MATERNAL AND NEWBORN HEALTH
NATIONAL PLANS (ROAD MAP) ASSESSMENT

African MNH Road Maps Assessment Report

UNFPA Technical Division
SRH Branch
(Luc de Bernis, Yaron Wolman)

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List of Acronyms Frequently Used in Report

AFRO- Regional Office for Africa WHO
ARO- Africa Regional Office UNFPA
CIDA- Canadian International Development Agency
CFR- Case Fatality Rate
CO- Country Office
CS- Caesarean Section
DANIDA- Danish Development Assistance
DFID- United Kingdom Department for International Development
EmONC- Emergency Obstetric and Neonatal Care
FP- Family Planning
GTZ- Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Development Agency)
HMIS- Health Monitoring Information System
HR- Human Resources
IHTP- International Healthcare Technology Package
JICA- Japan International Cooperation Agency
MBB- Marginal Budgeting for Bottlenecks
MDG- Millennium Development Goal
MMR- Maternal Mortality Ratio
MNH- Maternal and Newborn Health
MoH- Ministry of Health
MPoA- Maputo Plan of Action
NORAD- Norwegian Agency for Development Cooperation
RCH- Reproductive and Child Health
RH- Reproductive Health
RHCS- Reproductive Health Commodity Security
RO- Regional Office
SRH- Sexual and Reproductive Health
STI/HIV- Sexually Transmitted Infections/Human Immunodeficiency Virus
UNFPA - United Nations Population Fund
UNICEF- United Nations Children's Fund
WB- World Bank
WFP- World Food Programme
WHO- World Health Organization
Y&A- Youth and Adolescent

Key Findings and Conclusions

- The majority of African countries have already developed a national MNH Plan. Among the 35 countries who responded to this survey, 33 have developed their national MNH Plan (MNH Road Map) and 29 have finalized the document.

- Despite this strong effort and commitment to the health of women, newborns and children in Africa, very few countries have the necessary resources and support to fully implement their MNH Road Maps.

- Many countries (26) have costed their Road Maps, but far fewer have a plan for scaling-up or an operational plan at the district level (16). Only 24 countries have a monitoring plan and 13 an evaluation plan for their Road Maps.

- Several strategic elements of MNH planning have still to be developed and incorporated in the existing MNH Road Maps of a number of countries, in particular EmONC planning, Human resources planning and monitoring and evaluation.

- Efforts made in term of integration of MNH with SRH and other key public health programmes should be strengthened and reflected in the implementation of the national MNH Plans.

- This self-assessment of the Road Maps was cited by many countries as a beneficial opportunity to reflect on the ongoing process. The main recommendations formulated by the country teams are related to: 1) the strengthening of the situation analysis including national needs assessments in Emergency obstetric care and human resources and improvements in national health information systems, 2) the technical assistance in the costing process to ensure that appropriate tools are used to ensure an effective planning process and 3) the support in resources mobilization to fund the implementation and scale-up process.

- If we are going to make serious progress in reducing maternal and newborn mortality and morbidity and in achieving MDG5, every national Road Map must be built on solid situational analysis that provides adequate baseline data from which to measure progress on all of the MDG5 indicators. The Road Map cannot merely be a static document, but a plan that is costed, part of the national Health plan, financed, implemented and scaled-up.

Executive summary

Recognizing the lack of progress in reducing maternal and newborn mortality and morbidity in the African continent over the last two decades, WHO/AFRO recommended in 2004 (Regional Committee RC04) that countries develop a national *Road Map for accelerating the attainment of the Millennium Development Goals (MDGs) related to maternal and newborn health*[1]. This was immediately endorsed by partners, including UNFPA.

In September 2006 in Mozambique, African ministers of health endorsed the integrated *Sexual Reproductive Health and Rights Plan of Action*, known as the Maputo Plan of Action[2] (MPoA), proposed by the African Union, which included maternal and newborn health planning.

This has resulted in an unprecedented effort to plan for MNH in Africa during the last four years. A review of progress in MNH conducted by UNFPA in 2008/09, assessed strengths and weaknesses of the planning/programming processes and will be used to assist countries in the improvement and the implementation of such plans.

Main objectives of the survey were to document the planning process within the Road Map; to assess the availability of the essential maternal and newborn health outcomes and process indicators; to identify the possible gaps as they relate to the 3 MNH pillars (Family Planning, Skilled Attendance at Birth and Emergency Obstetric and Neonatal Care, the last one including prevention/management of unsafe abortion); to document whether the strategies and selected priority interventions are aimed as well at increasing demand for, access to and use of quality services toward the universal access/coverage to SRH services; to document whether the plans are costed and financed for the scaling-up towards universal access / coverage to SRH services; to document whether the plans are ready for operationalization at district level; and to describe the related monitoring and evaluation plans

Methodology: a questionnaire for country teams' self-assessment on Maputo Plan of Action and MNH Road map development was designed, peer-reviewed, field tested and sent to all UNFPA Representatives.

This survey is a self-assessment survey, conducted by the national teams (Ministry of Health, UN and sometimes other partners) in charge of developing the national MNH Road Map. The quality of the assessment is based on the motivation, the thoroughness, and the incisiveness of the questioning by the team members. There is a built in risk that respondents will not be sufficiently self-critical. However by intentionally designing the survey as a self assessment survey we aim to ensure a buy in by the National MNH team and senior MoH officials to the results; a buy in which is instrumental in using the survey's results to address the gaps and weaknesses identified. National MNH teams have seized the opportunity and seriously and thoroughly reviewed their respective MNH Road Maps.

In the second stage of the survey, meetings and conference calls were conducted to discuss and validate the findings during the first semester of 2009. In their recommendations and during teleconferences a substantial number of countries have strongly expressed their gratitude and

[1] http://afrolib.afro.who.int/

[2] http://www.africaunion.org/root/au/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/SRHR_%20Plan_of_Action_2007_Final.pdf

mentioned the benefits of conducting such an exercise, to improve their plans and implementation processes.

Results

35 African countries, out of 45 (77.7%), have responded[3].

In summary:

- 33 countries developed a national MNH Road Map
- 29 countries finalized their national MNH Road Map
- 21 national MNH Road Map are endorsed
- 22/33 countries established national MNH Committee (66.6%)
- 8 countries are engaged in resources mobilization for MNH
- 19/29 countries developed a national MNH action plan (65.5%), and
- 16 countries developed a District action plan for their MNH Road map implementation

Among the 22 countries (66.6%) who have established or re-stimulated a national MNH Committee, few have equipped them with a plan of action (12), and even fewer (6) with a budget.

The UN agencies (UNICEF, WHO and UNFPA) have supported the Road Map development process in all the 33 countries, with the World Bank and, in some cases, the African Development Bank (3 countries). Among bilateral partners supporting the development of the national MNH plan, fifteen countries mentioned USAID (bilateral signatory of the WHO Road Map); DFID and JICA were mentioned by 8 countries, GTZ by 5 countries, AFD (France) by 4 countries and CIDA (Sweden) was mentioned by 2 countries.

Six countries have mentioned the involvement of professional associations.

Countries have made an important effort to cost their final Road Map, with support provided by one among the three agencies, in a majority of cases. The costing of the national plans has been achieved in 26/33 countries (78,8%). Specific tools like the MBB (Mali), the IHTP (Malawi) or the RH Costing tool (Uganda, Congo) were used, but in some cases, usual budget mechanisms have been used.

Of 33 countries, 17 mentioned conducting resources mobilization activities.

The level of financial resources already mobilized seems to be a challenging question for country teams. Regarding the resources mobilized and available for the first phase of the national plan implementation, among 21 countries responding with available data, only 2 (Malawi (85.9%) and Equatorial Guinea) have mobilized more than 50% of the necessary funds, 9 have mobilized one third of the necessary budget and 8 less than 10%. All these responding countries except Lesotho are among those that started resource mobilization.

For 5 countries out of 18 (28%), the available funding from international partners is covering more than 50% of the available resources. The partners listed include all the specialized UN agencies (WHO, UNICEF and UNFPA) plus the WFP, and bilateral agencies: DANIDA, DFID, JICA, NORAD, SIDA, the Swiss Cooperation and USAID.

[3] Angola, Benin, Bissau Guinea, Burkina-Faso, Burundi, Cameroon, Central Africa Republic (CAR), Chad, Congo, Democratic Republic of Congo (DRC), Equatorial Guinea, Eritrea, Ethiopia, Gambia (The), Ghana, Guinea, Ivory Coast, Kenya, Lesotho, Madagascar, Malawi, Mali Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Sierra Leone, Swaziland, Tanzania, Uganda and Zambia

One third of the countries have established a SRH/MNH budget line.

Eleven components have been identified by the authors as main components of a MNH programme [4]. It is remarkable that only four countries have included all the mentioned components in their Road Map. Seven countries are missing only one component but seven countries have included in their MNH plan less than half of the 11 listed key components. The most often missing elements of a comprehensive MNH plan are: EmONC plan, Infrastructure plan, Human resources plan and Human resources strategy. Six countries have not included FP activities as main component of their MNH Plan.

Seven countries (21.2%) indicated that no Monitoring and Evaluation plan with a list of core indicators was attached to the national MNH Road Map.
Only thirteen countries have developed a plan for evaluating their national Road Map.

The questionnaire proposed, at the end of the self-assessment process, that the country team formulate recommendations to the MoH and partners, based on the findings of the review. A number of countries have used this opportunity to formulate recommendations regarding the national MNH Road Map finalization, improvement and/or implementation.

The main issues highlighted in the Report are:

1. The quality of the Situation Analyses, which are often poor which can impact negatively on the identification of innovative and context-specific strategies to be designed and activities to be implemented.
2. Supported by the increasing consensus on strategic MNH interventions, countries are in general well-focused on the three main strategies to efficiently reduce maternal and newborn mortality[5]. For a substantial number of countries though, FP programmes seem not to be clearly integrated with the MNH plans. EmONC plans are not well enough developed, and neither are human resources development and management plans.
3. Community involvement/mobilization is addressed but not all countries have defined detailed interventions linked with Newborn/Child health and HIV programmes.
4. Even if post-abortion care is included in the basic signal functions of EmONC, the abortion issue, one of the major causes of maternal deaths in all African countries, is very poorly addressed in general, even when allowed by law.
5. Not all countries have developed a scaling-up plan for the key strategies and interventions, with clear targets, a time frame and steps.
6. Substantial efforts have been conducted by countries in costing their Plans. However, only few countries have used costing tools to measure the cost of possible strategic service provision coverage scenarios and to facilitate decision making within the process of plan development.
7. Regarding budget issues, budget mechanisms and financial support: responses to the questionnaires were often a challenge. This probably indicates that the technical staff in charge of developing the plans is not familiar enough with these issues.
8. Maternal and newborn mortality reduction requires massive investments in strengthening health systems, infrastructure, and in training, recruiting and retaining the skilled health professionals who are acutely needed. No country will be able to mobilize these crucial

[4] The 11 elements are: Individual, Family and Community strategy (IFC), human resources strategy and plan (HR), Emergency obstetric and neonatal care strategy and plan (EmONC), Family Planning (FP), Abortion/Post-abortion care (Abort.), Youths and Adolescent Sexual reproductive health strategy (Y&A), HIV/AIDS strategy (HIV), Infrastructure (Infr.) and Reproductive health commodity security strategy (RHCS).
[5] Family Planning, Emergency Obstetric and Neonatal Care and Skilled Birth Attendance

resources on its own. Strong resources mobilization strategies are therefore strongly required. A number of countries have taken this point as a recommendation in the immediate follow-up to this self-assessment.

9. The monitoring and evaluation of the Road Maps' implementation would require well-established, multi-disciplinary teams with a clear mandate, work plan and budget. Not all countries have yet established such a team. Ensuring, in addition, that the key MNH indicators are included in the national Health monitoring information system (HMIS) and can be routinely or regularly measured is certainly a long-term action to be taken.
10. Developing national MNH Road Maps has certainly been an important step in many countries when MNH plans were characterized by their lack of comprehensiveness and strategic content. However, integrating these plans with the national health plans and financing processes is now the challenge majority of countries is facing.

In conclusion, planning is important but the real progress in women's health will be made in implementing and scaling-up the priority and cost-effective well defined interventions and monitoring it to track progress and improve the plans in a cycle planning process. Immediate and long-term activities are necessary, to be implemented at the same time with strong political support and appropriate investments. UNFPA, UNICEF, WHO and The World Bank (H4) working together with donor countries, global funds and foundations, regional and international NGOs, can be successful in providing the necessary support to countries toward MDG 5 and 4 achievements!

Résumé

Reconnaissant l'absence de progrès dans la réduction de la mortalité maternelle et infantile et de morbidité dans le continent africain au cours des deux dernières décennies, l'OMS / AFRO a recommandé en 2004 (Comité régional RC04) que les pays élaborent une Feuille de route nationale pour l'accélération de la réalisation des Objectifs du Millénaire pour le Développement (OMD) liés à la santé maternelle et néonatale6. Cela a été immédiatement entériné par les partenaires, y compris UNFPA.

En Septembre 2006 au Mozambique, les ministres africains de la Santé ont approuvé le Plan d'action intégré en Santé sexuelle et génésique et les droits humains, connu comme le Plan d'action de Maputo (MPoA)7, proposé par l'Union africaine, qui inclut la planification en santé maternelle et néonatale (SMN).

