ACCELERATING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH

AGENDA FOR THE AFRICAN REGION OF THE WORLD HEALTH ORGANIZATION

"Reproductive Health is a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity in all matters related to the reproductive system and its functions and processes", ICPD 1994

World Health Organization
REGIONAL OFFICE FOR Africa

ACCELERATING UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH

AGENDA FOR THE AFRICAN REGION OF THE WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville ● 2013

Printed in the Republic of Congo

Contents

Page

Foreword

Progress towards universal access to Sexual and Reproductive Health (SRH) as envisioned in the Millennium Development Goal (MDG) 5 in the African Region has been below expectation. With just about two years to reach the MDG target year of 2015, many of our countries are still not on track to achieve the MDGs. Countless women and children continue to die from easily preventable or treatable conditions. This should be the pressing issue around which we should mobilize our full energy and build a strong movement for continuing advocacy for equal access of women and children to quality Sexual and Reproductive Health services.

The adoption by Member States of the Regional Strategy for Sexual and Reproductive Health in 1998 was a landmark in the drive to attain Health for All in Africa. It introduced unprecedented high level of regional and global collaboration and became the umbrella for several initiatives addressing various thematic areas for promoting innovative and comprehensive approaches to reproductive health care covering maternal and perinatal health, adolescent sexual and reproductive health, unintended pregnancies, prevention and control of sexually transmitted infections including HIV/AIDS and cervical cancer, reduction of female genital mutilation, domestic and sexual violence.

Since then, several initiatives have been put forth, but their scaling up has not been far-reaching enough to make any meaningful difference in the status of reproductive health in the Region. Efforts to improve maternal, newborn and child health in the WHO African Region are hampered by: (i) inadequate access to, and inequitable distribution of, high-quality maternal and child health care services; (ii) inadequate financial resources; (iii) insufficient skilled human and institutional capacity; (iv) weak health information systems for tracking the progress made; and (v) weak community involvement and participation.

The WHO Regional Office for Africa, in collaboration with partners, has developed a regional agenda on "*Accelerating Universal Access to Sexual and Reproductive Health: Agenda for the WHO African Region*" to focus on few priority actions that give attention to new approaches to optimizing the delivery of key interventions in order to accelerate the attainment of Universal Access to Sexual and Reproductive Health in the African Region.

This is a collective agenda for action intended to accelerate Africa's progress towards universal access to sexual and reproductive health, especially working towards charting the way forward to achieving the Millennium Development Goal 5-b.

It is my cherished hope that this regional agenda will renew the urgency in our provision of support to countries to accelerate their progress towards achieving the MDG targets within the coming years.

Dr Tigest Mengestu Ketsela,
Director, Health Promotion cluster
WHO Regional Office for Africa

Acknowledgements

The World Health Organization would like to thank all those who contributed with their knowledge, experience and time to the development of this agenda. In particular, WHO acknowledges the contributions of all the individuals and institutions who took part in the Regional Consultation on Regional Agenda for Universal Access to Sexual and Reproductive Health, held in Nairobi, Kenya, namely:

- **Ministry of Health (MOH) representatives** from Angola, Botswana, Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Mali, Mozambique, Nigeria and Zimbabwe.

- **Partners**: The David and Lucile Packard Foundation, African Population and Health Research Centre (APHRC), Africa Family Health; East, Central and Southern Africa Health Community (ECSA); *Fédération des Associations de Sages-femmes d'Afrique Centrale et de l'Ouest* (FASFACO); Family Health International; Intrahealth; Ipas; Marie Stopes International; Medical Women's International Association (MWIA); Pathfinder International; Population Council; Population Council, Kenya; Planned Parenthood Federation of America (PPFA); *Société Africaine de Gynécologie Obstétrique* (SAGO); Institute for Reproductive Health, Georgetown University; United Nations Population Fund; United Nations Children's Fund; United States Agency for International Development.

- **Consultant**: Prof. Joseph Kasonde

This document has been developed under the auspices of the *Making Pregnancy Safer* team in the WHO Regional Office for Africa (WHO/AFRO), with invaluable contributions from other colleagues in the Health Promotion cluster, the Reproductive Health and Research team from WHO headquarters (WHO/RHR), the WHO Intercountry Support Teams (ISTs) from West, Central, and East and Southern Africa, and the WHO country offices in Cameroon, Ethiopia, Kenya, Mozambique, Sierra Leone, Senegal and Uganda.

WHO gratefully acknowledges the financial contributions made by the David and Lucile Packard Foundation in support of this and related activities within the Family and Reproductive Health Programme.

Executive summary

The health of women and children in the African Region has not seen significant improvement over the last two decades with regard to sexual and reproductive health (SRH). In 2010, the average maternal mortality ratio in the African Region was estimated at 480 per 100 000 live births, whereas the corresponding rates for all developing countries was 240 per 100 000 live births in 2010. In order to achieve the Millennium Development Goal (MDG) 5, maternal mortality ratio needs to decline at a rate of 5.5% per year, but in the African Region the rate of decline was only 2.7% over a whole period between 1990 and 2010 which is not enough. Furthermore, the HIV epidemic continues to have a huge negative impact on maternal and child health, particularly in the most heavily affected countries in sub Saharan Africa where it was estimated that the contribution of HIV to maternal deaths was 10% in 2010.[1]

The adoption by Member States of the Regional Strategy for Sexual and Reproductive Health in 1998 was a landmark in the movement towards health for all in Africa. It introduced a high level of regional and global collaboration not achieved before and became the umbrella for several initiatives addressing thematic areas or promoting innovative and comprehensive approaches to reproductive health care covering maternal and perinatal health, adolescent sexual and reproductive health, unintended pregnancies, control of sexually transmitted infection and HIV/AIDS, prevention of cervical cancer, and reduction of rates of female genital mutilation and domestic and sexual violence.

Since then, several initiatives have been put forth, but their scaling up has not been far-reaching enough to change the status of Reproductive health in the Region. Efforts to improve maternal, newborn and child health in the WHO Africa Region are constrained by: (i) inadequate access to, and inequitable distribution of high-quality maternal and child health care; (ii) inadequate financial resources; (iii) insufficient skilled human and institutional capacity and (iv)weak health information systems for tracking progress made; and (v) weak community involvement and participation.

