.2 years in 2002, infant mortality rate dropped from 35 deaths per 1000 live births in 1980 to 16/1000, and the maternal mortality ratio was reduced from 155/100,000 live births in 1946 to 23/100,000 in 2002.

27. The best practices identified included the emphasis on social development and social services, including basic education, delivery of close-to-client services, universal coverage for skilled attendance at childbirth, provision of accessible referral services, including essential obstetric care, provision of post-natal care through home visit during the first week of childbirth and more equitable distribution of wealth whereby only 7% of the population lived on less than \$1.

28. Botswana's antiretroviral therapy (ART) programme was highlighted as a best practice in mainstreaming HIV/AIDS services in primary health care leading to the exceeding the 3 by 5 ART targets. Botswana also stepped up IEC/BCC resulting in the reduction of HIV prevalence to 17.1% in a relatively short time. The patient survival rate at 12 months of treatment was a commendable 83% diagnosis.. Among the best practices identified in the programme was government commitment as reflected by raising 90% of the resources locally, commitment to proving HIV testing a routing PHC service and strong partnership with civil society.

(b) **Cost-effective Interventions for the Prevention of Maternal Morbidity and Mortality, including Unsafe Abortion**

29. The representative of the Ministry of Health of Mozambique introduced this item describing the territorial area of Mozambique as well as the surface and population size of the country. He also painted a dramatic picture of the absolute poverty conditions of people living in the rural areas. Therefore, health workers faced difficulties in having access to such areas due to conditions of roads. He considered that such access difficulties were the cause of the increase in maternal and child mortality in those regions.

30. He went on to highlight the strategic framework adopted by the Government of Mozambique to prevent causes of maternal and child mortality. One of the strategies adopted was the improvement of primary health care, building of new health facilities in the rural areas to reduce the number of people affected by cholera.

31. The speaker explained that the government had made remarkable efforts for capacity building in reproductive health as well as other important areas such as medicine, surgery, paediatrics and gynaecology and obstetrics. He also stressed that although much had been done by the government, mortality rate in the rural area remained one of the sources of concern to the government. He further highlighted improvement made in rural hospital infrastructure and facility building.

32. The representative informed delegates of Member States that the Mozambican government invested a lot in short-term training of health experts with the objective of meeting the needs in health workers in such rural hospitals.

33. In conclusion, the representative of the Ministry of Health made the following recommendations:

- Countries must endeavor to provide short term training for health workers in order to reduce shortage of Medical Doctors in the rural areas;
- Member States should adopt a strategic mechanism at regional level under the African Union coordination, in order to prevent increase in maternal mortality in the rural areas.

34. In the discussion that ensued, delegates reacted by observing that though the Mozambican Government had made efforts to train surgery staff on a short term basis, there was still need for training traditional midwives in the rural areas. They also felt that lack of information for such traditional midwives was one of the causes for the increase in maternal mortality rate in those regions.

(c) **Macro-economics of Sexual and Reproductive Health**

35. The Representative of the AU Commission started by outlining the status of maternal health in Africa. It highlighted the persistent excess fertility rates in both married and teenage populations, high maternal mortality ratios, and high infant mortality rates. As a result there was high disease burden related to sexuality and reproduction. As women constituted about 70% of the labour force and grew 80% of food in the continent, this diseases burden undermined economic development and increased poverty which was associated with ill health.

36. The advantages of investing in reproductive health were outlined, and the gains estimated. For example meeting the need for family planning would avert 22 million unsafe abortions thereby preventing 53,000 unsafe abortion deaths which during 2001 – 2021 would lead to savings of \$22 billion/10 years from maternal death and another \$23 billion /10 years from maternal disability. Egypt reported a saving of \$31 for every dollar invested in family planning according to a World Bank report of 1997.

37. The paper concluded by advocating for increased resources for sexual and reproductive services by showing the benefits of such increases by showing what those resources could be through the National Health Accounts; focusing on priority interventions that were associated with effectiveness and efficiency in reducing disease burden, strengthening health systems and monitoring progress towards universal access for sexual and reproductive health care.

38. During the discussion that ensued, resource mobilization strategies for SRHR services were suggested and should include increasing the allocation of the national budget for health to at least 15% as agreed by African Union member states, allocating to SRHR some of the saving from debt cancellation accorded to HIPCs, use of the Official Development Assistance.