Cela s'est traduit par un effort sans précédent pour planifier la SMN en Afrique au cours des quatre dernières années.
Un examen des progrès accomplis dans ce domaine réalisé par UNFPA en 2008/09, a évalué les forces et les faiblesses des processus de planification et programmation et ces résultats seront utilisés pour aider les pays dans l'amélioration et la mise en œuvre de ces plans.

Les principaux objectifs de l'étude étaient de documenter le processus de planification au travers de l'élaboration de la Feuille de route, d'évaluer l'existence d'indicateurs d'impact et de processus ; d'identifier les lacunes possibles en ce qui concerne les trois piliers de la stratégie de réduction de la mortalité maternelle (Planification familiale, Environnement professionnel qualifié à la naissance et Soins obstétricaux et néonatals d'urgence, y compris la prévention / prise en charge de l'avortement pratiqué dans de mauvaises conditions de sécurité); de documenter dans quelle meure les stratégies et les interventions prioritaires sélectionnées sont destinées aussi bien à augmenter la demande que l'utilisation des services de qualité afin d'atteindre l'accès universel/ couverture en soins de santé de la reproduction; de documenter dans quelle mesure les plans sont chiffrés et financés pour le passage à l'échelle et l'atteinte de l'accès universel/ couverture en soins de santé de la reproduction; de documenter si les plans sont prêts à être opérationnalisés au niveau du district de santé ; et enfin de décrire les plans relatifs au suivi et à l'évaluation de la mise en œuvre des Feuilles de route.

Méthodologie: un questionnaire d'auto-évaluation pour les équipes pays portant sur le Plan d'action de Maputo et le développement de la Feuille de route en SMN a été conçu, revu par les pairs, testé sur le terrain et ensuite envoyé à tous les Représentants UNFPA des pays d'Afrique sub-saharienne.

Cette enquête est donc une enquête d'auto-évaluation, réalisée par les équipes nationales (Ministère de la Santé, agences des Nations Unies et parfois d'autres partenaires) en charge du développement de la Feuille de route en SMN. La qualité de l'évaluation est fondée sur la motivation, la rigueur et le questionnement incisif des membres de l'équipe. Elle est développée en assumant le risque que les répondants ne seront pas suffisamment autocritiques. Toutefois c'est intentionnellement que par cette conception nous avons visé à obtenir un engagement de

[6] http://afrolib.afro.who.int/
[7]http://www.africaunion.org/root/au/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/SRHR_%20Plan_of_Action_2007_Final.pdf

l'équipe pays et des responsables du ministère de la santé vis-à-vis des résultats de l'enquête; cet engagement devrait jouer un rôle dans l'utilisation par le pays des résultats de l'enquête pour combler les lacunes et faiblesses qui auront été ainsi identifiées. Les équipes SN nationales ont saisi cette occasion et ont très sérieusement et soigneusement passé en revue leurs respectives Feuilles de routes en SMN.

Dans la deuxième étape de l'enquête, des réunions et des conférences téléphoniques ont eu lieu pour discuter et valider les résultats durant le premier semestre de 2009. Dans leurs recommandations lors des téléconférences un nombre important d'équipes pays ont vivement exprimé leur gratitude et mentionné les avantages de mener un tel exercice pour l'amélioration de leurs plans et des processus de mise en œuvre.

Résultats
35 pays africains sur 45 (77,7%) ont répondu 8.
En résumé:
- 33 pays ont élaboré une Feuille de route nationale SMN
- 29 pays ont finalisé leur plan national en SMN
- 21 plans nationaux en SMN sont officiellement agréés
- 22/33 pays ont établi Comité national en SMN(66,6%)
- 8 pays sont engagés dans la mobilisation des ressources pour la SMN
- 19/29 pays ont élaboré un plan national d'action MNH (65,5%), et
- 16 pays ont opérationnalisé leur Plan national au niveau District

Parmi les 22 pays (66,6%) qui ont établi ou restimulé un Comité national de santé maternelle et néonatale, peu ont équipé ces Comités d'un plan d'action (12), et encore moins (6) d'un budget.

Les agences des Nations Unies (UNICEF, OMS et UNFPA) ont soutenu le processus d'élaboration de la Feuille de route nationale dans l'ensemble des 33 pays, avec parfois l'appui de la Banque mondiale et, dans certains cas, de la Banque africaine de développement (3 pays). Parmi les partenaires bilatéraux soutenant le développement du plan national SMN, quinze pays ont mentionné l'USAID ; DFID (Grande Bretagne) et la JICA (Japon) ont été mentionnés par 8 pays, la GTZ (Allemagne) par 5 pays, l'AFD (France) par 4 pays et l'ACDI (Canada) a été mentionnée par 2 pays.

Six pays ont mentionné l'implication des associations professionnelles.

Les pays ont fait un effort important pour le chiffrage de leur Feuille de route, avec un appui fourni par l'une des trois agences dans la majorité des cas. Le calcul du coût des plans nationaux a été réalisé dans 26/33 pays (78,8%). Des outils spécifiques comme le « MBB » (au Mali), l'« IHTP » (au Malawi) ou le « RH Costing Tool » (en Ouganda et au Congo) ont été utilisés, mais dans certains cas, des mécanismes budgétaires habituels ont été utilisés.

[8] Angola, Bénin, Burkina-Faso, Burundi, Cameroun, République Centrafricaine (RCA), Congo, République démocratique du Congo (RDC), Côte d'Ivoire, Eritrée, Ethiopie, Gambie, Ghana, Guinée, Guinée-Bissau, Guinée Equatoriale, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritanie, Mozambique, Namibie, Nigeria, Rwanda, Sénégal, Sierra Leone, Swaziland, Tanzanie, Tchad, Ouganda et Zambie

Parmi les 33 pays, 17 ont mentionné mener des activités de mobilisation des ressources dans le cadre de leur Plan SMN.

Le niveau des ressources financières déjà mobilisées semble être une question difficile pour les équipes de pays. En ce qui concerne les ressources mobilisées et disponibles pour la première phase de l'exécution du plan national, parmi les 21 pays qui ont répondu avec des données disponibles, seulement 2 (Malawi et la Guinée équatoriale) ont mobilisé plus de 50% des fonds nécessaires (85,9% pour la Guinée équatoriale), 9 ont mobilisés un tiers du budget nécessaire et 8 moins de 10%. Tous ces pays, sauf le Lesotho, sont parmi ceux qui ont entrepris une mobilisation de ressources.
Pour 5 pays sur 18 (28%), les fonds mis à disposition par les partenaires internationaux couvrent plus de 50% des ressources disponibles. Les partenaires indiqués comprennent toutes les institutions spécialisées des Nations unies (OMS, UNICEF et UNFPA), le PAM et des agences bilatérales: DANIDA, DFID, JICA, NORAD, SIDA, la Coopération suisse l'USAID. Un tiers des pays ont établi une ligne budgétaire SR/SMN.

Onze éléments ont été identifiés par les auteurs comme principaux composants d'un programme de santé maternelle et néonatale. Il est remarquable que seuls quatre pays aient inclus dans leur Feuille de route tous les éléments identifiés comme principaux composants. Pour sept pays un seul composant est manquant, mais sept pays ont inclus dans leur plan SMN moins de la moitié des 11 composants clés identifiés. Les éléments le plus souvent absents sont: un plan SONU, un plan de développement des infrastructures, un plan de développement et de gestion des ressources humaines. Six pays n'ont pas inclus des activités de planification familiale comme composant essentiel de leur Plan SMN.

Sept pays (21,2%) ont indiqué qu'aucun plan de suivi et d'évaluation incluant une liste d'indicateurs principaux n'était attaché à leur Feuille de route nationale.
Seuls treize pays ont élaboré un plan pour évaluer leur Feuille de route.

Le questionnaire suggérait, à la fin du processus d'auto-évaluation, que l'équipe de pays puisse formuler des recommandations pour le Ministère de la Santé et les partenaires, fondé sur les conclusions de l'analyse. Un certain nombre de pays ont profité de cette occasion pour formuler des recommandations concernant la finalisation, l'amélioration et/ou la mise en œuvre de leur Feuille de route en SMN.

Les principaux problèmes mis en évidence dans le rapport sont les suivants:

1. La qualité des analyses de situation, qui sont souvent pauvres ce qui peut avoir un impact négatif sur le développement des stratégies innovantes et adaptées au contexte et des interventions devant être mises en œuvre.
2. Aidés par le consensus croissant concernant les interventions stratégiques en SMN, les pays ont en général bien focalisé leurs plans sur les trois principales stratégies de la réduction de la mortalité maternelle et néonatale. Pour un grand nombre de pays toutefois, les programmes de PF semblent ne pas être clairement intégrés aux plans SMN. Les Plans SONU ne sont pas suffisamment développés, pas plus que ceux de développement et de gestion des ressources

humaines.
3. L'implication et la mobilisation communautaires font partie des plans nationaux, mais tous les pays n'ont pas défini les interventions détaillées concernant la santé du nouveau-né et de l'enfant et le VIH/SIDA.
4. Même si les soins post-avortement font partie des SONU de base, la question de l'avortement, une des causes majeures de mortalité maternelle dans tous les pays africains, est très pauvrement traitée en général, même dans le cadre de la loi.
5. Tous les pays n'ont pas élaboré un plan de passage à l'échelle pour les stratégies et les interventions clés, avec des objectifs clairs, un calendrier et des étapes.
6. Des efforts substantiels ont été réalisés par les pays pour établir le coût de leurs plans. Toutefois, seuls quelques pays ont utilisé des outils de chiffrage spécifiques pour calculer le coût possible de différents scénarios stratégiques pour la couverture en services de soins et pour guider la prise de décision lors du processus d'élaboration du plan.
7. En ce qui concerne les questions budgétaires, les mécanismes de soutien budgétaire et de financement: les réponses aux questions sont souvent un défi pour les équipes pays. Cela indique sans doute que le personnel technique en charge de l'élaboration des plans n'est pas assez familier avec ces questions.
8. La réduction de la mortalité maternelle et néonatale nécessite des investissements massifs dans le renforcement des systèmes de santé, les infrastructures, dans la formation, le recrutement et la rétention des professionnels de la santé qualifiés qui sont hautement nécessaires. Aucun pays ne sera en mesure de mobiliser ces ressources cruciales à lui seul. D'efficaces stratégies de mobilisation des ressources sont donc requises. Un certain nombre de pays ont pris ce point comme une recommandation dans le suivi immédiat à cette auto-évaluation.
9. Le suivi et l'évaluation de la mise en œuvre des Feuilles de route exigent des équipes pluridisciplinaires bien établies et soutenues, ayant un mandat clair, un plan de travail et un budget. Tous les pays n'ont encore établi une telle équipe. Par ailleurs, veiller à ce que les indicateurs clés de santé maternelle et néonatale soient inclus dans le Plan national d'Information sanitaire et puissent être mesurés en routine ou de manière régulière est certainement important à considérer pour le long terme.
10. Développer une Feuille de route nationale en SMN a certainement été une étape importante dans de nombreux pays lorsque les plans de santé maternelle et néonatale étaient caractérisés par leur manque d'exhaustivité et de contenu stratégique. Cependant, l'intégration de ces plans avec les plans nationaux de santé et les processus de financement est maintenant le défi auquel la majorité des pays est confronté.

En conclusion, la planification est importante, mais les progrès réels dans la santé des femmes seront réalisés par la mise en œuvre et le passage à l'échelle des interventions prioritaires bien définies et coût-efficaces et par le suivi de cette mise en œuvre pour mesurer les progrès et améliorer les plans dans un processus cyclique de planification. Des actions immédiates et d'autres sur le long terme sont nécessaires, devant être mises en œuvre en même temps, avec un soutien politique fort et des investissements appropriés. UNFPA, l'UNICEF, l'OMS et la Banque mondiale (H4) travaillant ensemble avec les pays donateurs, les fonds mondiaux et des fondations, les ONG régionales et internationales, peuvent réussir dans l'appui dont les pays ont besoin pour l'atteinte des OMD 4 et 5 !

I. INTRODUCTION

The Millennium Development Goals (MDGs) give high prominence to health; three of the eight development goals, nine of the 18 targets spread over six of the goals, and 18 of the 48 indicators[9] are directly related to health. The new target for MDG5 calls for universal access to sexual and reproductive health (SRH), including HIV/AIDS prevention and treatment services. Therefore, achieving the health-related MDGs would be a major contribution toward attaining all of the international Millennium Development Goals globally. At the same time, achieving these goals represents a formidable challenge in international development, not least because it explicitly depends on operational, programmatic and environmental matters such as: doing the right thing at the right time, choosing the right strategies for programs to go to scale and choosing the right strategies to overcome constraints to effective health systems. It is well recognized that to meet the MDG targets will not only require the scaling-up of current efforts but also a better coordinated and focused approach.

Recognizing the lack of progress on MDG 5 and the high rates of maternal and newborn mortality and morbidity in Africa over the last two decades, WHO/AFRO recommended in 2004 (Regional Committee RC04) that countries develop a national ***Road Map for accelerating the attainment of the Millennium Development Goals (MDGs) related to maternal and newborn health[10].*** This was immediately endorsed by partners, including UNFPA.

The African Union (AU) formulated and adopted (Oct. 2005) the Continental Policy Framework for Sexual and Reproductive Health and Rights (SRHR)[11]. Subsequently, the Africa Health Strategy 2007-2015 for "*Strengthening of Health Systems for Equity and Development in Africa"* was adopted[12]. In order to implement this strategy at the continental level, a costed implementation action plan, known as the "Maputo Plan of Action" (MPoA) for the period 2007-2010, was formulated with the support of development partners and subsequently adopted in Sept. 2006[13]. This plan offers an opportunity to translate the commitment of the African Union countries and partners into coordinated, evidence based and focused strategies and implementation plans. It represents an important step forward in guiding countries in planning and programming for MDG 5, universal access to SRH services, but also MDGs 4 and 6. Therefore it is anticipated that the MPoA will be the comprehensive framework for Universal access to SRH and HIV-AIDS information and services in Africa.