The proposed priority actions in the Regional Agenda sets to reinforce the Member State's and partner's commitment to sexual and reproductive health in order to accelerate progress towards achievement of the MDGs especially MDG 4 and 5. It focuses on five priority thematic areas: maternal and newborn health; family planning; harmful practices, including female genital mutilation (FGM); preventing unsafe abortion, sexually transmitted infections (STIs), HIV/AIDS and cervical cancer. In response to the need to speed up implementation of key evidence-based interventions, five areas of action to concentrate on have been proposed for the Member states to address: (i) governance; (ii) health service delivery; (iii) human resources (iv) financial resources; and (v) health information.

The adoption of the Regional Agenda by the member states and its implementation will help scale up the key interventions to accelerate progress towards attainment of the MDG 5 by 2015. Strong political commitment and ownership are the basis for a rapid scaling up and sustainability of the interventions towards universal access to sexual and reproductive health care. The fulfilment of the Regional Agenda will also require strong partnership and involvement of ministries of finance, education, and other relevant sectors, as well as non-governmental actors, civil society organizations, academia, professional associations, human rights groups, women's associations, and political, religious and community leaders.

Introduction

The health of women and children in the African Region has not seen significant improvement over the last two decades. A slow pace of progress is reflected in very few countries being on track towards achieving the Millennium Development Goals (MDGs) 4 and 5, especially the Sexual and Reproductive Health.[1] Despite that several well intended initiatives have been put forth, their scaling up has not been far reaching enough to change the status quo as the challenges faced by many countries in addressing the poor health status of women and children are many and diverse.

The African Region continues to lag behind other regions of the world with regards to Sexual and Reproductive Health (SRH). For example, in 2010, the average maternal mortality ratio in African Region declined to 480 per 100 000 live births, whereas the corresponding rates for all developing countries was 240 per 100 000 live births in 2010.[1,2] In order to achieve MDG 5, maternal mortality ratio needs to decline at a rate of 5.5% per year, but in the African Region the current rate is only 2.7% for the period between 1990 and 2010. Contraceptive prevalence rate in 1990 in the Africa Region was 12% and rose to 24% in 2010, while unmet need for family planning remained correspondingly high at 26.5% in 1990 and remained at 25% in 2010. Adolescent birth rate remained high in the African Region at 117 per 1000 women aged 15–19years as compared to 50 per 1000 for the global estimate in 2010[2]. In addition, data for 22 countries in Sub-Saharan Africa from 1998 to 2009 show that 15–19 years old married or in-union women had much lower levels of contraceptive use (10%) compared with all women of reproductive age (20%).[3]

The unanimous adoption by Member States of the Regional Strategy for Sexual and Reproductive Health, 1998 to 2007 in 1998,[4] was a landmark in the movement towards health for all in the Africa Region. It introduced a high level of regional and global collaboration and became an umbrella for several initiatives addressing thematic areas or promoting innovative approaches to reproductive health care covering maternal and perinatal health, adolescent sexual and reproductive health, unintended pregnancies, sexually transmitted infections (STIs) and HIV/AIDS, cervical cancer, and female genital mutilation and domestic and sexual violence[4]. Further recognition of the importance of sexual and reproductive health came in 2004 when the WHO Global Reproductive Health Strategy was adopted by the Fifty- seventh session of the World Health Assembly,[5] the development of the Roadmap for Accelerating the Attainment of MDGs related to maternal and newborn health in the African Region[6] which was adopted by the Regional Committee for Africa in 2004 and endorsement of the Child Survival Strategy for the African Region in 2007 which is linked to Sexual Reproductive health.[7]

These resolutions were followed by the adoption of the Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action) by the African Union Commission,[8] the adoption of the Algiers Declaration by the Ministerial Conference on Research for Health in 2008, which calls on African nations to develop comprehensive plans for health research and information[9] and the Ouagadougou Declaration on Primary Health Care.[10] Furthermore in 2009, the African Union launched a Campaign for the Accelerated Reduction of Maternal Mortality in the Africa (CARMMA)[11] . All these International and Regional Frameworks support the implementation of sexual and reproductive health including ensuring inclusion

into the national planning, budgeting and monitoring system and strengthening capacity of health systems to deliver sexual and reproductive health interventions at different levels of the health service delivery.

Despite all these efforts, and only 3 years remaining to the 2015 target, the situation of sexual and reproductive health still lags behind. The United Nations Secretary General Global Strategy on Women's and Children's health[12] of which member states committed to implement, calls for urgent actions to be undertaken to attain MDG 5.

In this context, WHO Regional Office for Africa in collaboration with partners has developed Regional Agenda: "Accelerating Universal Access to Sexual and Reproductive Health: Agenda for the WHO African Region". Through a consultative process WHO and partners agreed to focus on few priority actions paying attention to new approaches to optimize the delivery of the key interventions to accelerate the attainment of Universal Access to Sexual and Reproductive Health in the African Region. The Regional Agenda focuses on five thematic areas: maternal and newborn health; family planning; harmful practices, including female genital mutilation (FGM); preventing unsafe abortion, sexually transmitted infections (STIs), HIV/AIDS; and cervical cancer. It articulates priority actions for universal access to sexual and reproductive health namely (i) governance; (ii) health service delivery; (iii) human resources; (iv) health financing and (v) health information.[13]

The process of the developing the Regional Agenda involved three phases, phase I involved the development of the draft Regional Agenda, phase II involved consultation with experts from countries and partners and phase III , endorsement by the Member States for implementation. The Regional Agenda will provide further guidance to the national programmes implemented by Members States and Partners to re-examine their programmes in scaling up sexual and reproductive health interventions.

Issues and challenges

Efforts to improve maternal, newborn and child health in the African Region are constrained by lack of coherence between policies and programme implementation, resulting in poor programme performance and lack of accountability mechanisms. In addition there is inadequate access to and utilization of quality Maternal, Newborn and Child Health (MNCH) services; inadequate financial resources (external resources which are unpredictable, non-sustainable, and not aligned to country priorities; inadequate domestic resources which are inefficiently and not equitably utilized); insufficient skilled human resources and institutional capacity; and weak health information systems for tracking progress ; and inadequate community involvement.

Governance: Good governance for SRH in the African Region would entail coherence of policies (health in all policies) that seek to address sexual and reproductive health across population groups.[14] Other features include community participation, good leadership, partnership and alliances across sectors, and political commitment, accountability, roles and responsibilities are defined to sustain agreed actions.