(d) **Elimination of Harmful Traditional Practices Including the Prevention and Management of Obstetric Fistulae in Africa**

39. In his presentation, the Representative of the AU Commission, outlined the different types of harmful traditional practices such as Female Genital Mutilation (FGM), early marriage, violence against women and children. He also pointed out some of the immediate and long term consequences of harmful traditional practices such as pain, hemorrhage, infection, obstructed labour, as well as psychoemotional and social problems, especially lack of marital compatibility.

40. He then made some recommendations in order for Member State to address the challenges of harmful traditional practices on reproductive health. These include:

- Adopting a rights-based approach to the promotion of women's health, including reproductive health;
- Refocusing on the goals and targets of the ICPD and MDGs with emphasis on the health of women and girls;
- Integrating reproductive health into national poverty reduction strategies and sustainable development; and
- Revising respective national legislations in the areas of women's health, particularly those related to the fight against harmful traditional practices.

41. In the discussions that followed, delegates from Member States reiterated the need for eliminating harmful traditional practices and pointed out that some encouraging efforts are being made in their respective countries, including formulating laws against female circumcision; promotion of information and communication programmes, involving religious leaders and the community in the elimination of harmful traditional practices. In addition, it was noted that the African Union has put a number of legal instruments in place to tackle the impact of those practices and to promote Sexual Reproductive Health and Rights (SRHR).

42. Participants also noted the challenges associated with identifying and addressing some of the harmful practices which are done clandestinely and which make these practices a myth rather than a reality. Other participants emphasized the need for focusing on "couples" rather than on either women or men in the process of promoting reproductive health as well as in discouraging harmful traditional practices.

43. Finally, the presenter appreciated all the interventions and assured participants that some of the reproductive health initiatives of Member States deserve to be recorded and disseminated as best practices.

VII. PANEL DISCUSSION ON INCREASING SRHR SERVICES AND UNIVERSAL ACCESS

(a) Programme Approaches for the linking of Sexual and Reproductive Health and rights and HIV/AIDS Services

44. Susan Rich of the Bill and Melinda Gates Foundation presented the challenge and rationale for linking RH and HIV services. With dwindling resources governments and donors are considering the integration of services. With examples from several African countries, the speaker showed how integrating RH and HIV, HIV+STI and PMTCT services in family planning, antenatal care and postnatal care, can improve access to services, improve

quality of care, increase utilization of services, increase cost effectiveness, increase knowledge, reduce stigma and improve equity.

45. Integration must be customized based on the prevalence of HIV. When prevalence is above 1% among pregnant women, FP and HIV should be integrated. When it is at lower level, there can be FP for the general population and HIV services for high risk populations. Policymakers can include integration in strategies, budgets and plans. Ministries of Health can consider how integration can change training, staffing, and supply chains.

46. During the discussion that followed delegates recommended that integration in this respect should also include Malaria.

(b) **Repositioning Family Planning to reduce unmet need**

47. In his presentation the Representative of the AU Commission defined Family planning as the planning of pregnancies by couples and individuals to achieve reproductive intentions in a timely manner and went on to say that it is more than the avoidance of *unwanted* pregnancies and births. It also includes conceptional care to achieve *wanted* pregnancies, particularly in the face of reproductive barriers.

48. The presenter then acknowledged that competing priorities in health budgets with HIV/AIDS, malaria and other infectious disease programs have dramatically reduced the visibility of and funding for family planning. Donors from Western countries where fertility levels are low now accord family planning assistance less priority. Meanwhile, with unmet need for family planning increasing, it is up to African leaders to show their support in providing women and men reproductive choices by embracing and invigorating the family planning field.

49. He then observed Family Planning Repositioning means increasing awareness, relevance and use of contraceptive information and services through related reproductive health and development policies and programs currently operating in a country. He further noted that Family planning's benefits are numerous. Family planning can:

- Increase the prospects of regional economic development and equity
- Improve gender equity
- Reduce maternal mortality and morbidity and improve women's health
- Improve child survival
- Reduce HIV and STI transmission
- Improve reproductive health for other populations, such as men, youth, and infertile couples

50. In terms of The Way Forward in Leadership the presenter observed that Today's African leaders have the opportunity to be at the forefront of redefining,

revitalizing, and repositioning of family planning and that, to do so, they should set their sights on accomplishing four goals:

- Fostering and nurturing new leadership in family planning
- Expanding and improving the quality of family planning services
- Accelerating the integration and linkage of family planning with sexual and reproductive health services, and
- Advocating a continental message on family planning that resonates with the donor community

51. In the discussion that followed, delegates shared their experiences in reposition of family planning and cautioned that there was need to involve men more this time around in order to exert the desired impact.