The *African Road Map for Accelerating the Attainment of the MDGs related to maternal and newborn health* (MNH), adopted by all Health Ministers of the African Union in 2004 and endorsed by the key partners in the region, is at the core of the Maputo Plan of Action. The process of developing national MNH Road Maps started in the African Union countries in 2004. To support countries in the process, tools are available and have been developed to guide quality, evidence based planning and programming and to cost strategies and plans[14].

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[9] UNGASS/RES/55/2: UN millenium Déclaration: Sept 18, 2000

[10] http://afrolib.afro.who.int/

[11] AU. Doc. EX.CL/225 (VIII) Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa, Oct. 2005

[12] AU.CAMH/MIN/5(III), 9 – 13 April 2007

[13] AU. Sp/Min/CAMH/5(1), 16-22 Sept. 2006. www.africa-union.org

[14] WHO Implementation guide for the Road map for accelerating the attainment of the MDGs related to MNH in countries; Steps and Guidelines for developing and scaling-up national Road maps for accelerating the attainment of the MDGs related to MNH (available at the UNFPA website)

Since the launch of the Maputo PoA, substantial progress in SRH has been made in African countries, as demonstrated by the growing importance given to interventions aiming to improve maternal newborn and child health, including HIV/AIDS, in national policy, strategy, and programme documents[15]. For example, Sector reforms have taken place in some countries with clear attempts to integrate health in national development frameworks (Rwanda, Tanzania). Countries are working to reduce financial and other barriers and to increase access to MNH services through innovative financing strategies (abolishing user fees, risk sharing, etc.). The Paris Declaration principles are being adhered to in many countries leading to more harmonized efforts led by the government. The UN Reform advocates for "UN Agencies delivering as One" and UNFPA, WHO, UNICEF and the World Bank have issued a joint statement pledging to [16] accelerate their joint support to countries to improve maternal and newborn survival by strengthening the continuum of care. In addition, the Countdown to 2015 initiative on maternal, newborn and child survival aims to track coverage for interventions that are essential to the attainment of Millennium Development Goals 4 and 5and represents a good opportunity for monitoring progress in the MNH field.

Support for the development of Maternal and Newborn Health Road Maps has been of high priority to the agencies working in SRH (UNICEF, WHO/AFRO and UNFPA). Since 2005, inter-agency sub-regional workshops have been jointly organised (some with USAID/Africa 2010 support) to assist countries and joint technical assistance has increased. In this context, sub regional orientation workshops on national Road Map development, implementation and evaluation have already been conducted in Senegal in 2007 for West African countries, in Uganda in April 2008 for Anglophone African countries, and in Douala in May 2008 for Central African francophone countries. A similar workshop has been conducted in Ghana in December 2008 for West African Anglophone countries.

The **Maternal Health Thematic Fund (MHTF)**, established by UNFPA, is aiming to support countries where the Maternal Mortality Rate and Unmet Need for Family Planning are very high. The assessment of the national MNH Road Maps has been conducted as well to guide programming and funding and to ensure success in implementing the key evidence based interventions necessary to attain the targets of MDGs 4 (newborns), 5 and 6. Having a strong MNH Road Map will be an asset to all countries, in particular those targeted by global initiatives aiming to strengthen health systems[17].

These activities at country, regional and global levels should be considered as part of the efforts to operationalise the Maputo Plan of Action and the implementation of the Road Maps to accelerate the reduction of maternal and newborn mortality. However so far, no study has been conducted to assess the implementation of the MNH Road Maps. In this context, UNFPA has conducted a systematic review of the progress in implementing national MNH Road maps, in order to analyse potential strengths and weaknesses, to share best practices and to identify existing gaps, with the objective of being able to better support countries in the further development, costing, implementation and scaling up of such plans.

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[15] CSTAA Annual Report, 2007. http://docs.unfpa.org/dsweb/Get/UNFPA_Publication-15539/2007+AR-CSTAA-Final+05+February-1.pdf

[16] WHO, UNFPA, UNICEF, The World Bank. Joint Statement on Maternal and Newborn Health: Accelerating Efforts to Save the Lives of Women and Newborns. September 2008.

[17] The International Health Partnership (IHP) and the Catalytic Initiative to save 1 Million lives, which are part of the Global Campaign for the Health MDGs, the Health 8, the GAVI Alliance, the GFATM and the Bill and Melinda Gates Foundation.

To date (July 2009), more than 40 Sub-Saharan African countries have developed their national MNH Road Map and the majority of them are already in the implementation phase.

The General Objective of the MNH Road Map is: "To accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Africa". The Specific objectives are: a) "To provide skilled attendance during pregnancy, childbirth, and the postnatal period, at all levels of the health care delivery system, and b) To strengthen the capacity of Individuals, Families and Communities to improve MNH."

The Road Map assessment will refer to these objectives as well as to how the MNH Road Maps reflect multi-sectorality, community involvement, and integration within primary health care. Two important additional principles have been highlighted more recently, which are (1) the national ownership and country led process (Paris declaration) and (2) the results oriented management of programmes. Ensuring that the plans are well addressing the key evidence-based strategies and activities, the scaling-up and the monitoring and evaluation is important for the success of their implementation and to ensure a substantial and positive impact on the health of mothers and newborns.

II. METHODOLOGY

The tool used to assess the national Road Maps was a questionnaire designed for completion by country MNH teams. This questionnaire was part of the much larger survey intended to assess progress in the implementation of the Maputo Plan of Action. Following internal circulation for peer review, the questionnaire was field-tested in Burkina-Faso and in Madagascar before being finalized. The questionnaire tool is attached (**Annex I**).

Part I of the questionnaire describes the policy and programme development context. Questions 1 to 11 deal with the policy aspects while Questions 12 to 28 deal exclusively with the development process of the national MNH Road Maps. Part II of the questionnaire analyses the content of the national MNH Road Map. In Part III, the national team is requested to make recommendations, based on the findings of their review, for improving the implementation and the scaling up of their national MNH plan. Finally, in Part IV, the national MNH team respondents are requested to list and provide all relevant national documents.

The UNFPA Africa Regional Office (ARO) sent the questionnaire (in French and in English) to all UNFPA Representatives in African Country Offices (COs) with a request to assign their SRH and/or MNH/SRH Focal Persons to coordinate the response to this comprehensive questionnaire with their colleagues and counterparts from the National MNH teams (MoH and Development Partner Agencies).

The questionnaire was designed as a comprehensive self assessment tool to analyze the development status of the MNH Road Maps and their substantive contents. It was aimed to provide the respondents with an opportunity to reflect and critically analyze their MNH Road Maps.

Objectives of the Questionnaire:
The objective of this assessment is to analyse the development and the implementation of the MNH Road Maps

1. To document the planning process within the Road Map (Is the plan based on a strong situation analysis, well structured with clear goals, strategies, priority interventions, outputs, coverage and outcome targets and indicators?)
2. To assess the availability of the essential maternal and newborn health outcomes and process indicators as described in the national Road Map and related documents, including maternal and neonatal mortality and morbidity
3. To identify the possible gaps in the national Road Maps, as they relate to the 3 MNH pillars (Family Planning, Skilled Attendance at Birth and Emergency Obstetric and Neonatal Care, the last one including prevention/management of unsafe abortion and obstetric fistula)
4. To document whether the strategies and selected priority interventions are sufficiently aimed as well at increasing demand for, access to and use of quality services toward universal access to / coverage of SRH services
5. To document whether the plans are costed and financed for the scaling up towards universal access to / coverage of SRH services
6. To document whether the plans are ready for operationalisation and scaling up at district level
7. To describe the related monitoring and evaluation plans

8. To conduct an environmental scanning and stakeholder analysis by mapping out existing MNH initiatives and contributing organizations to determine how they interact and to what extent is the Ministry of Health leading the process.

The MNH Road Map assessment was conducted in two stages: the first was conducted in June 2008 and following the preliminary analysis of the questionnaire a second round of requests for clarifications and additional data collection was conducted between January and May 2009.

The assessment process was structured in a participative and collaborative manner. It was suggested by the national teams that the MNH/SRH focal point in each Country Office would coordinate the completion of the questionnaire in collaboration with key partners from the ministries of health (MoH) and other UN agencies and partners. The focal persons were responsible for (1) collecting all relevant background documents and sending electronic copies of those most pertinent (see table I); (2) studying carefully the questionnaire and then (3) planning and conducting a review meeting with MoH, WHO, UNICEF and development partners. The objectives of the MNH Road Map assessment were shared with the national MNH Teams at an early stage to ensure their buy in and understanding of this assessment as an opportunity for critical self reflection, strategic thinking, and planning.

The questionnaires were sent back to the UNFPA Technical Division where they were thoroughly reviewed for content and clarity. Follow-up email messages and teleconferences were initiated in all instances where more information, additional inputs and/or further clarifications were needed.

The feedback received from the National MNH teams regarding this process of critical self-reflection and analysis, including the assessment tool (questionnaire), was mostly very positive. Many teams found the assessment tool very useful, timely and beneficial for the evaluation of their MNH Road Maps. In the case of Kenya, the feedback provided during this assessment process to the National MNH Team on the draft version of the Kenyan MNH Road Map was used during its finalization.

III. RESULTS

The response rate was 77.7% with 35 out of 45 African countries conducting in the self-assessment of their national MNH Road Maps and returning the questionnaire to the Technical Division. However, this report includes mostly findings from 33 countries, as two respondents (Cape Verde and South Africa) have not yet developed a MNH Road Map. Cape Verde had still not started the process in early 2009. South Africa is currently in the final stages of drafting its Maternal, Newborn, Child and Women Health and nutrition policy which will cover similar areas as the MNH Road Map. Kenya completed finalizing its MNH Road Map during the period that this survey was being conducted. As mentioned earlier, the feedback provided to the national MNH Team on the draft version of the Kenyan MNH Road Map was found beneficial and was used during its finalization. Similarly Eritrea, Mauritania, Swaziland and Rwanda are in the final development stages of their MNH Road Maps. These four countries' MNH Road Maps were therefore excluded from some analyses.

Ethiopia has developed and costed an MNH component of the national RH Strategy, which, though not a separate and distinct national MNH Road Map, was considered as such and included in the study/assessment.

In place of a National Road Map for accelerating the reduction of maternal and newborn mortality, the Ministry of Health of Sierra Leone and its Health Development Partners developed a Reproductive and Child Health (RCH) Strategy. This RCH Strategy addresses all that would appear in a National Road Map for accelerating the reduction of maternal and newborn mortality, and therefore, the Sierra Leone data were included in this study/assessment.

Box 1. Responses and MNH Road Map status

- 35 Responses out of 45 (77.7%)
- 33 countries developed a national MNH Road Map
- 29 countries finalized their national MNH Road Map
- 21 countries officially endorsed their national MNH Road Map
- 22/33 countries have established a national MNH Committee (66.6%)
- 8 countries are engaged in resources mobilization for MNH
- 19/29 countries developed a MNH Plan of action (65.5%), and
- 16 countries developed a District action plan (operationalization)

III. 1. Policy and Programme Development Context (35 countries)

Over the last three years, following the publication of the Africa Union's Maputo Plan of Action (MPoA), eight countries developed or revised their national Health Policy. Five are currently doing so.

Twelve countries (34.3%) have developed/revised their national SRH Policy, eleven their RH strategy and ten their national SRH programme. Ten countries are revising their national SRH policy.

Seven countries have developed or revised their Youth Health Policy and seven are currently doing so.

Others developed or revised other policies related to SRH, including their National Policy on Population for sustainable development 2004 (1) and National Gender Policy (1).

Fifteen countries have developed a national Reproductive Health Commodity Security (RHCS) plan since the launch of the MPoA and in eleven countries the process is ongoing.

At the same time, 33 countries have developed their MNH Road Map!! This clearly demonstrates a renewed commitment for comprehensively addressing maternal and newborn mortality and morbidity reduction. This effort made by countries certainly justifies increased coordinated and support from Health Development Partners as well as from donors.

III. 2. National MNH Road Map Management (33 Countries)

To develop their national MNH Road Map, 22 countries out of 33 (66.6%), have established or re-vitalized a multi-stakeholder national MNH Committee, led by the MoH and with a clear mandate. In the remaining countries, ad-hoc teams and/or consultants have been assigned to develop the national MNH Road Map. Very few MNH Committees have developed their plan of action (12), and even fewer (6) have received a formal budget.

The composition of these national Task Forces is very similar across countries; the Ministry of Health, UN Agencies, the World Bank (7 countries) and, sometimes bilateral donors and/or civil society are represented. Ten countries have been able to involve one or more ministries, in addition to the ministry of health, in their national MNH or SRH/MNH committee. Fifteen countries reported that one to five bilateral are members of the national MNH Task Force. Only three countries have involved professional associations.

These management arrangements may reflect as well the political commitment and the capacity of countries to develop, implement, monitor and evaluate their MNH plans. How the country is managing to develop its MNH plan and is planning to implement, monitor and evaluate it demonstrates two conditions. It may indicate the commitment to obtain substantial results in terms of maternal and newborn mortality and morbidity reduction and it demonstrates the constraints and gaps to be addressed by the government and partners.