To date, SRH initiatives are fragmented in terms of planning and implementation. The implementation gap is due to policy incoherencies regarding national commitments and actual resource allocation for implementation of SRH interventions, resulting into inadequate translation of commitment into action. While medical causes of poor SRH can be addressed

through the health sector, the underlying causes, such as good roads to facilitate referrals, need a comprehensive multisectoral approach. In addition to policy coherence, there is also the absence of dialogue to identify SRH priorities and the effective strategies among concerned sectors including government, communities, civil society and international partners.

Poor public awareness of SRH issues limits the involvement of community and local leaders in the development and implementation of SRH interventions. The lack of an established mechanism to engage individuals, households and communities in all phases of programme cycles hampers progress in realizing universal access to quality SRH interventions.

Health services delivery: Efforts to improve sexual and reproductive health in the Region are constrained by inadequate access to and inequitable distribution of quality SRH services. For example, the coverage of births attended by skilled personnel in most of the African Region countries varies from 3% to 75% for rural residents and from 45% to 97% for urban residents. The access also varies with level of wealth, ranging from 1% for lowest (poor) quintile to 98% for highest (rich) quintiles.[2]

The main challenges to access to and availability of sexual and reproductive health are mainly due to insufficient skilled human resources, infrastructures, equipment, medicines and technologies. These are compounded by the lack of supervision and weak community involvement and participation. Other challenges to universal access to sexual and reproductive health include non-comprehensive package of services and lack of integrated service delivery leading to inadequacies between the sexual and reproductive health service needs of the population and the service provision.

Human resources: One of the underlying causes of poor quality of SRH services, particularly maternal and newborn health, is the lack of skilled health providers. The WHO Health Report on Human Resources noted the shortage of doctors, nurses and midwives who are the first line health providers for SRH was higher in the African Region estimated at 817 992 which requires 139% increase to meet the gap from the current levels.[15]

The human resources gaps in all African Region are mainly related to inadequate training and limited opportunities for continuous education of health-care providers, urban/rural differences in quantity and quality of personnel, inappropriate policies and programmes for staff retention, poor human resources information systems, poor performance evaluation and accountability and inadequate practice regulations.

Health Financing: The underinvestment in health in general and in SRH in particular is one of the major causes of the failure of health systems in the African Region countries to provide accessible and quality of SRH services to address poor performance of SRH indicators. In 2001, governments endorsed the Abuja Declaration urging African Union States to allocate at least 15% of national budgets to the health sector. Unfortunately by 2010, this target has been achieved by only 5 out of 45 countries and 21out 45 countries allocated between 10 and 15%.[16] Subsequently, it results in underfunding for priority interventions to achieve universal access to sexual and reproductive health. In the past years the number of initiatives addressing

SRH has greatly increased and governments face difficulties in coordinating the different funding sources as well as tracking the available funds for SRH. Also there is low capacity of health system to absorb funding, inadequate national ownership and weak accountability by both donors and government.

Out-of-pocket (OOP) payment for health care, the most significant form of health system financing in the Region, has led to an overall decline in the utilization of health services, mainly for women as they depend often on men's resources and decisions for a timely access to services.

Health information: Poor health information limits the national capacity to monitor progress towards the set targets on SRH and to take specific and appropriate decisions to optimize the health system's ability to scale up essential SRH interventions. Lack of accurate data for health information compromises the possibility to link resources to the results, outcomes and impact they produce. Almost all countries in the African Region are facing continuous problems of quality, accuracy, completeness, disaggregation and timeliness of reporting of SRH data. In addition, data from community and private sector is not adequately captured in the national system.

Data on many important SRH issues such as cervical cancer, Sexually Transmitted Infections (STIs), infertility, congenital syphilis, Female Genital Mutilation (FGM), and abortion are usually not included in routine Health Management Information System (HMIS). In most cases lack of coordination between programmes for example between maternal, newborn and child health and family planning results in vertical and dual systems increasing the burden of reporting.

Priority areas and actions for accelerating universal access to SRH in the African Region

Noting that there is need to accelerate the implementation of key evidence based interventions towards universal access to Sexual and Reproductive Health and the attainment of MDG 4 and 5,[17] five priority areas for actions are proposed for the Ministries of Health to lead while strengthening coordination within and outside the ministry such as: (i) governance, (ii) health service delivery, (iii) human resources, (iv) health financing, and (v) health information.

Required actions for the African Regional Agenda

Governance: Building good governance for SRH requires not only strong political commitment but calls for government and different constituent sectors, other social organizations and citizens to engage each other in decision making to promote ownership and

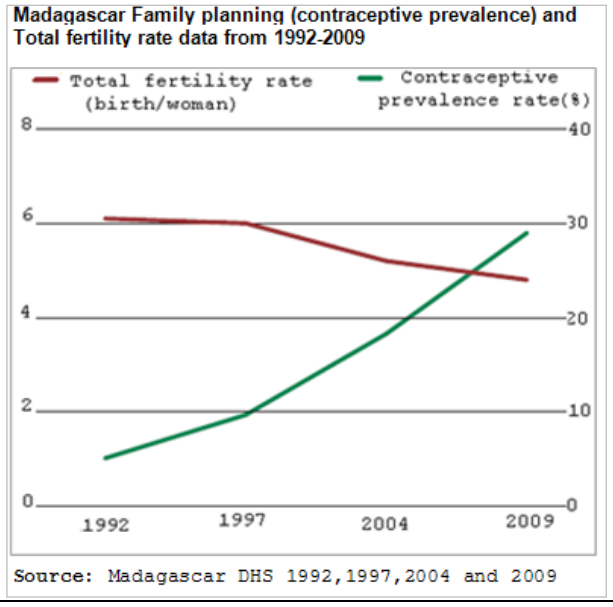
multisectoral approach for a rapid scale up and sustainability of the interventions towards universal access to SRH. It involves higher political levels, such as a president's or a prime minister's office to impact the importance of SRH in socio-economic development and generate support for accelerated progress. The required actions are to:

- Strengthen multisectoral coordination among relevant ministries and agencies, such as health, finance, gender, social affairs and justice; and increase funding for comprehensive RH services;
- Develop a costed SRH plan with evidence-based national targets which is prioritized within health sector planning processes and overall national development plans and are coherent with policy and legislative frameworks;
- Establish an accountability framework for monitoring of progress, performance and finance for SRH programme;
- Promote community empowerment in SRH activities as part of strengthening leadership and empowerment of individuals, households and communities to demand for quality SRH services;
- Engage governmental sectors, non-governmental actors such as health professional bodies, legal experts, human rights groups, women's associations, political leaders and parties, religious and community leaders to champion SRH issues.