(c) Reproductive Health Commodity Security

52. The presentation was made by the UNFPA Representative. Reproductive Health Commodity Security (RHCS) was defined as the ability of all individuals to obtain and use quality, affordable reproductive health commodities of their choice whenever necessary. RHCS is more than just the supply of contraceptives. The rationale for investing in RHCS was explained and donor commitment and support given for Sub Saharan Africa highlighted. It was explained that RHCS underpins maternal health and HIV prevention and is part of an integrated approach. Key issues facing the region include facilitating country efforts to ensure that stakeholders define, own and drive their own RHCS plans and that the national capacity for addressing RHCS needs is enhanced through efficient supply management.

53. The political commitment required for RHCS was outlined as were the key challenges being faced at the national level. It was stated that the Global Partnership for Reproductive Health Commodity Supplies has been established to enhance commodity security and work with countries. It was reported that there needed to be political commitment to include RHCS in the national budget and national action plans and that RHCS coordination mechanisms need to be put in place. It was also stated that reproductive health commodities should be part of the essential drug list.

54. It was reported that some progress had been made for RHCS at the country level and that most RHC stockouts had been averted. In addition, there had been an increase in the number of: a) countries with budget lines dedicated to reproductive health commodities b) countries with reproductive health security committees and c) an increase in the number of countries with reproductive health security national action plans.

(d) **Strategies for improving the quality of maternal and perinatal care**

55. This paper was introduced by Dr. Anna Voce of the University of Kwa-Zulu-Natal, South Africa. She presented the significant achievements of South Africa on indicators that measure the availability and utilisation of contraceptive services, and services for antenatal and intrapartum care. Within a context of increasing availability, accessibility and utilisation of reproductive and maternal health services, and within a context where a legal framework exists for recording maternal deaths, it is possible to implement an effective confidential enquiry system for analysing the major causes of maternal death, the avoidable factors, and the quality of care provided.

56. She listed the major causes of death and the avoidable factors of maternal mortality in South Africa, and identified the major challenges in the provision of quality maternal care. She identified strategies to address these challenges *viz*: (1) Establishing an effective information system (supported by relevant software e.g. MaMMAS (Maternal Morbidity and Mortality Auditing System) which supports the national confidential enquiry into maternal deaths; and the PPIP (Perinatal Problem Identification Programme) which assists with recording perinatal and maternal deaths at institutional level. (2) Implementing an effective supervision system. (3) Establishing an effective in-service training programme. (4) Providing outreach programmes from higher levels of care. (5) Effective team management of the levels of care to provide leadership, management and co-ordination at district level for a seamless reproductive and maternal health system. (6) Ensuring adequate staffing.

57. During the discussion that ensued, delegates raised a number of issues. In response to the query about the source of information for the maternal mortality ratios it was indicated that this was obtained from UNICEF/UNFPA/WHO Maternal Mortality in 2000: estimates developed by WHO/UNICEF/UNFPA and published in 2004. On rural/urban disparities, the presenter indicated that this was addressed through increasing accessibility to rural health facilities attributed to the clinic building and upgrading programme, and the hospital revitalisation programme, and to the provision of free primary health care services and free health services for pregnant and lactating women. Delegates also pointed out the need for strategies for ensuring availability of blood safety and availability of software for effective audit needs to be expanded on the continent.

(e) **State of the African Population 2006: Reproductive Health Component**

58. Dr. Jotham Musinguzi of Uganda pointed out that population growth is not a problem in itself, but that social and infrastructural facilities should match with the pace of population growth. Education is also an important aspect of the demographic dynamics. Worth noting, according to the presenter, is also the

population structure which has implications on poverty levels, commodity security for Reproductive Health (RH); and other issues.

59. He finally stressed that there was need to ensure the balance between population and development in other sectors, growth in investment (eg. Funding RH services; need for building partnership with the North as well as South-South Cooperation between Africa, Latin-America and South America.