III.3. Level of Development of the National Road Maps (33 countries)

Twenty-nine countries (87.8%) have now reached the finalization step of their national MNH Road Map, , and 21 have endorsed it,. Among them, only 8 countries are carrying out a strategy to mobilize resources in order to implement the MNH Road-map, and 13 countries are already in the implementation stage (the implementation in a number of countries was commenced prior to engaging in a resource mobilization strategy).

Four countries – Eritrea, Mauritania Rwanda and Swaziland – are still in the midst of their MNH planning and programming process. Cape Verde is planning to commence the development of its MNH Road Map very soon.

Among the 29 countries with finalized MNH Road Maps, 19 countries (65,5%) have developed a plan of action and 16 (55,2%) have operationalised it with a District action plan for their Road Map implementation. The operationalisation and development of sub-national action plans is the last step before effective implementation of the national plans at both regional/provincial and district levels. Angola, Equatorial Guinea, Eritrea, Ivory Coast (ongoing), Lesotho, Madagascar, Mauritania, Nigeria, Rwanda, Tanzania, The Gambia, Uganda and Zambia have not yet developed their MNH plan of action and Chad, Congo, CAR, Namibia, Senegal and Swaziland have yet to operationalise it at district level.

III. 4. Planning and Budgeting Time Frames

Twenty-eight countries (84,8%) have planned strategies and main activities up until 2014/15 to be aligned with the MDGs. Sierra Leone and Eritrea are still planning for shorter periods, three or five years programmes. Within this MDG-related time frame, countries very often respect their usual planning cycle. Among 27 countries, 11 have developed a budget covering the period until 2014 or 2015 and 14 are budgeting only for the first three to five years.

Territory and Coverage

Among the 29 countries it is commendable that nearly all (28/29) are planning to cover 100% of their national territory. Only one country - Benin, is planning not at national level, but rather for a number of “zones” that represent less than 50% of the national territory.

III. 5. PARTNERSHIPS

All National Road Map development activities are supported by the three UN agencies – UNICEF, UNFPA, WHO and by The World Bank. In 3 countries, the African Development Bank, is also contributing. Among bilateral partners supporting the development of the national MNH plan, fifteen countries mentioned USAID (bilateral signatory of the WHO Road Map); DFID and JICA were mentioned by 8 countries, GTZ by 5 countries, AFD (France) by 4 countries and CIDA (Sweden) was mentioned by 2 countries.

The number of bilateral donors engaged in supporting the Road Map in each country ranges between 1 and 6. Two countries (Tanzania, Eritrea) have not mentioned any signatory from bilateral donors.
Belgium, Italy, Norway, Qatar, Netherlands, Luxemburg, Ireland, Sweden, Switzerland and the European Commission are also mentioned by some countries, as well as additional UN agencies (ILO, WFP and UNESCO). Fourteen countries mentioned International NGOs as signatories of their national MNH Road Map. Eight countries have not mentioned any collaboration with international NGOs. The international NGOs listed include: Family Health International, IPPF, Pathfinder and PSI.
In 6 countries one or more professional associations have signed the national MNH Road Map.

III. 6. COSTING, BUDGET, RESOURCE MOBILIZATION AND FINANCING

Countries have made an important effort to cost their MNH Road Maps, with technical support provided by one of the three Development Partners, in a majority of cases. The costing of the MNH Road Map national implementation plans has been achieved in 26 countries (78,8%). Specific tools like the Marginal Budgeting for Bottlenecks-MBB (Mali), the Integrated Health Technology Package-IHTP (Malawi) or the RH Costing tool (Uganda, Congo) were used, but in some cases, usual budgeting tools have been used.
Among the 26 countries which have costed their national plan, 12 have not conducted a detailed costing of a scaling-up plan. Those 12 countries are Benin, Burundi, CAR, Chad, Congo, DRC, Guinea, Lesotho, Madagascar, Mali, Senegal and Tanzania.
Currently, 6 countries (18,2%) have not yet costed their MNH Road Map (among them, 4 have not yet finalized their Road Map): Angola, Eritrea, Mauritania, Namibia, Swaziland and The Gambia.

11 countries have developed long term budgets, until 2014 or 15, based on some scaling-up strategy.
Of 33 countries, 17 mentioned conducting resources mobilization activities (51.5%). However, only 8 have developed a resources mobilization strategy (24.2%).

The level of financial resources already mobilized for the implementation of the MNH Road Map activities appears to be challenging for country teams to ascertain. Regarding the resources mobilized and available for the first phase of the national plan implementation, among 21 countries responding, only 2 (Malawi (85.9%) and Equatorial Guinea[18]) have mobilized more than half of the necessary funds for implementation and scale-up, 9 have mobilized one third of the necessary budget [Burundi, Ghana, Ivory Coast, Lesotho, Madagascar, Mozambique, Congo, The Gambia and Uganda] and another 8 have mobilized less than 10%.

Among 20 countries, 2 have declared that the national health budget was covering half or more of the Road Map funded budget [Malawi[19] and Congo], and 4 that the national health budget was covering one third of the Road map funded budget [Cameroon, Lesotho, Equatorial Guinea and Uganda]. For all the others (14), the national budget is covering less than 10% of the Road Map funded budget.

For 5 countries out of 18 (28%), the available funding from international partners is covering 50% or more of the resources (Burundi, Cameroon, Malawi (see footnote 11), Mali and The Gambia). The partners listed include all the specialized UN agencies (WHO, UNICEF and UNFPA) plus the WFP, and bilateral agencies: DANIDA, DFID, JICA, NORAD, SIDA, the Swiss Cooperation and USAID.

19 countries mentioned that the MNH budget was well integrated within the national SRH/MNCH and Health budgets and with the budget processes (PRSPs, SWAPs), while 12 said it is not. Few countries (13) indicated that government and partners' commitments in term of financial, human and material support were specifically stated in the national MNH Plan.

One third of the countries have established a SRH/MNH budget line.

[18] Early 2009 Equatorial Guinea 'MoH was provided by 3 milliards EGF for national MNH Road map implementation 2009-15
[19] The health SWAP is covering the national MNH Plan, using earmarked DFID funding

III. 7. SITUATION ANALYSIS

III.7.1. Available Data Presented

Among the 33 countries that have achieved or are in an advanced stage of development of their MNH Road Map (Cape Verde and South Africa are excluded), not all presented a full set of data.

III.7.2. Maternal Mortality Ratio (MMR)

Of the 33 countries that responded, 19 are using 1990 baseline MMR data. 1990 baseline MMR data is in fact not available in a number of countries. The Gambia reported no current MMR data. Four countries have not mentioned any MDG 2015 target for the MMR.

III.7.3. Assisted Deliveries

Eight countries' MNH Road Maps Situation Analysis are not providing current data on skilled attendance at birth [Burundi, Cameroon, CAR, Chad, Equatorial Guinea, Namibia, Sierra Leone and Swaziland]. This indicator, like the MMR, is an MDG5 target. Six MNH Road Maps are not providing the 2015 target to be attained [CAR, DRC, Namibia, Sierra Leone and Swaziland and The Gambia]. 13 national Road Maps are not referring to the international definition of a skilled birth attendant.

III.7.4. Contraceptive Prevalence Rate (CPR) and Unmet need for FP

Seven countries' MNH Road Maps Situation Analysis (21,2%) are not providing current data on CPR and one third are not providing targets for 2015. Even when available, approximately half of countries are not providing current Unmet Needs for FP data and only 30% are providing 2015 targets for Unmet Need for Family Planning.

III.7.5. Antenatal Care (1 and 4 visits)

It is quite surprising to see that in 9 countries the MNH Road Map Situation Analysis does not provide current estimates of women attending at least one antenatal care visit. Only 15 MNH Road Maps have provided a 2015 target for this MDG indicator.
Regarding the 4 ANC visits indicator, only 17 countries have used this indicator in their situation analysis. Eighteen countries MNH Road Maps have not defined a MDG target for this indicator.

III.7.6. Emergency Obstetric and Newborn Care (EmONC)

Very few countries' MNH Road Maps (seven) are able to present data related to 1990 on the percent of assisted facility deliveries (deliveries at EmONC facilities). In 12 countries, the MNH Road Maps are not providing current data on the deliveries occurring in EmONC facilities, and only 13MNH Road Maps define a 2015 target for this indicator.

The majority of countries (24/33) are not using 1990 baseline data on the availability of EmONC services. In addition, 10 do not provide any current data, and 11 have not defined a 2015 target on this important indicator.

Only 6 countries (18,2%) are showing trends from the 1990 period regarding the geographical distribution of the EmONC services. Less than half of the countries (16) are using current geographical distribution data and 15 countries' MNH Road Maps have defined the level of distribution to reach in 2015. Only seventeen Road Maps present data on the current Unmet Needs for EmONC and 14 have defined a 2015 target for this indicator.

III.7.7. Cesarean section Rate, Case Fatality Rate

Few countries' MNH Road Maps, just seven, are able to use a cesarean section (CS) rate baseline from 1990. Only 20 provide a current national CS rate, and 16 set targets for a 2015 CS rate.
Only eighteen countries' MNH Road Maps present a national case fatality rate (CFR) for maternal complications (54,5%).

III.7.8. HIV prevalence among pregnant women

Only in 24 countries the MNH Road Maps are using current data on HIV prevalence among pregnant women (72,7%)

III.7.9. Adolescent Pregnancy

Only seventeen countries' MNH Roadmaps (51%) have integrated data on adolescent pregnancy prevalence in their MNH situation analysis.

III.7.10. Health System Context

Although thirty-two countries responded that the Road Map situation analysis includes a description of the MNH related health system, only 20 Road Maps include data on the national MNH Human resources for health strategies and plans.

Only 16 Road Maps describe the existing national FP/RHCS plans. All respondent countries have included contraceptives, Oxytocin and Magnesium Sulfate in their national essential drugs list.

It is particularly notable that 14 countries' MNH Roadmaps (42%) are not using or analyzing their country experiences and lessons learned from recent/past projects and/or programmes in their situation analysis.

For only 19 countries the national MNH Road Map describes the existing SRH&R policies and plans. Only 19 identify in the situation analysis the strategic links to be established with the national SRH&R and for 18 with the STI/HIV Policies and plans.
However, despite all the above, 29 countries reported that all the MNH problems have been well identified in the Road Map situation analysis chapter and 28 that the causes of the FP/MNH problems and the potential for addressing them through the Road Map process were analyzed adequately. The identified MNH problems are related to (1) access to and use of services; (2) quality of care; (3) low CPR; (4) RHCS; and (5) financing.

III.7.11. Political and Stakeholder analysis

Nineteen countries reported having developed a political advocacy strategy for improving MNH.
However, only 16 countries' MNH Roadmaps include a stakeholder analysis.

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III.8. Strategies and Interventions

The questionnaire included eleven components identified as the main strategic components of a comprehensive MNH Road Map: Individual, Family and Community strategy (IFC), Human resources strategy and plan (HR), Emergency obstetric and neonatal care strategy and plan (EmONC), Family Planning (FP), Abortion/Post-abortion care (Abort.), Youths and Adolescent Sexual reproductive health strategy (Y&A), HIV/AIDS strategy (HIV), Infrastructure (Infr.) and Reproductive health commodity security strategy (RHCS).

Table I below scores countries on the existing components of their MNH plans.

Table I. MNH Plans: Main strategic Road Map components.

Country	Total
Angola	10
Benin	7
Burkina Faso	4
Burundi	7
Cameroon	9
CAR	8
Chad	5
DR of Congo	6
Congo	10
The Gambia	6
Eq. Guinea	11
Eritrea	4
Ethiopia	10
Ghana	8
Guinea	11
Guinea- Bissau	11
Ivory Coast	9
Kenya	8
Lesotho	5
Madagascar	2
Malawi	10
Mali	9
Mauritania	7
Mozambique	10
Namibia	9
Nigeria	4
Rwanda	6
Senegal	10
Sierra Leone	8
Swaziland	2
Tanzania	9
Uganda	10
Zambia	11

Note: 33 countries are considered. Among these countries, 16 have developed an operation plan (red).

It is remarkable that only four countries have included all the mentioned components in their Road Map: Equatorial Guinea, Guinea, Guinea Bissau and Zambia. Seven countries are missing only one strategic component: Angola, Congo, Ethiopia, Malawi, Mozambique, Senegal and Uganda. Seven countries have included in their MNH plan less than half of the 11 listed key components. The most often missing elements of a comprehensive MNH Road Map are: EmONC plan, Infrastructure plan and a Human resources plan and strategy.

Six countries have not included FP activities as a main component of their MNH Plan.
Out of those, 4 countries who have integrated FP are not promoting universal access to FP services including youths and unmarried people.

Only four countries have not integrated in their Road map strategies involving communities in Maternal and newborn health, a critical component for maternal and newborn mortality reduction. In 24 plans activities are described and in 22 these activities are linked to HIV and Newborn health strategies and activities conducted at community level.