Despite the challenges in governance, there are some examples of best practices which show that translation of commitment into actions has led to programme improvement. For example, Madagascar was able to improve contraceptive prevalence rate from 5.1% to 29% (Box 1).

Box 1: Lessons learnt from Madagascar's Family planning success

Contraceptive prevalence rate in Madagascar rose from 5.1% in 1992 to 29% in 2009, according to the Demographic and Health Surveys[18,19]. The programme attributes the success to the strong leadership at the highest level of the government, the inclusion of family planning target in the national development plans and the provision of contraceptives for free in all public health facilities. Furthermore, effective multisectoral collaboration and sensitization campaigns at national and community levels involving community and women's leaders played a key facilitating role to the success of the programme.



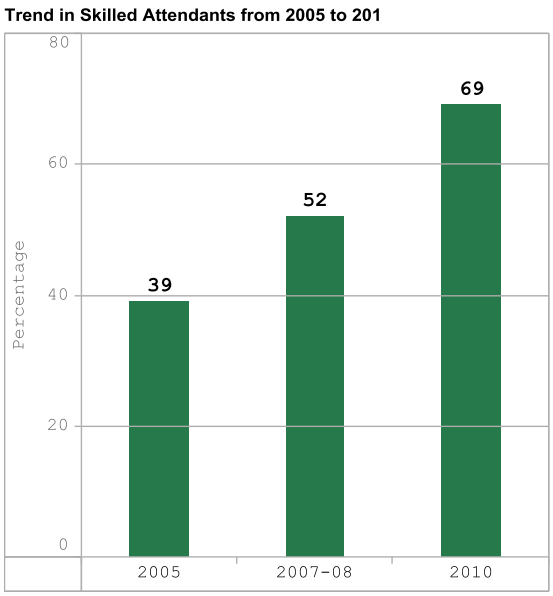
Health services delivery: A range of elements should be incorporated into the actions to ensure universal access to SRH including; availability, accessibility and quality integrated essential SRH services. The required measures are to:

- Implement and scale up an integrated quality SRH service package in a continuum of care, including family planning, prevention of sexual violence and management of survivors of violence, post abortion care, cancer screening, prevention and management of STI/HIV, prevention of FGM and management of FGM complication, adolescent reproductive health and nutrition;
- Develop and implement a community mobilization strategies /plans including behavior change communication interventions to increase the utilization of SRH services;
- Strengthen services delivery management capacity and institutionalize quality assurance mechanisms to ensure availability of functioning health facilities, and SRH commodities security (including local production of medicines, commodities and medical supplies for SRH);
- Develop and implement integrated monitoring and supervision plans addressing essential SRH intervention packages at all levels to ensure quality and efficient SRH service delivery.

Rwanda is an example of a country where improvement in service delivery has led to rapid increase in access to births assisted by a skilled personnel from 39% to 69% (Box 2).

Box 2: Rwanda's Strategies for increasing skilled birth attendance

Over the period of 5 years, Rwanda demonstrated a significant increase in proportion of women delivered by skilled attendance from 39% in 2005 to 69% in 2010[20]. The increase was as a result of commitment from the high level of the Government, implementation of exemption policy; development of the Roadmap for the reduction of maternal and newborn deaths; introduction of pay for performance policy at all levels including at community level; improvement of the supply management ensuring facilities are equipped with essential equipment, supplies and skilled personnel; improvement of communication through ICT and referral system; and coordination and management at all levels of service delivery. The increase in the proportion of births attended by skilled birth attendants has greatly contributed to the reduction of maternal and newborn mortality in Rwanda.



Human resources: In addressing human resources challenges, it is important to consider the need to ensure a continuum of care for the individual and provision of comprehensive care to address reproductive health needs in an integrated manner which depends on a wide range of

cadres from doctors, nurses, midwives and paramedical professionals. The required actions are to:

- Develop and implement policies to ensure appropriate production, equitable distribution of SRH health providers and retention(e.g. multi-prong approaches combining decentralized training and management of human resources as well as staff rotation rules from urban to rural areas and providing incentives and increased motivations);
- Review and update pre-service and in service training curricula for standardized competency-based training approach including emergency obstetrics and newborn care and SRH (contraceptive technology, supply-chain management, management of STIs/HIV/AIDS, management of FGM , fistula repair, sexual and gender-based violence management, screening of reproductive system cancers and post-abortion care);
- Strengthen the capacity of training institutions to deliver quality competency based education and training through development and adoption of standards, practice regulations, accreditation criteria, regular monitoring and supervision;
- Strengthen the competencies for integrated supportive supervision at all levels and for all areas of work;
- Conduct regular mapping on reproductive health competencies based on functioning human resources information systems to ensure congruence between competence development and reproductive health service needs.

Deliberate efforts to address human resources challenges have shown progress in improving the human resource situation in some countries. For example the Emergency Human Resources Programme in Malawi (Box 3).

Box 3: Lessons learnt from Malawi's experience on Emergency Human Resources Programme (EHRP)[21]

In April 2004, the Ministry of Health in Malawi described the country's human resources situation as 'near collapse,' as it was critically low such that of the available health workers were overwhelmed by the demand for services resulting from population growth and high levels of HIV/AIDS, along with migration of nurses and doctors out of the country.[22] The Ministry of Health in collaboration with partners under the Sector Wide Approach (SWAp) developed an Emergency Human Resources Programme from 2004 to 2009. The components of the programme included:

- *Improving incentives for recruitment and retention of staff in government and mission hospitals through a 52% taxed salary top-up;*
- *Expanding training capacity by over 50% including doubling the number of nurses and tripling the number of doctors and clinical officers enrolled in training institutions;*
- *Using international volunteer doctors and nurse tutors as a stop-gap measure to fill critical posts;*
- *Providing international technical assistance to strengthen capacity and build skills within the Ministry of Health;*
- *Establishing more robust monitoring and evaluation capacity for human resources.*