60. In the discussions, the delegates emphasized that there was need to invest in population as the demographic outlook of the African continent is still of great concern. It was announced that the State of African Population Report was actually to be launched during the Ministerial Meeting of the Special Session.

(f) **Better utilization of human and financial resources for reproductive health and involvement of the private sector**

61. The speaker, Dr. Ladi Awosika of Nigeria stated that the Millennium Development Goals could not be attained without the assistance of the private sector and that the ownership of reproductive health services by communities had to be facilitated. The challenges being faced in Africa were listed and the need to improve financing emphasized. He highlighted the importance of increasing human resources in relation to the recruitment, retention and utilization of health sector staff and gave examples which included various benefits such as top up salaries and free housing. Also highlighted was the importance of making services for clients available at convenient times and locations.

62. He stated that the private sector could increase access to reproductive health through the scaling up of both the number of services and number of health providers available. This would allow the public sector to focus services on underserved communities through the utilization of private providers. He also emphasized that private sector providers required little support from governments or donors. He also mentioned that the private sector would be motivated by earning profits, but not at the expense of the public and that social marketing organizations had many new products to introduce lower priced contraceptives with full cost recovery. He recommended improving financing for reproductive health and developing partnerships with the private sector.

63. During the debate that followed, it was emphasized that partnership between Government and the Private Sector and civil society should be encouraged, and that Government should contribute to the budget of private clinics. Experiences of other private enterprises and NGOs were shared. Note was made that the private sector was best to utilize resources rationally.

64. At the end of the debate, it was noted that the objective of the panel discussion was to enrich input into the Action Plan which was being developed for implementation of the Continental Policy Framework on SRHR.

VIII. CONSIDERATION OF THE DRAFT ACTION PLAN FOR THE OPERATIONALIZATION OF THE CONTINENTAL POLICY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND THE APPLICATION OF THE GENERIC MONITORING, EVALUATION AND REPORTING TOOLS

65. Introducing this item Dr Thomas Bisika, Head of Health at the African Union Commission, observed that the AU developed the Continental Policy Framework for the Promotion of Sexual and Reproductive Health in collaboration with IPPF and UNFPA which was adopted by Health Ministers in October 2005 in Gaborone, Botswana and endorsed by the AU Heads of State and Government in Khartoum in January 2006. He further observed that the Draft Action Plan he was presenting was designed to operationalise the SRHR Policy Framework.

66. He then informed the delegates that a 4-Year Plan was being proposed for the period 2007 – 2010 which would be followed by another 5-year plan covering the period 2011 - 2015. This would facilitate an assessment of achievement of the MDGs in 2015.

67. With respect to content, the presenter indicated that the Action Plan was based on the Operational Plan Matrix of the Continental SRHR Policy Framework and that the content was flexible to accommodate national objectives/goals. The Action Plan was mainly designed to accelerate achievement of MDGs.

68. The presenter outlined the strategic areas covered in the Action Plan as follows:

- (i) Development of integrated HIV/AIDS and SRHR programmes and services to maximize the effectiveness of resource utilization and to attain a synergetic complementarities of the two strategies;
- (ii) Repositioning family planning as an essential part for the attainment of health MDGs;
- (iii) Addressing the sexual and reproductive health needs of adolescents and youth as a key SRH component;
- (iv) Addressing unsafe abortion;
- (v) Delivering quality and affordable services in order to promote Safe Motherhood, child survival maternal, newborn and child health.
- (vi) Reproductive Health Commodity Security

69. The related operational strategies, according to the presenter, were increasing resources for sexual and reproductive health and rights, Strengthening SRH commodity security and putting in place effective monitoring

tools to track progress made on the implementation of this Plan of Action. The main challenge at hand was mobilizing the necessary resources for universal access to comprehensive Sexual and Reproductive Health services.

70. The opportunities for the successful implementation for the Action Plan were cited as great interest in SRHR from Civil Society, South-South co-operation and broad international support for the improvement of maternal and child health in developing countries and Africa in particular - as demonstrated by the large presence of development partners at the conference.

71. The presenter concluded by observing that the matrix presented should be perceived as a Framework for national Cost Estimate and that the proposed costs were based on UN Population Division medium variant projections of fertility decline during the period 2007 – 2010 on the needs for achieving universal access for comprehensive SRH services by 2015. Finally the presenter indicated that the figure of \$3.5 billion required for SRH services in 2007 needed to be supplemented by \$2.2 billion for HIV/AIDS prevention and the further resources needed for HIV/AIDS treatment.