III.9. Integration of MNH Programmes and Activities with other Related Programmes / Areas

Table II. Integration

Country	Total
Angola	7
Benin	6
Burkina-Faso	2
Burundi	7
Cameroon	9
CAR	10
Chad	5
DR of Congo	7
Congo	12
The Gambia	8
Eq. Guinea	12
Eritrea	4
Ethiopia	11
Ghana	9
Guinea	11
Bissau-Guinea	11
Ivory Coast	11
Kenya	10
Lesotho	6
Madagascar	1
Malawi	6
Mali	8
Mauritania	9
Mozambique	10
Namibia	11
Nigeria	5
Rwanda	10
Senegal	10
Sierra Leone	8
Swaziland	4
Tanzania	9
Uganda	10
Zambia	8

Note: 33 countries are considered. Among these countries, 16 have developed an operation plan (red). [20]

In addressing the integration of a comprehensive MNH programme with other key related programmes (Table II), ten key programmes have been identified (in 12 questions): Sexual reproductive health strategy (SRH), Human resource strategy for health (HR), Family Planning (FP), Youth and Adolescent Health (Y&A), HIV (HIV-SRH and HIV-MNH), Infrastructures (Infra.), Reproductive health commodity security (RHCS), Obstetric Fistula (OF), Child survival (Child) and Gender.

- Twenty countries described their national Sexual Reproductive Health and Rights strategy and 18 (54.5%) have declared having integrated SRH&R issues with the national MNH Road Map.
- In 18 countries that have developed their HR for MNH strategy, this strategy is integrated with the national HR for Health strategy.
- Twenty seven countries (81.8%) have reflected their national FP strategy and workplan in their MNH Road Map.
- Only 24 countries have established links between MNH and Youth and Adolescent SRH programmes.
- Integrating the national Obstetric Fistula elimination strategy can be not relevant in countries were OF doesn't exist. However, it would be important for Benin, Burkina-Faso, Cameroon, Eritrea, Ethiopia, Ghana, Madagascar and Mozambique which have not done this yet. Only 8 African countries have yet developed a national strategy to eradicate Obstetric Fistula (Benin, Chad, DRC, Kenya, Mauritania, Niger, Nigeria and Uganda).
- Twenty three countries have linked their MNH Road Map with the national child survival strategy, which is encouraging.
- Twenty seven countries have considered Gender issues well-integrated with their MNH Road Map.

III.10. Monitoring and Evaluation

Seven countries (21.2%) indicated that no Monitoring and Evaluation plan with a list of core indicators was attached to the national MNH Road Map: Angola, Congo, CAR, Guinea,

[20] Regarding the integration issue, it appears that additional substantive efforts should be conducted as a priority in the areas of (1) human resources planning (skilled birth attendants), (2) emergency obstetric and neonatal care services and (3) youths and adolescents MNH.

Madagascar, Rwanda and Swaziland. Only thirteen countries have developed a plan for evaluating their national Road Map. Of those, eleven have included result-monitoring systems and strategies to develop capacities in monitoring and evaluation: Benin, Cameroon, Equatorial Guinea, Ethiopia, Ivory Coast, Namibia, Nigeria, Senegal, Sierra Leone, Tanzania and The Gambia.

III.11. Recommendations from Countries

The questionnaire proposed, at the end of the self-assessment process, that the country team formulate recommendations to the MoH and partners based on the findings of the review. A number of countries have used this opportunity to formulate recommendations regarding the national MNH Road Map finalization, improvement and/or implementation (18 countries). Among those with an advanced document, nine countries have not responded. Regarding the recommendations, the main points are the following:

1. To improve, finalize and review the existing Road Map document using the findings of the review. This is an important point, as the objectives of this exercise were, first, to support country teams in pointing out the weaknesses and gaps, and by learning (through the review) from other countries' experiences and best practices, to address them. Many countries have responded to this opportunity very positively.
2. The main points for improvement are the following: the situation analysis, the scaling-up planning and operationalisation, the costing and the monitoring and evaluation plan for the MNH Road Map implementation.
3. A number of countries proposed complementing their national MNH Road Map with a resource mobilization strategy and plan, a human resources development and management plan, and to improve on the integration issues.
4. Nine countries mentioned the need for costing: Angola, Benin, Burkina-Faso, Burundi, CAR, Eritrea, Lesotho, Madagascar, Mali, Mauritania and Namibia.
5. Technical assistance was specifically requested by Equatorial Guinea, for operationalisation/implementation, by Eritrea, for costing and finalization of the Sexual and Reproductive Health Policy, and by CAR, for planning and costing.
6. Burkina-Faso, Ethiopia (where currently the results are already being analyzed) and Mali mentioned the need to conduct an EmONC needs assessment. Rwanda mentioned the need to analyze the EmONC needs assessment recently conducted but has not mentioned the need for technical assistance in this regard.

IV. DISCUSSION

1. Limitations of the methodology

Not all countries have responded and some of those which are missing are very important in terms of high maternal mortality. Data are available for only 35 out of 45 countries in Africa, and yet more than 40 countries have already developed their national MNH Road Map.

This survey is a self-assessment survey, conducted by the national teams (Ministry of Health, UN Development Partners and sometimes additional partners) engaged in developing and implementing the national MNH Road Maps. The quality of the assessment is based on the willingness, thoroughness, and incisiveness of the respondents. As all national team members have a substantial work load in their respective positions, the process of comprehensively replying to the assessment questionnaire was quite lengthy. We acknowledge the risk that the respondents might not have been sufficiently self-critical. We believe that the responses reflect the reality as the respondents perceive it. However the questionnaire's methodology was intentionally designed to be a critical self assessment survey. By designing it in such a way we aim to ensure a buy in by the National MNH team and senior MoH officials to the results; a buy in which is instrumental in using the survey's results to address the gaps and weaknesses identified.

The issue of integrating the MNH strategies and activities with the key relevant public health programmes can be addressed in different ways. For example: mentioning HIV as a challenge is not enough to consider that HIV and MNH programmes are really integrated. Furthermore an additional weakness in the questionnaire is that about it intentionally does not address the process used to develop the operational plans and their quality.

In order to avoid these above mentioned limitations, it would have been necessary to have an observer participating in all the self-assessments conducted. The participation of an external expert in this review would have probably helped in some cases to strengthen the analysis. The trade off would have been a decreased buy in and willingness by MoHs to use the process of critical self reflection and feedback receipt to revise their respective MNH Road Maps addressing the gaps and weaknesses identified.

We feel strongly that the national MNH teams have seized the opportunity and seriously and thoroughly reviewed their respective MNH Road Maps. We would like to take this opportunity to thank them for their excellent work. A substantial number of respondents have expressed their gratitude for the conducting of this survey. A keen interest was demonstrated by many of the national MNH teams in having the opportunity to further assess progress on a regular basis with joint or coordinated technical support from the UN partners.

Political commitment, crucial element for substantive progress in maternal health, cannot be evaluated by such survey. Issues like integration in the national planning and budgeting processes were only indirectly addressed through questions on financial resources and resources mobilization: it is worrying that these questions were challenging for colleagues involved in the national MNH team.

2. Policy context

Following the launch of the Africa Union Maputo Plan of Action, most African countries are engaged in developing and/or, revising their SRH policies and strategies. It is remarkable that, over the last five years (from 2004) most African countries have followed the recommendations by WHO/AFRO, supported by the development partners, including UNFPA, and commenced planning for Maternal and Newborn Health. It should be noted that the technical assistance to the national MNH Road Maps development has been a high priority of inter-agency work (UNICEF/WHO/UNFPA) during the last five years. However, while inter-agency sub-regional workshops have been successfully conducted, joint direct technical assistance to countries has been provided more rarely. This could reflect, to some extent, a gap in inter-agency collaboration at country level. The findings of this survey demonstrate clearly the gaps in the technical support provided to countries, analyzed below.

3. MNH Road Map management and developmental status

Box 1 summarizes the status of development of the national MNH plans in the respondent countries.

While 29 countries have finalized their plan, only 13 declared to have really started implementation. Planning and programming is a lengthy process for the national MNH teams. According to the information provided by countries, it lasted more than two years for the majority of countries. Contributing factors to this lengthy process are probably the competing priorities, and manpower and the expertise constraints. These constraints were noted at Ministry of Health level, but also, at CO level, for all UN development partners. Sub-regional joint technical assistance has not been sufficient in overcoming these constraints.

Few countries (6) have commenced resource mobilization activities to fund their national MNH Road Map. This is certainly a significant shortfall as we know that (1) maternal and newborn health requires substantial long term investments to strengthen the health systems; (2) national resources exist but need to be identified and channeled to MNH; and that (3) the global commitment for MDG 5 is increasing. There is certainly a need for better supporting the MoHs in advocating at national, regional and/or global levels for the funding of their national MNH Road Map implementation plans.

The operationalisation of the national plans is a critical step, without which implementation of the key interventions cannot be successful. Based on the national strategies priority interventions and plans, planning should be conducted at sub-national levels before it becomes operational at district level. This issue was strongly addressed in the inter-agency, sub-regional workshops on MNH Road Map development. WHO/AFRO are ready to provide additional guidance on this important issue, as a guide is ready to be published[21]. Training district managers in assessing and evaluating the needs in SRH/MNH and in planning, programming, monitoring and evaluating MNH programmes, is certainly one of the strategic areas of focus for technical assistance. WHO/MPS is planning to publish a District Planning Guide for MNH. Technical assistance should be made available to successfully address this step at national and at sub-national levels in countries with needs.

[21] The WHO/AFRO Manual for operationalization of the national MNH Road Maps has been recently revised with partners at a meeting held in Addis-Ababa, Ethiopia, September 2008.

Successful implementation of the national MNH plans requires integration with national RMNCH and Health plans with, at the same time, specific monitoring and regular evaluation. Not all countries have established MNH coordination committees with clear mandate and budget.

4. Time frame and coverage

It is remarkable and commendable that all countries (except Benin) are planning and programming at a national level for universal coverage with MNH services. This can be related to the fact that many countries have already shifted from MNH projects to programmes and that UN agencies are more engaged now with the Ministries of Health to ensure the success of national strategies rather than local and limited projects.
The majority of countries are adopting short- and long-term planning. Short-term is guiding immediate efforts in line with the national planning cycles. Long-term planning includes scaling-up strategies for reaching 2015 targets. However, as said elsewhere, scaling-up plans with targets and indicators, merging short and mid-long term strategies and interventions is often missing.

5. Partnership

The UN development partners are improving their collaboration in working in Africa, following in particular the Regional Directors meetings' recommendations[22], and they are supporting all countries in the MNH field in a coordinated manner. Hopefully the findings of this assessment will guide the future efforts of the RMNH4 (UNICEF, UNFPA, WHO and The World Bank) in leading the technical assistance to countries. It seems however that just a small number of bilateral agencies and international NGOs are engaged in MNH implementation plans, and in a small number of countries. USAID is mentioned as MNH national committee member in 15 countries and 15 countries have declared a partnership with one or more bilateral. In 14 countries partnerships involve one or more international NGO.
The mentioned bilateral agencies are DANIDA, DFID, GTZ, JICA, NORAD, SIDA, Swiss Cooperation and USAID. WFP and ADB's support are mentioned in several countries as well.
The restructuring and regionalization processes ongoing in the three development partners (UNFPA, UNICEF and WHO/AFRO), are nearing completion and are expected to lead to a reinforcement of their MNH regional staff, who are instrumental in supporting the strengthening of the CO's capacities. The recently developed RMNH Plan of action (H4) and the Maternal Health Thematic Fund (MHTF) will be instrumental to lead a reinforced collaborative financial and technical assistance.

6. Costing, budget, resources mobilization and financing

A substantial effort is currently being conducted by the UN development partners (including UNFPA) to harmonize the existing costing tools and to cost the national MNH plans. Still however, countries require additional support in this area. Some countries, which have already costed their plan using non-specific budget tools, may decide to go for a new costing exercise, using the more specific available tools. UNFPA has started developing national and regional expertise for costing national SRH/MNH plans in coordination with partners, in

[22] Dakar 2007, Nairobi 2008

particular UNICEF. This effort needs to be further strengthened, as this expertise is greatly needed to cost the existing plans and to allow countries to move ahead on their own in costing national plans in a regular basis, as part of the normal planning cycle.

The available data on financing levels for MNH demonstrate well the general and severe underfunding of MNH Plans in Africa. This must be related as well to the level of political commitment for MNH at country, regional and at global levels. The survey demonstrates clearly that the national teams often lack information on financing levels for MNH in their countries. In many countries, and not only countries with a Sector Wide Approach (SWAp), accurate information on funding for MNH and for SRH programmes, is either missing or very difficult to obtain through the MNH experts. It is certainly linked to the fact that only few national MNH teams (8) have planned for resource mobilization activities. This is also related to the probable general lack of integration of MNH Road Maps with national Health plans and financing mechanisms. The area of funding and financing is certainly critical for successful MNH Road Map implantation plans and appears to be an area where technical support (advocacy, resources mobilization) is most needed.

This analysis does not reflect new global and regional initiatives by bilaterals that target among others, MDG5 (International Health Partnership, the Global Campaign for the Health MDGs). It is strongly expected that recently announced health systems-strengthening funding initiatives (in addition to the efforts made by the Global Fund for HIV, Malaria and TB and the GAVI Alliance) will contribute to a substantial increase in funding for maternal and newborn health. It is hoped that the current financial crisis will not hamper funding for health -systems strengthening and maternal and new born health. The Maternal Health Thematic Fund recently established at UNFPA and now working with 11 countries, including 8 in Africa, aims to fund strategic activities and to ensure that MNH programmes are running (addressing, as a priority, the identified bottlenecks). However it is currently not yet equipped with sufficient resources to fund ambitious programmes for scaling-up MNH interventions.