In 2009, the Ministry of Health conducted an evaluation of the programme which indicated that the EHRP contributed to the increase the number of professional health workers across

the 11 priority cadres, the total number of professional health workers increased by 53%, from 5453 in 2004 to 8369 in 2009. The physician increased from 43 in 2004 to 241 (460%) in 2009 and Nurses increased by 36%. This contributed to increase in utilization of priority services such as 49% increase in OPD services 15% increase in safe deliveries, 7% increase in ANC, 10% increase in immunisation, 18% increase in PMTCT

The lessons learnt from the implementation of the programme were:

- *Government commitment in taking the leadership and ownership of the programme is critical;*
- *Implementation of a comprehensive Human Resources plan needs the collaboration and commitment of a multi-sector stakeholders;*
- *Implementation of short-term emergency interventions and longer-term interventions need to be combined for success;*
- *Planning for sustainability must be considered from the beginning of the programme;*
- *An integrated and well-functioning Human Resource Management system (recruitment, deployment, transfer, promotion, performance management) is the foundation for implementation of the Human Resource strategy.*

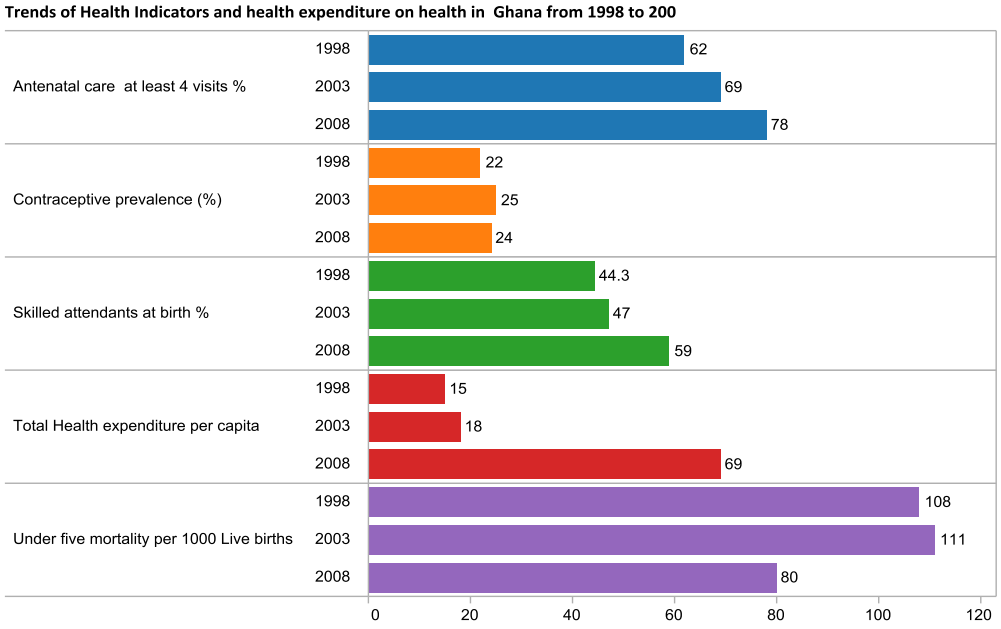
Health Financing : In order to provide high quality and sustainable services, funds should be secured for improving infrastructure, availability of supplies and commodities, training, supervision and mentorship. To increase funding for SRH the required actions are to:

- Increase national funding for health, keeping in mind the Abuja target (at least 15% of national revenue channelled to the health sector) to ensure adequate funding for the costed SRH plan;
- Institutionalize national and district health accounts including SRH sub-accounts to allow tracking and monitoring of funds allocated for SRH in order to facilitate accountability for the government and partner agencies, harmonization, alignment and advocacy towards increase of resources in line with the Paris Declaration on Aid effectiveness;
- Develop social protection mechanisms to cushion households from out-of-pocket expenditure on health services (example community health insurance);
- Stabilize and include in national budgets funding for SRH commodities, technologies and health information systems.

Institutionalization of the prepayment schemes in some countries has improved access to health services particularly maternal and child health services in some countries for example pre-payment schemes in Ghana (Box 4).

Box 4: Ghana‘s experience in organizing prepayment schemes for improving access to health services

Ghana is among the African Region a country, striving to achieve the Abuja target commitment, currently allocates about 12% of the budget to health and has a total health expenditure of over US$44 per capita. Ghana embarked on a health financing reform process in late 1990's which led to the establishment of the National Health Insurance Scheme (NHIS). The implementation process relied on existing mutual health insurance organizations which were established in 1990's which were expanded to district wide mutual health insurance schemes. The schemes were formalized in 2003 by the National Health Insurance Act, which transformed the whole system. The contribution for NHIS comes from value added tax (VAT) of which a 2.5% is earmarked for NHIS, 2.5% of the payroll pension scheme for formal sector workers and a minimum contribution from the members. The current coverage of the NHIS is 34.7%. In addition, the insurance scheme pays for the exemptions for services for children under-five years and maternal health services including immunization, treatment of malaria, services for pregnant women. This has contributed to improvement in the indicators related to maternal and child health especially access to antenatal care, delivery care and treatment for sick children and ensuring availability of essential commodities and supplies.[14]



Sourc : Ghana Demographic and Health Survey,1998,2003 and 2008 and Health Financing in Africa Report fo the Interministerial Consultation, July 201

Heath information: Better information for better results has been recognized at global and regional levels and well elaborated in the Report of the United Secretary General Commission on Information and Accountability.[23] The accountability framework[24] published by the Commission of Information and Accountability highlights the three interconnected processes of *monitor, review and act* which are aimed at learning and continuous improvement. To strengthen information system for tracking SRH outcomes, the required actions are to:

- Strengthen capacities for data collection and analysis about health status, its underlying determinants and the functioning of health services at local, district and national levels with appropriate and qualified human resource and the required equipment;
- Strengthen integration of data for family planning, STIs and HIV/AIDS, cervical cancers, infertility and harmful practices into existing HMIS, data from communities, and private sector;

- Establish and strengthen the system for registration of births, deaths and causes of death, and institutionalize national-level maternal mortality and near-miss registers and make maternal and perinatal mortality notifiable;
- Disaggregate the key indicators on reproductive, maternal and child health, by gender, lowest wealth quintile, age, urban/rural residence, geographical location, ethnicity and education and other equity considerations;
- Make health research a national priority and use research findings to inform SRH policies and programmes;
- Monitor and report annually on the core set of indicators to better measure progress against Millennium Development Goals 1c, 4, 5 and 6.