72. The discussion that followed the presentation was rich and interactive. Many issues were proposed for improving the content, format, priorities and strategies of the Action. It was emphasized that the Policy Framework and its Action Plan were indeed frameworks to guide Member States as they develop or strengthen appropriate national policies and programmes. The priority areas of the Action Plan should follow the Policy Framework. Some of the issues raised include the following:

- Leverage the opportunity of Incorporating malaria into SRHR programmes,
- STI programmes should be integrated into all Reproductive Health and HIV and AIDS programmes.
- Highlighting issues such as harmful traditional practices;
- Recognizing the role of the private sector;
- The need to prioritize strategies that can be implemented within 04 years;
- Ensuring sustainable funding, for example, through establishing an AU fund;
- Ways of ensuring a sustained supply of health workers were proposed, including tailoring training for local consumption.
- Comprehensive Reproductive Health Commodity Security is imperative
- The need for ensuring media and communication was emphasized;
- It was noted that poverty reduction should be part and parcel of health care provision;
- It was noted that the estimated budget was indeed an estimate to guide Member States as they plan and mobilize resources;

- A proposal was made that all commitments of African Leaders on Health and Development should have one all-encompassing Action Plan rather than the many fragmented ones;
- The role to be played in implementation of the Continental SRHR Policy Framework by the AU, RECs and International Development Partners should be clearly outlined;
- It was reiterated that men were part and parcel of the target groups and tools for change. As such, they should be mobilized, together with women and youth;
- A Monitoring, Evaluation and Reporting Mechanism should be part and parcel of the Action Plan;
- It was found difficult to decide on how much detail to include in the Action Plan for the Continental Policy Framework, or what issues were specifically for national level;
- It was also proposed that time frames for implementation be included to assist Monitoring and Evaluation (M&E);
- The indicators need to include the degree of satisfaction of the beneficiaries;
- The interventions that are not in this plan should be catered for between 2010 – 2015.

73. Finally, the Drafting Committee was charged with revising the Draft Action Plan and incorporating appropriate changes. The revised Action Plan would be reconsidered by the Experts in a Plenary Session.

IX. ANY OTHER BUSINESS

74. There was no other business.

X. ADOPTION OF THE DRAFT ACTION PLAN AND REPORT OF THE EXPERT MEETING

75. The Secretariat was commended on the changes made to the Draft Action Plan consequent on the comments of the Experts Meeting. Further comments were received and the Draft Plan of Action on the Operationalization of the Continental Sexual and Reproductive Health and Rights in Africa was recommended to the Ministers of Health for adoption subject to the incorporation of the additional changes agreed to.

XI. CLOSING

76. The closing of the Experts Meeting was presided over by Mrs. Kabo Mompoti, Chief Health Officer at the Ministry of Health of Botswana. She commended all the delegates and development partners for their contribution. She said they had worked together as a team and accomplished a great amount. She expressed her appreciation to the Ministry of Health of Mozambique for the facilities that were availed to the delegates. She also thanked the Secretariat and

the volunteers who contributed to the success of the Experts Meeting. She expressed the hope that both the delegates and development partners would collaborate and play their respective roles in implementing the Action Plan for improvement of Sexual and Reproductive Health and Rights in Africa and attainment of its development goals. She concluded by thanking the delegates for their hard work, patience and solidarity.

ANNEXURE 1: ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
BCC	Behavioural change communication
CPR	Contraceptive prevalence rate
CYP	Couple year protection
EmOC	Emergency Obstetric Care
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
ICPD	International Conference on Population and Development, Cairo, 1994
IMR	Infant Mortality Rate
LMS	Logistic Management Systems
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MMR	Maternal Mortality Rate
NGOs	Non-governmental organisations
NDPs	National development plans
NDSs	National development strategies
PLWHAs	People living with HIV and AIDS
PMTCT	Prevention of mother- to-child transmission
POA	Plan of action
RH	Reproductive health
RHCS	Reproductive Health Commodity Security
SDPs	Service delivery points
SRHR	Sexual and reproductive health and rights
TBAs	Traditional birth attendants
VCT	Voluntary counselling and testing