7. Situation analysis

In general, the situation analyses developed in the MNH Road Maps are of insufficient quality. Analyses include incomplete data, without sufficient trends' discussion. They often include short descriptions of the health systems, listings of existing programmes and lists of key problems or constraints, but usually without analysis of the roots and determinants of these problems and with no lessons learned from past valuable experiences and no sufficient political analysis. Insufficient data could be related to weaknesses of the health information systems, which have to be strengthened at all levels. This is also reflecting the lack of reporting and evaluation of national or sub-national programmes, an important concern in many African countries. If planning is perceived as critical for making progress in reducing maternal and newborn mortality and morbidity, it should be based on quality situation analysis with explicit mentioning of obstacles to be overcome, lessons to be learned and experiences (to be or not to be) replicated. In summary, insufficient effort has been made in the MNH country situation analyses, and this can lead to "planning as usual" and most probably to the repetition of errors already made in the past.

The lack of data and the limited use of available data are critical. As an example, not using data for current national skilled birth attendance coverage hampers the measurement of progress toward achieving the MDG target. It is certainly an issue to be addressed seriously in all countries. 40% of the countries are not referring to the international definition of the

skilled birth attendant. Among these countries, some might still be using different definitions, which is a challenge: the international definition of a skilled birth attendant was not always mentioned as reference. It is important to ensure that all countries are able to report in a standardized manner.

The lack of data present for all important issues:

- Family planning: one country out of five is not providing current data on CPR, 40% are not providing current unmet needs for FP and most (60%) are not providing a 2015 target regarding this indicator
- ANC attendance: one indicator used to measure the Universal access to sexual and reproductive health within the Millennium Development Goal 5.
- EmONC: one of the three pillars of maternal mortality reduction strategies. Lack of data regarding the current situation is certainly detrimental for planning and programming in this critical issue for maternal and newborn health. There is a critical need to conduct national EmONC needs-assessment to be able to plan for EmONC services, one of the MNH mortality reduction pillars.
- Caesarian Section rate: despite progress in measurement capacities, still only few countries are measuring (or using) a national CS rate. It is important to note that very few countries are reaching the 5% minimum level recommended, many being very far from this objective, in particular in rural areas. The CFR is a key quality indicator for maternal care services. More facilities are measuring it however further progress is strongly necessary in this issue for quality care improvement.

The main strategies to reduce maternal and neonatal mortality and morbidity are well known. However, their implementation is country-specific. Each country has specificities that pertain to the status of women, gender issues, political will and socio-economic development priorities. Each country has a unique history for addressing health and women's health problems with experiences and lessons learned. All of these elements are important for building relevant strategies. Some countries already while conducting this review, became aware of the gaps and the need for having a better analysis of the current situation. UNFPA's MHTF, in collaboration with partners, is funding and technically supporting countries to conduct EmONC Needs Assessments surveys to determine the current situation in this area – data which will form the basis for planning and programming in this critical area for maternal and newborn health.

Efforts are strongly needed to improve national health information systems which include routine measurement and use of SRH/MNH indicators.

8. Strategies and interventions

As mentioned earlier, few countries have comprehensive MNH Road Maps, and the most commonly missing elements are EmONC plans, Infrastructure plans and Human resources plans and strategies. EmONC and skilled health professionals are key elements for reducing maternal and newborn mortality in any country, in addition to Family Planning. The ongoing support to countries in conducting EmONC needs-assessment surveys and subsequently their results in planning to address the lack of EmONC services is essential and needs to be further scaled up. This includes building and/or renovating infrastructures and developing human resources (HR) strategies. It seems that in many countries MNH teams assume that the human resources issues are (or should be) addressed by the MoH/HR Department. It is certain however, that in order to ensure that the specific needs for SRH/MNH in terms of human

resources are well understood and well addressed by these ministerial departments, human resources models have to be drawn (midwives vs. nurse-midwives, doctors vs. non-physicians clinicians, etc.) and the needs calculated (in terms of quality and quantity) and costed. These are certainly areas where training of nationals and technical support are highly needed. HR strategies for SRH/MNH have to be subsequently integrated within the national HR strategies for health.

Strategies include short term strategies aimed to maximize existing resources (deployment of existing midwives, task shifting, facility and community-based distribution of contraceptives) or to introduce innovative interventions with potential immediate impact (Magnesium sulfate available in all maternal health facilities with appropriate packaging and guidance) to be implemented at the same time that substantial carefully planned investments are made in mid and long-term strategies (training, recruitment and management of midwives, training of non-physicians clinicians, infrastructure development).

Working with communities to ensure services are used and respond to the needs is critical. Majority of countries have mentioned Community involvement strategy in their MNH Plan, only 24 have described interventions aimed to involve/mobilize communities and 22 have mentioned linkages with HIV and Newborn health community-based interventions.

Maternal death reviews at facility and community level were not addressed by the questionnaire. However, these interventions well known for their potential impact on quality of care and reporting have been recently evaluated in the African countries.[23] Efforts are recommended to scale-up maternal death reviews at national level.

9. Integration

It appears that integration of MNH with related programmes is not sufficiently achieved in a number of countries; in particular regarding issues like SRH&R, Youth and Adolescent SRH and Human resources national plans. The quality of integration of MNH Plans with HIV national strategies and plans, which is claimed to be well achieved by all countries, would require more in-depth surveys and analysis. Not all countries have integrated FP (27) and RHCS (28) interventions in their MNH Plan. This current assessment looks at integration only as it is addressed in the national MNH Road Maps. A critical step is then to ensure the effective integration of the different programmes and activities at the implementation stages at national and district levels, which is essential. At this date only few (13) countries have already operationalised their plans at district level. However, ensuring that national teams are able to plan for integrating activities at all levels is certainly an important achievement.

10. Monitoring and Evaluation

Monitoring SRH and MNH impact and process indicators is essential for assessing progress, constraints and barriers, and MDGs' attainment. Monitoring the actual implementation of the MNH Road Map in order to be able to improve mechanisms and performances is critical as well. This is certainly an area where additional efforts should be made: improvement of the national health information system, Road Map monitoring and evaluation plan, and MNH Task Force plan of action and budget.

[23] Pearson, de Bernis, Shoo. Maternal death reviews in Africa. Int J Gynecol Obstet (2009)

11. Recommendations from country teams

It is commendable that a number of countries used this assessment as an opportunity to seriously analyze the process used to develop the national MNH Plan and to analyze their current situation in order to develop recommendations for solving identified bottlenecks, gaps and challenges. As explicitly stated earlier, the objective of this assessment is certainly not to request countries to postpone implementation of MNH strategic activities, but rather to provide an opportunity to analyze the gaps and weaknesses which could be corrected in order to ensure better situation analysis and better planning, programming and monitoring and evaluation.

The majority of countries have identified areas for improvements in their MNH Plans and formulated relevant recommendations. Implementing them can be done during the normal planning process when strategies have to be revisited, evaluated, refined or fine-tuned. Needs for additional technical support have also been identified in some countries. This should be further discussed with each country team in order to plan for continued technical support in national and sub-regional levels. A need for substantial technical support has been identified in many countries for the costing of their MNH Road Maps and for succeeding in resource mobilization.

V. CONCLUSIONS AND RECOMMENDATIONS

This first report is a part of a broader report on the Maputo Plan of Action assessment under development. Thirty five countries have positively responded to the proposal to conduct a self-assessment of their planning and programming processes in SRH&R and MNH areas. In addition, in their recommendations a number of countries have mentioned the benefits of conducting such exercises to improve their plans and implementation processes.

The main gaps are concerning:

1. The quality of the Situation Analyses, which are often incomplete and not detailed enough, can impact negatively on the identification of innovative and context-specific strategies to be designed and activities to be implemented. Such high levels of maternal and newborn mortality and morbidity require massive engagement of countries and partners. How can we identify where and how to progress when we don't know well where we are? Furthermore, for some countries, clear targets are missing. Conducting a quality situation analysis, using existing data and trends and using lessons learned, including a stakeholder's analysis, is the first step for quality planning and programming. It is certainly an area where more technical assistance could be necessary. Refining a situation analysis, as some countries are proposing to do, could be part of the process of monitoring and evaluating regularly the implementation of the national Road Map (planning cycle). Generating more of necessary data through appropriate assessments (EmONC Needs assessments, FP Needs assessments, Human resources assessments), national population-based surveys (DHS, MICS, Census) and improvement of the national Health information system should be planned. Quality also matters. Progress in implementing Maternal death reviews at referral hospitals level should result in the scaling-up of such critical intervention aimed at improving quality of care and reporting and mobilizing health professionals.
2. However, guided by the increasing consensus on strategic MNH interventions, countries are in general well-focused on the three main strategies to efficiently reduce maternal and newborn mortality: Family Planning, EmONC and Skilled Attendance at Birth. For too many countries, family planning programmes seem not to be clearly integrated with the MNH Road Maps. EmONC plans are often not sufficiently developed, neither are human resources development and management plans. This last area, human resources, is often where the largest gaps/needs lie.
3. Community involvement/mobilization is addressed but not all countries have defined detailed interventions linked with Newborn/Child health and HIV programmes.
4. Even if post-abortion care is included in the basic signal functions of EmONC, the abortion issue, one of the major causes of maternal deaths in all African countries, is very poorly addressed in general, even when allowed by law. Tremendous efforts should be conducted by countries, with all necessary technical and financial assistance, to develop these key strategies and interventions as required.
5. Not all countries have developed a scaling-up plan for the key strategies and interventions, with clear targets and steps. Planning capacities require multidisciplinary approaches, not always possible at country level. Capacity-building and technical assistance are particularly needed in this area. Having good and well detailed plans allow to have a quality costing and to monitor progress efficiently.
6. Substantial efforts have been conducted by countries in costing their MNH Road Maps. Only several countries have used costing tools to measure the cost of alternative possible strategies and interventions and to facilitate decision making within the process of plan

development. Nevertheless the majority of countries have now costed MNH Road Maps that can be used for resources mobilization. However, technical assistance for additional countries is still needed. It is urgent that the review, standardization and harmonization of the currently available costing tools progresses rapidly and that health and development partners better coordinate their efforts.

7. Regarding budgetary issues, budget mechanisms and financial support: responses to questionnaire were often partial or lacking. This probably indicates that the technical staff members in charge of developing the plans are not familiar enough with these issues. It would be necessary to have a more specific and in-depth survey to better explore the situations countries face regarding budgeting for MNH. However, we should recognize that care financing issues, like free care, subsidized care, exemptions, user-fees, etc., were not addressed by this questionnaire, as this would have required a specific survey.
8. Maternal and newborn mortality reduction require massive long term investments in strengthening health systems, in training, recruiting and retaining the skilled health professionals who are critically needed. Many countries will find mobilizing the necessary financial and technical resources very challenging. The currently available secured budgets to finance MNH Road Map implementations plans are extremely limited. It is the reason why strong and innovative resource mobilization strategies are required. A number of countries have explicitly mentioned this point as a recommendation for the immediate follow-up to this self-assessment. At the same time short-tem interventions with potential high impact should be implemented to maximize the existing human and logistic resources.
9. Developing national MNH Road Maps has certainly been an important step in many countries when MNH plans were characterized by their lack of comprehensiveness and strategic content. However, integrating these plans with the national health plans and financing processes is now the challenge majority of countries is facing.
10. The monitoring and evaluation of the Road Maps' implementation would require well-established, multi-disciplinary teams with a clear mandate, work plan and budget. Not all countries have yet established such teams. Ensuring, in addition, that the key MNH indicators are included in the national Health monitoring information system (HMIS) and can be routinely or regularly measured is certainly important to be considered.

Conclusion

The findings of this assessment conducted jointly at country level by the UN Health and Development partner agencies, with UNFPA coordination and endorsed by Ministries of Health are important to measure the progress made in planning and programming for MNH in Africa during the last six years. An additional result of this assessment is the explicit realization of what still needs to be conducted and achieved in the coming months and years to accelerate progress to the attainment of the MDG 5. Having relevant and realistic Road Maps and implementation plans to address the complex and challenging issues of maternal and newborn health, as major public health issues are as well an entry point for the achievement of universal access to SRH services. The results of this assessment are expected to encourage countries to commit themselves to take the lead in integrating RMNH in their national Health planning processes. This should further encourage as well all Health and Development partners and donors to strongly support, financially and technically, these national MNH Plans, and ensure that they benefit from the important currently ongoing and future international initiatives aimed to support health MDGs related activities. This support which is strongly needed will provide all women with the right to access to the health services and support they need before, during and after their pregnancy.

Planning is important but the real progress in women's health will be made in implementing and scaling-up the priority and cost-effective well defined interventions and monitoring it to track progress and improve the plans in a cycle planning process. Immediate and long-term activities are necessary, to be implemented at the same time with strong political support and appropriate investments. UNFPA, UNICEF, WHO and The World Bank (H4) working together with donor countries, global funds and foundations, regional and international NGOs UNFPA, UNICEF, WHO and The World Bank (H4) working together with donor countries, global funds and foundations, regional and international NGOs, can be successful in providing the necessary support to countries toward MDG 5 and 4 achievements!