Roles and responsibilities

The need to better plan, organise, manage, monitor and increase investments in SRH programmes for effective implementation of essential interventions, calls for a concerted approach on the part of governments, partners and the community at large with clear definition of roles and responsibilities.

Member States

Governments taking the lead will ensure harmonized and coordinated actions to accelerate universal access to SRH and increase accountability to:

- Develop and implement prioritized and costed national SRH acceleration plan;
- Facilitate coordination, collaboration and partnership among all stakeholders including academics, healthcare organizations, the private sector, civil society, healthcare workers and donors, families and communities, at local and national levels;
- Establish a mechanism for mobilization of adequate resources and for ensuring effective use of these resources;
- Introduce or amend legislation and policies in line with the principles of sexual and reproductive rights for optimal access and utilization of SRH services;
- Conduct research and use findings to review and update SRH policies and programmes;
- Promote multisectoral actions involving health and non-health sectors (education, road/transportation, etc.)

Partners

WHO and partners will contribute to the strengthening of comprehensive and integrated national SRH programs by providing support to all members' states to:

- Implement and scale up of integrated packages of SRH services;
- Strengthen institutional and managerial capacity;
- Enhance capacity for resources mobilization;

- Strengthen monitoring and evaluation mechanisms and health management information systems;
- Generate information and evidence to inform program development, planning, implementation and tracking of progress;
- Facilitate networking, documenting, sharing of experience and joint reviews.

Monitoring and evaluation

Countries should strengthen their monitoring and evaluation processes for timely, accurate and good quality data to ensure regular measuring of their progress, and to prepare annual reports for use at national and Regional levels. A set of core standardized indicators [25,26](see annexes) will be used to monitor and evaluate the Regional Agenda.

Operations research will be conducted to understand inhibiting factors and to develop new approaches to improve the delivery of SRH services.

The African Region will capitalize on other on-going initiatives for the monitoring of progress on SRH such as the review of National Road Maps, the Regional and National Health Observatories, the Countdown to 2015, the United Nations Secretary General Global Strategy on Women`s and Children`s Health[12] and the Commission on Information and Accountability Framework. The progress will be tracked on yearly basis in collaboration with all partners. A progress report will be presented at each Regional Committee.

Call for action

The adoption by the African Countries of the proposed priority action of this Regional Agenda and its implementation and scale up will constitute an impulse towards attainment of the MDG 5 by 2015. The Regional Agenda Calls for Member States and partners to support the implementation of the proposed actions to ensure Universal Access to Sexual and reproductive Health.

This requires strong political commitment, ownership and sustainability of the interventions towards universal access to SRH. It also requires creating a dynamic environment for strong support for rights-based sexual and reproductive health initiatives and involvement of not only ministries of health, but also ministries of finance, education and other sectors, as well as non-governmental actors, civil society organizations human rights groups, women's associations, political leaders, religious and community leaders.

Annexes

Annex 1: Proposed Framework for Monitoring Sexual and Reproductive Health on selected indicators

N	Indicator	Value 2010	Category	Definition	Measure		Data source
					Numerator	Denominator	
1	**Maternal mortality ratio (MMR)**	480 per 100 000	outcome/ Impact	The number of maternal deaths per 100 000 live births	All maternal deaths occurring in a period (usually a year)	Total number of live births occurring in the same period	(a) Vital registration; (b) health facility-based data; (c) population-based surveys or surveillance; d) Census
2	**Under-five mortality rate**	119 per 1000 per live births	Outcome/ Impact	The probability of dying between birth and fifth birthday	Not applicable[5]	Not applicable[5]	(a) Vital registration; (b) population census data; (c) population-based surveys.
3	**Infant mortality rate**	75 per 1000 live births	Outcome/ /Impact	The probability of dying before the first birthday	Not applicable[5]	Not applicable[5]	(a) Vital registration; (b) population census data; (c) population-based surveys.
4	**Neonatal mortality rate[5]**	34 per 1000 live births	outcome/ Impact	Number of infant deaths up to 28 days after delivery per 1,000 live birth	Total number of infant deaths occurred up to 28 days after delivery x 1000	The total number of births	(a) Vital registration; (b) population-based surveys or surveillance.
5	**Perinatal[i] mortality rate**	59 per 1000 deaths	outcome/ Impact	The number of perinatal deaths per 1,000 total births	Total number of perinatal deaths x 1000	The total number of births	(a) Vital registration; (b) population-based surveys or surveillance.
6	**Contraceptive prevalence rate**	24%	outcome/ Impact	The proportion of women of reproductive age (15-49 years) who are using (or whose partner is using) a contraceptive method at a given point in time	Number of women of reproductive age (15-49 years) who are using (or whose partner is using) a contraceptive method at a given point in time	Total number of women of reproductive age (15-49 years) at the same point in time	Population based survey data
7	**Adolescent birth rate**	117 per 1000	outcome/ Impact	Number of live births per 1,000 women aged 15-19 years	Total number of live births occurred to women aged 15-19 years in a specified period (usually a year) x 1000	Total number of women aged 15-19 years in the same period	(a) Vital registration; (b) health facility-based data; (c) population-based surveys or surveillance; (d) Census
8	**Total fertility rate**	4.8	outcome/ Impact	The number of births a woman would have by the end of her reproductive life if she	Sum of the seven ASFRs (for 5-year age groups: 15-19; 20-24; 25-29; 30-34; 35-39; 40-45; 45-	1,000	(a) Vital registration; (b) population census data; (c) population-based

[i] The perinatal period commences at 22 completed weeks (154 days) of gestation and ends at seven completed days after birth.