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Annex I
Maputo Plan of Action Assessment Survey

Questionnaire

I. Assessment of Maputo Plan of Action in your country

1 Name of the country……

2 Name and title of the respondent……..

3 Among the Officials listed below, who represented your country at the Special Session of the African Union Conference of Ministers of Health, held in Maputo from18-22 Sept 2006 to sign to the Maputo Plan of Action (MPoA)? Please **circle** as appropriate

i. High level
- Minister of Health
- Permanent Secretary, MoH
- Secretary General, MoH

ii. Middle level
- Central level director
- Chief of Division

iii. Other level
- Others (specify)

4 Since the adoption of the MPoA (Sept 2006) for the period 2007-2010, has there been any formulation/revision of any national policy, strategy, plan, programme or project document(s) to align it/them with the MPoA ? Yes or No

5 If yes, what are this /these documents? (Circle as appropriate)

A Policy
- National Heath Policy
- National Sexual and Reproductive Health policy
- National Youth Health policy

B Strategy
- National Sexual and Reproductive Health strategy
- National IST/VIH/SIDA strategy

C Plans
- National Health Sector Development Plan
- National Plan for Reproductive health commodity security
- National Maternal and Newborn Health Plan

D Programmes

- National Sexual and Reproductive Health Programme
- National Programme for Child Survival
- National Road map for accelerating the reduction of maternal and newborn mortality

E Others (specify)

6 Since the adoption of the MPoA (Sept 2006) for the period 2007-2010, is/are there any national policy, strategy, plan, programme or project document(s) under formulation/revision to align it/them with the MPoA ? Yes or No

7 If yes, what are this /these documents? Please **circle** as appropriate

A Policy

- National Heath Policy
- National Sexual and Reproductive Health policy
- National Youth Health policy

B Strategy

- National Sexual and Reproductive Health strategy
- National IST/VIH/SIDA strategy

C Plans

- National Health Sector Development Plan
- National Plan for Reproductive health commodity security
- National Maternal and Newborn Health Plan

D Programmes

- National Sexual and Reproductive Health Programme
- National Programme for Child Survival
- National Road Map for accelerating the reduction of maternal and new born mortality

E Others documents (specify)

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8 Maputo Plan of Action outputs

Box 1 : List of key Outputs of the Maputo Plan of Action

a) Access to quality Safe Motherhood and child survival services increased
b) HIV, STI, Malaria and SRH services integrated into primary health care
c) Strengthened community-based STI/HIV/AIDS/STI and SRHR services
d) Family planning repositioned as key strategy for attainment of MDGs
e) Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and wellbeing
f) Incidence of unsafe abortion reduced
g) Resources for SRHR increased

h) SRH commodity security strategies for all SRH components achieved
i) Monitoring, evaluation and coordination mechanism for the Plan of Action established

Under some of the documents as per questions 5 &7 above, some key outputs of the MPoA, in the above box 1, are clearly addressed. Yes or No ……

9 If yes, what are the key outputs of the Maputo plan of action that are clearly addressed by which document? Please **circle** the document as well as the key outputs of the MPoA it addresses.

A Policy
Ai. National Heath Policy
a, b, c, d, e, f, g, h, i

Aii. National Sexual and Reproductive Health policy
a, b, c, d, e, f, g, h, i

Aiii. National Youth Health policy
a, b, c, d, e, f, g, h, i

Aiv. Other policy documents
a, b, c, d, e, f, g, h, i

B Strategy
Bi. National Sexual and Reproductive Health strategy
a, b, c, d, e, f, g, h, i

Bii. National IST/VIH/SIDA strategy
a, b, c, d, e, f, g, h, i

Biii. Others National Strategies
a, b, c, d, e, f, g, h, i

C Plans
Ci. National Health Sector Development Plan
a, b, c, d, e, f, g, h, i

Cii. National Plan for Reproductive health commodity security
a, b, c, d, e, f, g, h, i

Ciii. National Maternal and Newborn Health Plan
a, b, c, d, e, f, g, h, i

Civ Other National Plans

a, b, c, d, e, f, g, h, i

D Programmes
Di. National Sexual and Reproductive Health Programme
a, b, c, d, e, f, g, h, i

Dii. National programme for Child Survival
a, b, c, d, e, f, g, h, i

Diii. National road map for the reduction of maternal and new born mortality
a, b, c, d, e, f, g, h, i

Div. Others National Programmes (specify)……
a, b, c, d, e, f, g, h, i

10 Using the table below, indicate which current UNFPA interventions (if any) aim to achieve which one(s) of the MPoA key outputs (as in box 1, above), in your country (add blank rows as needed)

Table 1: Current UNFPA interventions and target MPOA outputs

UNFPA Intervention	The Key MPOA targeted	Remarks

11 Using the table below, indicate which current other partners' interventions (if any) aim to achieve which one(s) of the MPoA key outputs in box 1, as above, in your country (add blanc rows as needed)

Table 2: Current other partners' interventions and target MPOA outputs

Others' Interventions	The Key MPOA targeted	Remarks

All question below are related to the Road Map to accelerate the attainment of maternal and newborn health related MDGs

12 List hereunder the partner agencies signatories of the African MNH Road Map document, adopted on Feb 2004 at the Harare meeting, that are working in your country to implement the national road map for the reduction of maternal and neonatal mortality

a. Government……..
……
b. Multi lateral agencies……
……
c. Bilateral agencies …….

……

d. NGOs ……
……

e. Others……..
……

13 List hereunder the partner agencies non signatories of the African MNH Road Map document, adopted on Feb 2004 at the Harare meeting, that are working in your country to implement the national road map for the reduction of maternal and neonatal mortality

a. Government agencies……
……

b. Multilateral agencies ……
……

c. Bilateral agencies ……
……

d. NGOs ……
……

e. Others ……
……

14 Has Government re-dynamized/established a multi disciplinary/ multisectoral national MNH Road Map Task Force/Steering Comity or Working Group with a:

a) Clear mandate & terms of reference, Yes or No
b) Plan of action Yes or No
c) Budget? Yes or No

15 If yes, list hereunder the partners represented in the national MNH Road Map Task Force/ Steering Committee/ Working Group. If No, go to next question

a. Government agencies……
……

b. Multilateral agencies ……
……

c. Bilateral agencies ……
……

d. NGOs ……
……

e. Others ……

16 At what development stage is the national MNH Road Map for the reduction of maternal and neonatal mortality?

a) Initial stage
b) Development stage
c) Finalisation stage
d) Adoption
e) Resource mobilisation
f) Implementation stage
g) Other, specify

17 As of its actual development stage (determined in question 16 above) list hereunder the partners who have signed up to the national MNH Road Map

a. Government agencies……
……
b. Multilateral agencies ……
……
c. Bilateral agencies ……
……
d. NGOs ……
……
e. Others ……

18 Has any operational plan (national, district, etc.) resulted from the national MNH Road Map? Yes or No

19 If yes, list hereunder the partners who have signed up to the (national, district, etc.) MNH Road Map operational plan

a. Government agencies……
b. Multilateral agencies ……
c. Bilateral agencies ……
d. NGOs ……
e. Others ……

20 Based on the national MNH road map document, what is the time frame (year of start and year of end) of the national MNH Road Map?

21 Based on the national MNH road map document, give an estimate of the % of the national territory (geography and population) targeted under the planned national road map implementation. Please **circle**

a. 0-10%
b. 11-50%
c. Over 50%

22 Has the national MNH road map been costed yet? Yes or No

23 What is the time frame of the prepared budget?

24 Has any resource mobilisation activity taken place in favour of the national MNH road map implementation yet?
Yes or No

25 If yes, give an estimate of levels (in % of total costs) of financial resources mobilised to meet the costs for the planned implementation of the national road map.

a. <10%
b. 33%
c. 50%
d. Over 50%

26 What proportion (%) of the funded Road Map Budget is covered by the national Health budget?

a. <10%
b. 33%
c. 50%
d. Over 50%

27 What proportion (%) of the funded Road Map budget is covered by international partners?

a. <10%
b. 33%
c. 50%
d. Over 50%

28 Please provide information on partners and % of budget covered

Table 3: budget covered by partners' contribution

Name of Partners	**% of Road map budget covered**	**Remarks**

Annex II

II. Review of the MNH Road Map document

	Road Map Assessment (content)					
No.	**Issue**	**Yes**	**No**	**Not available**	**Value**	**Comment**
	Situation Analysis					
1	**1.1.1** Does the national MNH road map include **Maternal Mortality Ratio** (MMR) data for 1990 (baseline)?					
	1.1.2. for the current time period, 2005-07 (year)?					
	1.1.3. the projected target for 2015?					
	1.2.1. Does the national MNH road map include **percentage of assisted deliveries** (with skilled attendant) data for 1990?					
	1.2.2. for the the current time period, 2005-07 (year)?					
	1.2.3. the projected target for 2015?					
	1.2.4. Does the national MNH road map include the definition of a **skilled birth attendant** which is consistent with international requirements?					
	1.3.1. Does the national MNH road map include data **on Contraceptive Prevalence Rate** (CPR) for 1990?					
	1.3.2. for the current time period 2005-07 (year)?					
	1.3.3. the projected target for 2015?					
	1.4.1. Does the national MNH road map include data on **Unmet need for FP** for 1990?					
	1.4.2. for the current time period 2005-07 (year)?					
	1.4.3. the projected MDG target for 2015?					
	1.5.1. Does the national MNH road map include data on the **Proportion of women who had at least one ante-natal visit during their last pregnancy** for 1990?					
	1.5.2. for the current time period 2005-07 (year)?					
	1.5.3. the projected MDG target for 2015?					

	1.6.1. Does the national MNH road map include data on the **Proportion of women who had at least four ante-natal visits during their last pregnancy** for 1990?					
	1.6.2. for the current time period 2005-07 (year)?					

No.	Issue	Yes	No	Not available	Value	Comment
	1.6.3. the projected MDG target for 2015?					
	1.7.1. Does the national MNH road map include data on **percentage of deliveries occurring in EmONC facilities** for 1990?					
	1.7.2. for the current time period 2005-07 (year)?					
	1.7.3. the projected target for 2015?					
	1.8.1. Does the national MNH road map include data on **availability of EmONC services in 1990?**					
	1.8.2. for the current time period 2005-07 (year)?					
	1.8.3. the projected target for 2015?					
	1.9.1. Does the national MNH road map include data on the **geographical distribution of EmONC services** for 1990?					
	1.9.2. for the current time period 2005-07 (year)?					
	1.9.3. the projected target for 2015?					
	1.10.1. Does the national MNH road map include data on the **Met needs for EmONC** for 1990?					
	1.10.2. for the current time period 2005-07 (year)?					
	1.10.3. the projected target for 2015?					
	1.11.1. Does the national MNH road map include data on **CS Rate** for 1990?					
	1.11.2. for the current time period 2005-07 (year)?					
	1.11.3. the projected target for 2015?					
	1.12. Does the national MNH road map include data on **Case Fatality Rate for Obstetric complications**?					

No.	Issue	Yes	No	Not available	Value	Comment
	1.13. Does the national MNH road map include data on **HIV prevalence among pregnant women**?					
	1.14. Does the national MNH road map include data on **% of pregnancies among adolescents**?					

No.	Issue	Yes	No	Comment
2	**2.1.** Does the national MNH road map describe the existing **national MNH Health System**?			
	2.2. Does the national MNH road map describe the existing national Human resources for MNH development and management plan, including midwives and others with midwifery skills (MOMS)?			
	2.3. Does the national MNH road map describe the existing FP/RHCS plans?			
	2.4. Are contraceptives part of the national Essential Drug List?			
	2.5. Are Oxytocin and Magnesium Sulfate part of the national Essential Drug List?			
3	Does the national MNH road map include country experiences and lessons learned from past and/or ongoing pilot projects/programmes? Please list them.			
4	**4.1.** Does the national MNH road map describe the national Sexual reproductive health and rights policy and plan (Maputo)?			
	4.2. Does the national MNH road map identify areas for integration with the national Sexual reproductive health and rights policy and plan?			
5	Does the road map describe the national STI and HIV/AIDS policy and plan and indicate if they are integrated with SRH&R policy and plan?			
	Analysis of problems' causes and selection of priority problems			
6	Are the FP and MNH problems that will need to be addressed as high			

No.	Issue	Yes	No	Comment
	priority identified? Please list them.			
7	Are the causes of FP and MNH problems and the potential for addressing them through the Road Map process analyzed?			
8	**8.1.** Did the situation analysis mention the total government budget allocated for Health? Please provide data.			
	8.2. Did the situation analysis mention the percentage of the total government health budget allocated for SRH/MNH? If so, please provide the percent.			
9	Did the situation analysis mention if a RH budget line, a budget line for contraceptives and/or other reproductive health supplies in the National Budget exist? Please provide details.			
Political Analysis and Strategy				
10	**10.1.** Does the road map include an SRH stakeholders' analysis?			
	10.2. Please list the donors and stakeholders involved in Road Map development and implementation.			
11	Is a political strategy for improving maternal and newborn health developed?			
Vision, goals and objectives for MNH and FP				
12	Does the Road Map include a Vision statement?			
13	Does the Road Map include national MNH goals that are aligned to MDG5 and targets?			
14	Does the Road Map include a set of SMART[24] MNH and FP objectives?			
Strategic orientations, action plans and integration				
15	Are there logical links between the situation analysis the proposed results and the Road Map strategies?			