				experienced the currently prevailing age-specific fertility rates (ASFR)[ii] from age 15 to 49 years.	49) x 5		surveys.
9	**% Women reporting to have undergone female genital mutilation (FGM) disaggregated by age groups**	41%	outcome	Percentage of women of reproductive age 15-49 years who report to have undergone female genital mutilation disaggregated by 5 year age groups in a specified period	Number of women of reproductive age 15-49 years who report to have undergone female genital mutilation disaggregated by 5 year age groups in a specified period x 100	Total number of women of reproductive age 15-49 years disaggregated by 5 year age groups in the same period	(a) HIS; (b) population based survey data
10	**Unmet need for family planning**	25%	access/demand	The proportion of all women that are at risk of pregnancy and wanting to space or limit their childbearing who are not currently using any method of contraception	*Not applicable*[iii]	*Not applicable*	Population based surveys
11	**% Deliveries attended by skilled attendant**[iv]	48%	service use	The proportion of births attended by a skilled attendant (personnel)	Number of live births to women ages 15-49 years in the specified period attended during delivery by skilled personnel (doctor, nurse, midwife or auxiliary midwife) during a specified period x 100	Total number of live birth during the same period	(a) HIS; (b) population based survey data.
12	**% Pregnant women attended at least 4 antenatal care visits by skilled attendant**	44%	service use	The proportion of pregnant women attended at least 4 antenatal care visits, related to pregnancy, by skilled attendant	Number of pregnant women attended at least 4 antenatal care visits, during their pregnancy, by skilled attendant, during a specified period x 100	Total number of live births during the same period	(a) HIS; (b) population based survey data.
13	**% Deliveries in health facilities**	48%	service use	The percentage of deliveries occurring in the health facilities	Number of deliveries occurred in the health facility in a specified period x 100	Total number of deliveries occurred in a same period	(a) Vital registration; (b) population-based surveys or surveillance.
14	**% Caesarean section**	4%	service use	Caesarean section deliveries as percentage of all deliveries	Total number of C-sections in a specified period x100	Total number of deliveries in the same period	(a) HIS; (b) population based survey data.

[ii] **ASFR**=Births in a year to women aged X / No. of women aged X at mid-year.

[iii] **Formula for calculating unmet need for contraception** is specifically defined in a particular survey methodology.

[iv] **Skilled attendant** – "an accredited health professional-such as a midwife, doctor or nurse-who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns". Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. MPS/RHR/WHO Geneva, 2004.

15	**% Pregnant women attending antenatal clinics tested for syphilis**	59%	service use	Percentage of pregnant women aged 15-24 years attending antenatal care clinics tested for syphilis	Number of pregnant women aged 15-24 years attending antenatal care clinics tested for syphilis during a specific period x 100	Total Number of pregnant women aged 15-24 years attending antenatal care clinics during the same period	(a) HIS; (b) population based survey data.
16	**% Pregnant women received 2 or more doses of tetanus vaccination**	80%	service use	Percentage of pregnant women who received tetanus vaccination	Number of pregnant women who received tetanus vaccination in a specified period x 100	Total number of pregnant women in the same period	(a) HIS; (b) population based survey data.
17	**Early initiation of breastfeeding**	46%	service use	Percentage of new-borns put on the breast within one hour of birth	Number of women with live birth in the X years prior to the survey who put newborn infant to the breast within one hour of birth	Total number of women with live birth in the X years prior to the survey	(a) HIS; (b) population based survey data
118	**Exclusive breastfeeding rate for 6 months**	33%	service use	Proportion of infants 0-5 months of age who are fed exclusively on breast milk	Number of infants 0-5 months of age who received only breast milk during the previous day	Total number of Infants 0-5 months of age surveyed	(a) HIS; (b) population based survey data
19	**Proportion of pregnant women tested for HIV**	42%	service use	Proportion of pregnant women tested for HIV	Number of pregnant women tested for HIV during a specific period x 100	Total Number of pregnant women attending Antenatal care during the same period	(a) HIS; (b) population based survey data
20	**HIV-positive pregnant women receiving anti-retroviral (ARV) for prevention of mother-to-child transmission of HIV (PMTCT)**	50%	service use	Percentage of HIV-positive pregnant women received antiretrovirals (ARV) to reduce the risk of prevention of mother-to-child transmission of HIV	Number of HIV positive pregnant women received antiretrovirals in the last 12 months to reduce mother to child transmission during a specific period x 100	Estimated unrounded number of HIV positive pregnant women	(a) HIS; (b) population based survey data
21	**Infants of HIV-positive mothers receiving ARV – for prevention of mother-to-child transmission of HIV – at birth**	42%	service use	Percentage of HIV exposed infants receiving ARV to reduce the risk of mother to child transmission	Number of HIV exposed children started on ARV during the specific period	Total number of live HIV exposed children born to HIV positive women during the specific period	HIS data (*for numerator*); and census data (*for denominator*);
22	**Notification of maternal deaths is mandatory**	No data	input	Notification of maternal deaths is mandatory (Yes/No)	Not applicable	Not applicable	Policy documents;

Health System and Policy Indicators							
23	**National sexual and reproductive health policy /MNCH (or strategy)**	46 (Yes)	Input	Existence of the RH/MNCH policy/strategy (Yes/No)	Not applicable	Not applicable	Policy Review
24	**Existence of policy on cervical cancer screening**	No data	input	Existence of policy on cervical cancer screening (Yes/No)	Not applicable	Not applicable	Policy documents;
25	**Government budget allocated to health**	46 (yes)	Outcome/ Impact	Percentage of government budget allocated to health	Amount of funds allocated to health during a specified period	Total government budget in the specified period	Administrative records, NHA, PER
26	**% Government expenditure directed towards reproductive health**	No data	Outcome	Percentage of government expenditure spent on reproductive health	Amount of government expenditure spent on reproductive health in a specified period X 100	Amount of total government expenditure on health during the same period	Administrative records.
27	**Dedicated budget allocation for sexual and reproductive health commodities in national budget or other nationally controlled sources**	No data	Input	Existence of budget dedicated to SRH commodities (Yes/No)	Not applicable	Not applicable	Administrative records, NHA, PER

Annex 2: Essential, evidence-based interventions to reduce reproductive, maternal, newborn and child mortality, and promote reproductive health

Continuum of care	Adolescence & pre-pregnancy	Pregnancy (Antenatal)	Childbirth	Postnatal (Mother)	Postnatal (Newborn)	Infancy and Childhood
All levels: **Community** **Primary** **Referral**	• Family planning (advice, hormonal and barrier methods) • Prevent and manage sexually transmitted infections, HIV. • Folic acid fortification/supplementation to prevent neural tube defects	• Iron and folic acid supplementation • Tetanus vaccination • Prevention and management of malaria with insecticide treated nets and antimalarial medicines • Prevention and management of sexually transmitted infections and HIV, including with antiretroviral medicines • Calcium supplementation to prevent hypertension (high blood pressure) • Interventions for cessation of smoking	• Prophylactic uterotonics to prevent postpartum haemorrhage excessive bleeding after birth) • Manage postpartum haemorrhage using uterine massage and uterotonics • Social support during childbirth	• Family planning advice and Contraceptives • Nutrition counselling	• Immediate thermal care (to keep the baby warm) • Initiation of early breastfeeding (within the first hour) • Hygienic cord and skin care	• Exclusive breastfeeding for 6 months Continued breastfeeding and complementary feeding from 6 months • Prevention and case management of childhood malaria Vitamin A supplementation from 6 months of age • Routine immunization plus *H.influenzae*, meningococcal, pneumococcal and rotavirus vaccines • Management of severe acute malnutrition • Case management of childhood pneumonia • Case management of diarrhea
Primary and referral	• Family planning (hormonal, barrier and selected surgical methods)	• Screening for and treatment of syphilis • Low dose aspirin to prevent pre-eclampsia • Antihypertensive drugs (to treat high blood pressure) • Magnesium sulphate for eclampsia • Antibiotics for preterm prelabour rupture of membranes	• Active management of third stage of labour (to deliver the placenta) to prevent postpartum haemorrhage (*as above plus controlled cord traction)* • Management of postpartum haemorrhage (*as*	• Screen for and initiate or continue antiretroviral therapy for HIV • Treat maternal anaemia	• Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth) • Kangaroo mother care for preterm (premature) and for less than 2000g babies • Extra support for feeding small and preterm babies	• Comprehensive care of children infected with, or exposed to, HIV

		• Corticosteroids to prevent respiratory distress syndrome in preterm babies • Safe abortion • Post abortion care	*above plus manual removal of placenta)* • Screen and manage HIV (if not already tested)		• Management of newborns with jaundice ("yellow" newborns) • Initiate prophylactic antiretroviral therapy for babies exposed to HIV	
Referral*	• Family planning (surgical methods)	• Reduce malpresentation at term with External Cephalic Version • Induction of labour to manage pre labour rupture of membranes at term (initiate labour)	• Caesarean section for maternal/foetal indication (to save the life of the mother/baby) • Prophylactic antibiotic for caesarean section • Induction of labour for prolonged pregnancy (initiate labour) • Management of postpartum haemorrhage *(as above plus surgical procedures)*	• Detect and manage postpartum sepsis (serious infections after birth)	• Presumptive antibiotic therapy for newborns at risk of bacterial infection • Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies • Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome • Case management of neonatal sepsis, meningitis and pneumonia	• Case management of meningitis
Community strategies	• Home visits for women and children across the continuum of care • Women's groups			* Family planning interventions at Referral level include those provided at the Primary level		
	Adolescence/before Pregnancy — Pregnancy — Delivery — Postnatal Mother and Newborn -					

References

[1] WHO, UNICEF, UNFPA, The World Bank. Trends in Maternal Mortality: 1990 to 2010, Geneva, World Health Organization, 2012.

[2] World Health Statistics Report 2012, Geneva, World Health Organization, 2012.

[3] United Nations MDG Report for 2011.

[4] World Health Organization, Regional Office for Africa. Reproductive Health Strategy for the African Region, 1998 to 2007, Harare, 1998.

[5] Reproductive Health Strategy to accelerate progress towards the attainment of international development goals and targets, World health Organization, 2004.

[6] Road Map for Accelerating the Attainment of Millennium Development Goals related to Maternal and Newborn health in the African region, AFR/RC54/INF/DOC.6, Brazzaville, 2004.

[7] Child Survival: A Strategy for the African Region, WHO Regional Office for Africa, 2007, AFR/RC56/R2, Addis Ababa, 2006.

[8] African Union. Maputo Plan of Action for operationalization of the continental policy framework for sexual and reproductive health and rights 2007–2010. Addis Ababa, Ethiopia, 2006.

[9] Algiers Declaration Ministerial Conference on Health Research in African Region: Narrowing the gap to improve Africa's health , 2008.

[10] Ouagadougou Declaration on Primary Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. Burkina Faso, 2008.

[11] African Union. Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), 2009.

[12] United Nations Secretary General Ban Ki-moon. Global Strategy for Women's and Children's Health. New York, United Nations, 2010.

[13] World Health Organization, Universal Access to Reproductive Health: Accelerated Actions to enhance progress on Millennium Development Goal 5 through advancing Target 5B, World Health Organization, 2011.

[14] Graham, J, Amos B, Plumptre T. Principles for good governance in the 21st century. Policy brief no. 15. New York, UNDP, 2003.

[15] The World Health Report 2006: Working Together for Health, World Health Organization, 2006.

[16] State of Health Financing in the African Region, Discussion paper for the Interministerial conference: Achieving Results for Value for Money in health, 4-5 July 2012, Tunis Tunisia, WHO Regional Office for Africa.

[17] World Health Organisation, Reproductive Health Strategy: To accelerate progress towards the attainment of international development goals and targets. WHO Geneva, 2010.

[18] Madagascar Demographic and Health Surveys, 1992, 1997, 2004 and 2009.

[19] Countdown to 2015 Decade Report (2000- 2010): Taking stock of maternal, newborn and child health. 2010 Report.

[20] Rwanda Demographic and Health Surveys, 2005,2007-08 and ,2010

[21] Ministry of Health, Malawi and Management Sciences for Health: Final report of the Evaluation of Emergency Human resources Programme, July 2012.

[22] Ministry of Health, Republic of Malawi: Human Resources in the Health Sector: Towards a Solution. Blantyre 2004.

[23] Commission on Information and Accountability for Women's and Children's Health, Keeping Promises, measuring results, Report, The World Health Organization 2011.

[24] Country Accountability for Women and Children Framework: A guide for using the self-assessment tool, WHO Geneva, 2012.

[25] Reproductive health indicators : guidelines for their generation, interpretation and analysis for global monitoring, World Health Organization, 2006.

[26] National-level monitoring of the achievement of universal access to reproductive health : conceptual and practical considerations and related indicators -- report of a WHO/UNFPA Technical Consultation, 13–15 March 2007, Geneva.