[24] SMART = Specific, measurable, achievable, realistic and time bounded

No.	Issue	Yes	No	Comment
16	**16.1.** Is a **Road Map Action Plan** developed to operationalise the strategies at national, sub-national and district levels?			
	16.2. Is the Road Map Action Plan developed delineate the activities related to each strategy? Please comment.			
17	**17.1.** Are the strategies to address the **individuals, families and communities'** involvement and mobilization defined?			
	17.2. Does the workplan include evidence-based individuals, families and communities (IFC) involvement and mobilization activities?			
	17.3. Is the IFC involvement and mobilization Plan linked with RH/HIV and Newborn and Child Health community-based activities/plans?			
18	**18.1.** Is a Human **resources** for MNH development and management strategy defined?			
	18.2. Is the Human resources for MNH development and management strategy, when exist, include midwives and others with midwifery skills (MOMS)?			
	18.3. Is a **HR** development and management Plan for SRH/MNH included in the Road Map, as part of the national HR for Health plan?			
	18.4. If a HR for SRH/MNH plan is not yet developed, is the development of such a plan included in the MNH Road Map workplan?			
19	**19.1.** Is an **EmONC** strategy developed?			
	19.2. Is an **EmONC** workplan developed?			
	19.3. When no recent (within 3 years) EmONC Needs Assessment exists, is it planned to conduct one as part of the Road Map workplan?			
20	**20.1.** Are the national **FP** strategy and workplan reflected in the MNH Road Map?			
	20.2. Does the Road Map promote universal access to contraception including youths and adolescents and unmarried people?			
21	Is the Road Map Action Plan include provision of safe **abortion** (when legal) and **post-abortion services** integrated with RH/MNH services?			
22	**23.1.** Does the Road Map include **Youth and Adolescent Health** issues?			

No.	Issue	Yes	No	Comment
	23.2. Are **Youth and adolescent** friendly MNH and FP services planned to be developed?			
23	**24.1.** Does the road map take into account **HIV/AIDS**?			
	24.2. Is a **PMTCT** workplan, including the four prongs, integrated within the Road Map?			
24	Is an **Infrastructure development plan** developed?			
25	**26.1.** Does the road map address **RHCS?**			
	26.2. Is the MNH road map integrated with the national **RHCS** workplan?			
26	Is the national **Obstetric Fistula** strategy, where it exists, or OF elimination related activities, when relevant, fully embedded into the MNH Road Map?			
27	Are the links between Newborn and **Child survival** programmes planned?			
28	**29.1.** Is cultural sensitivity addressed in the proposed priority interventions?			
	29.2. Are **gender issues**, including male involvement, addressed in the proposed priority interventions?			
29	Is an **Advocacy and communication strategy** included in the MNH Road Map?			
30	Have the proposed strategies been costed and various options studied to assist in the decision-making process during the development of the Road Map?			
Planning for scale-up				
31	Under the current MNH operational plan, what is the coverage of the national territory? (%)			
32	Does the Road Map include a plan for scale-up with baseline, coverage targets and time lines for each major Road Map strategic component?			
Costing and financing of the final draft Road Map				
33	Has a detailed **costing** of the national MNH road map been done, which			

No.	Issue	Yes	No	Comment
	highlights the scale up costs? If yes, please indicate the tool(s) used and annex the document.			
34	Is the national MNH road map **budget** developed with financial resource gaps provided?			
35	Is there a **resource mobilization strategy**?			
36	**36.1.** Is the financial resources mobilization strategy being implemented?			
	36.2. Who are the main sources of funding (please list: government, UNs, multilaterals, bilaterals, NGOs, others).			
	36.3. What proportion of the budget is covered by donors vs government? (see question 7 in Questionnaire Part II)			
	36.4. What percent of required funding has been secured?			
37	Is the Road Map budget well integrated with the national SRH/MNCH and Health budgets and with the budget processes (PRSPs, SWAPs)?			
38	Are the government and partners commitments (financial, human, material) specifically indicated?			
Monitoring and evaluation plan				
39	Is a **plan for monitoring**, including list of core indicators, developed?			
40	Is a Road Map **evaluation plan** developed?			
41	Does it include reference to systems for results monitoring as well as strategies to develop national capacity in M&E?			
Indicators				
42	Is each indicator direct i.e. closely tracks the result it intends to measure?			
43	Is each indicator objective i.e. has a precise operational definition that allows for clarity on what is being measured and how data can be obtained?			
44	Is each indicator practical i.e. data selected to track indicators is available periodically and obtainable at a reasonable cost?			

No.	Issue	Yes	No	Comment
45	Are indicators adequate i.e. the number of indicators is sufficient and not too many to adequately tracking the expected result?			
46	Does each indicator include a performance target?			
47	Is there a baseline for each indicator?			
Means of Verification				
48	Have data sources or data collection methods been specified for all indicators?			
49	Has provision been made in the Road Map budget for data collection costs?			
Risks and Assumptions				
50	Have risks and assumptions that influence achievements at each level of results (output, outcome, impact) been identified?			
Finalization				
51	Is the Road Map finalized and officially endorsed by the government?			
52	If not, what elements/steps are missing and is a plan for finalization exists? If yes, please provide.			
Partnerships				
53	Are the range of partners (e.g. UN, donors, NGOs and CSOs) and national development frameworks (PRSPs, SWAPs, Sector Reform) adequately identified and partnership strategies highlighted?			
54	Is the leading role of the government in coordinating partners for the Road Map implementation and monitoring and evaluation clearly defined with coordination framework?			
55	Are gender/women NGOs organizations involved?			
56	Is there indication of potential synergy and complementarity with interventions of UN agencies? Please provide the list of UN agencies and development partners (donors) involved in supporting the national MNH road map implementation.			

No.	Issue	Yes	No	Comment
Capacity development and sustainability				
57	Have the implementing partners' capacity gaps been adequately identified?			
58	Does the Road Map strategy include a capacity development component that addresses the capacity gaps identified within the implementing partners?			
Management arrangements				
59	Does the Road map clearly describe the **implementation modalities** and indicate the arrangements for management?			

III. Review of the MNH Road Map Document: recommendations

No.	Recommendations

IV. Background documents

Please provide information on the following documents (assessments and plans)

Sexual RH and Rights (Maputo Plan of Action)			
Document	**Name**	**Year**	**Comments**
National MDG assessment (or equivalent)			
PRSP			
Census			

Health situation analysis			
Population-based surveys (DHS, MICS, etc.)			
Countdown to 2015 Country profile			
National Health Plan			
National Health Account			
SRH&R Plan (Maputo)*****			
FP/RHCS Needs Assessment*****			
EmOC Needs Assessment and/or other MNH Assessment*****			
National MNH Road Map*****			
National MNH Road Map Costing*****			
Human resources for health national plan			
Human Resources for MNH / Midwifery development national strategy and plan*****			
National Obstetric Fistula elimination strategy / plan*****			
Other			
Other			

***Please provide an electronic copy of the documents with a ***

Annex III

Table I bis. MNH Plans: Main programme components.

[1= yes; 2= no; 9= not known]

Issue → Country	II, 17.1 IFC	II, 18.1 HR Strat.	II, 18.3 HR Plan	II, 19.1 EmONC Strat.	II, 19.2 EmONC Plan	II, 20.1 FP	II, 21 Abort.	II, 23.1 Y/A	II, 24.1 HIV	II, 24 Infrastr	II, 26.1 RHCS	Total
Angola	1	1	1	2	1	1	1	1	1	1	1	**10**
Benin	1	2	2	1	1	1	1	2	1	2	1	**7**
Burkina-Faso	1	2	2	1	2	1	9	2	2	2	1	**4**
Burundi	1	1	2	1	2	1	2	1	1	2	1	**7**
Cameroon	1	1	1	1	1	1	1	1	1	2	2	**9**
CAR	1	2	2	1	1	1	1	1	1	1	9	**8**
Chad	1	2	1	2	2	1	1	1	2	2	2	**5**
DRC	1	2	2	1	2	1	1	2	1	2	1	**6**
Congo	1	1	1	1	2	1	1	1	1	1	1	**10**
The Gambia	1	2	2	2	2	1	1	1	1	2	1	**6**
Eq. Guinea	1	1	1	1	1	1	1	1	1	1	1	**11**
Eritrea	2	2	2	2	2	2	1	1	1	2	1	**4**
Ethiopia	1	1	1	1	2	1	1	1	1	1	1	**10**
Ghana	1	1	1	2	2	1	1	2	1	1	1	**8**
Guinea	1	1	1	1	1	1	1	1	1	1	1	**11**
Bissau Guinea	1	1	1	1	1	1	1	1	1	1	1	**11**
Ivory Coast	1	1	9	1	9	1	1	1	1	1	1	**9**
Kenya	1	1	2	1	2	1	1	1	1	2	1	**8**
Lesotho	1	2	1	2	2	2	2	1	1	2	1	**5**
Madagascar	2	2	2	2	2	2	1	2	2	2	1	**2**
Malawi	1	1	1	1	1	1	1	1	1	1	2	**10**
Mali	1	1	2	1	1	1	1	1	1	2	1	**9**
Mauritania	1	2	2	1	1	1	2	1	1	2	1	**7**
Mozamb.	1	1	1	1	1	1	1	2	1	1	1	**10**
Namibia	1	1	1	1	2	1	1	1	1	2	1	9

Nigeria	1	1	2	2	2	2	2	2	1	2	1	**4**
Rwanda	9	1	1	2	2	1	9	1	1	2	1	**6**
Senegal	1	1	1	1	1	1	1	2	1	1	1	**10**
Sierra Leone	1	2	2	1	1	2	1	1	1	1	1	**8**
Swaziland	2	2	2	2	2	2	1	2	1	2	2	**2**
Tanzania	1	1	1	1	2	1	1	1	1	9	1	**9**
Uganda	1	1	1	1	1	1	2	1	1	1	1	**10**
Zambia	1	1	1	1	1	1	1	1	1	1	1	**11**
TOTAL	**29**	**21**	**18**	**23**	**15**	**27**	**26**	**24**	**30**	**15**	**28**	

1 = Yes; 2 = No; 9 = no response

33 countries are considered.
Among these 33 countries, less than half, 16 have developed an operation plan (in red).

Regarding the key components of a MNH Plan:
- 29 countries said they have developed IFC strategy and plan (II, 17.1)
- Only 21 countries have developed a Human resources strategy for MNH. (II, 18.1)
- Only 23 countries have developed an EmONC strategy (II, 19.1) and only 15 an EmONC plan. (II, 19.2)
- 27 countries have developed a FP component. (II, 20.1)
- Abortion services (post-abortion care and safe abortion services, when legal) are included in the MNH plans in 26 countries. (II, 21)
- Youth and Adolescents services are elements of the national MNH Plan in only 24 countries. (II, 23.1)
- 30 countries have included HIV interventions in their Road Map. (II, 24.1)
- Only 15 countries have planned for infrastructures in their MNH plan. (II, 24)
- 28 countries have addressed the RHCS issues in their MNH plan. (II, 26.1)

Table II bis. Integration

Issue → Country	II4.1 SHR Strat	II4.2 SRH Int	II18.3 HR Strat	II20.1 FP	II23.1 Y/A	II5 HIV SRH	II24.1 HIV MNH	II24 Infrastr	II26.1 RHCS	II26 OF	II27 Child	II29.2 Gender	Total
Angola	2	2	1	1	1	2	1	1	1	2	2	1	**7**
Benin	2	2	2	1	2	1	1	2	1	2	1	1	**6**
Burkina-Faso	2	2	2	1	2	2	2	2	1	2	9	2	**2**
Burundi	2	2	2	1	1	2	1	2	1	1	1	1	**7**
Cameroon	1	1	1	1	1	1	1	2	2	2	1	1	**9**
CAR	1	1	2	1	1	1	1	1	9	1	1	1	**10**
Chad	2	2	1	1	1	2	2	2	2	1	2	1	**5**
DRC	1	1	2	1	2	2	1	2	1	1	2	1	**7**
Congo	1	1	1	1	1	1	1	1	1	1	1	1	**12**
The Gambia	1	9	2	1	1	1	1	2	1	1	1	2	**8**
Eq. Guinea	1	1	1	1	1	1	1	1	1	1	1	1	**12**
Eritrea	2	2	2	2	1	2	1	2	1	2	2	1	**4**
Ethiopia	1	1	1	1	1	1	1	1	1	2	1	1	**11**
Ghana	1	1	1	1	2	2	1	1	1	2	1	1	**9**
Guinea	1	9	1	1	1	1	1	1	1	1	1	1	**11**
Bissau Guinea	1	1	1	1	1	9	1	1	1	1	1	1	**11**
Ivory Coast	1	1	9	1	1	1	1	1	1	1	1	1	**11**
Kenya	1	1	2	1	1	1	1	2	1	1	1	1	**10**
Lesotho	1	2	1	2	1	1	1	2	1	2	2	2	**6**
Madagascar	2	2	2	2	2	2	2	2	1	2	2	2	**1**
Malawi	2	2	1	1	1	2	1	1	2	2	2	1	**6**
Mali	2	2	2	1	1	1	1	2	1	1	1	1	**8**
Mauritania	1	1	2	1	1	2	1	2	1	1	1	1	**9**
Mozambiqu	1	1	1	1	2	1	1	1	1	2	1	1	**10**
Namibia	1	1	1	1	1	1	1	2	1	1	1	1	**11**
Nigeria	2	2	2	2	2	2	1	2	1	1	1	1	**5**

Rwanda	1	1	1	1	1	1	1	2	1	9	1	1	**10**
Senegal	1	1	1	1	2	1	1	1	1	1	2	1	**10**
Sierra Leone	2	1	2	2	1	1	1	1	1	2	1	1	**8**
Swaziland	1	1	2	2	2	2	1	2	2	2	1	2	**4**
Tanzania	9	9	1	1	1	1	1	9	1	1	1	1	**9**
Uganda	1	1	1	1	1	2	1	1	1	1	2	1	**10**
Zambia	2	2	1	1	1	2	1	1	1	1	1	2	**8**
Total	**20**	**18**	**18**	**27**	**24**	**18**	**30**	**15**	**28**	**19**	**23**	**27**	

1 = Yes; 2 = No; 9 = no response

33 countries are considered. Among these countries, 16 have developed an operation plan (red).