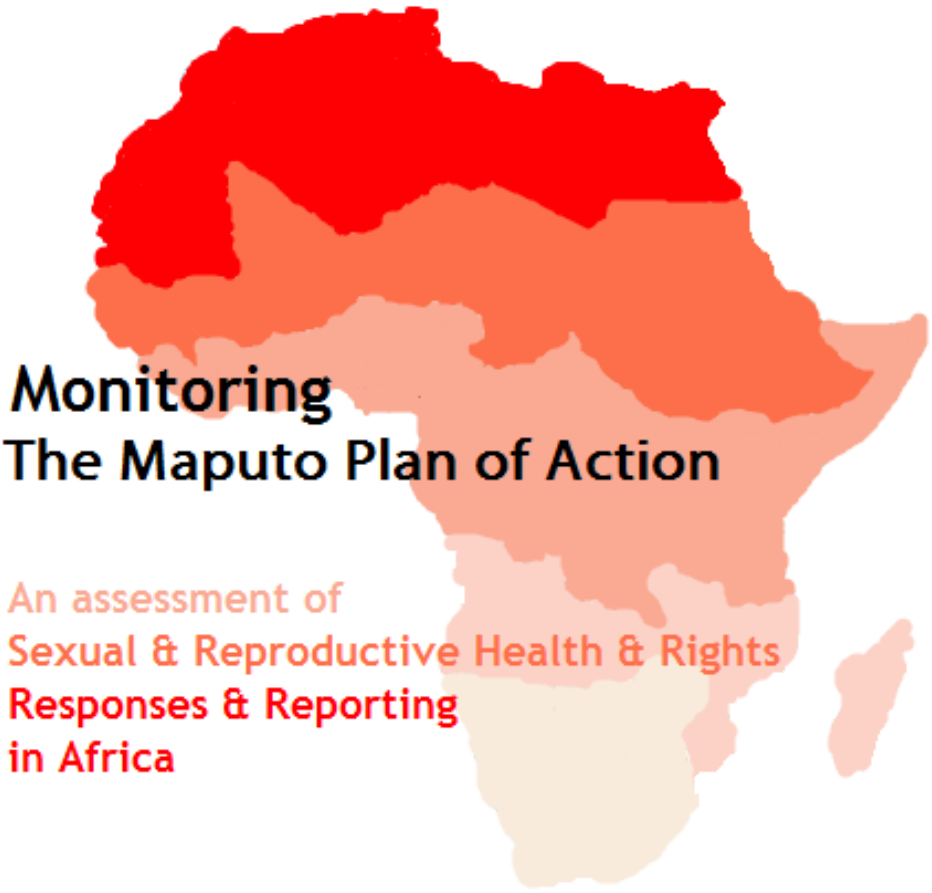

MPOA Scorecard

An assessment of Southern African Development Community Responses and Reporting on Sexual and Reproductive Health and Rights

Sept 2012

Phillipa Tucker

Holding leaders accountable

AIDS Accountability International

About AIDS Accountability International

AAI is an independent non-profit organization established to increase accountability and inspire bolder leadership in the response to the AIDS epidemic. It does so by rating and comparing the degree to which state and non-state actors are fulfilling the commitments they have made to respond to the epidemic.

AAI aims to build bridges between actors and institutions that collect and analyze primary data in the field of HIV/AIDS and those who make use of this data in different contexts, such as policy makers and advocates. AAI provides these actors with a compass that points to new policy and programmatic directions and helps stimulate debate on the need for greater accountability and leadership.

AAI's efforts are made possible through the support of
Ford Foundation, Swedish International Development Cooperation Agency (Sida), Norwegian Ministry of Foreign Affairs and Open Society Foundation for South Africa as well as leading experts and civil society organizations in the field of HIV/AIDS.

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Feedback

Phillipa Tucker, AAI Regional Manager for Africa is the author of this report.

Every attempt has been made to ensure the accuracy of this report but the author and AAI welcome any feedback, comments, and/or corrections on the content.
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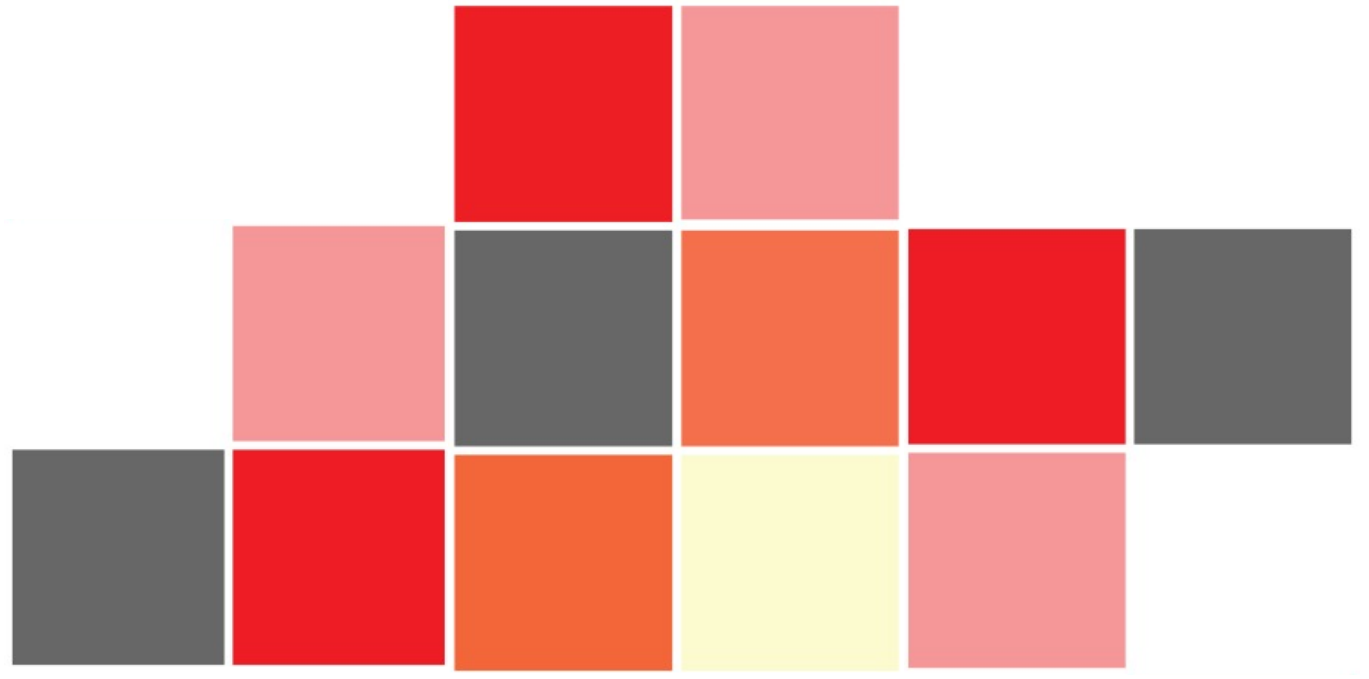

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1. Find out more about our work at http://www.aidsaccountability.org
2. Subscribe to our newsletter on our website (see sidebar on the right of the page) and get updates on meetings, discussions, advocacy tools and trainings.
3. Follow us on Facebook
4. Follow us on Twitter: AAI_Aidswatch
5. Join the discussion at the AIDS Accountability International Sexual and Reproductive Health and Rights LinkedIn Discussion Forum

Introduction

The MPOA Scorecard provides data and an analysis of statistics provided by African governments to the African Union Commission in the Maputo Plan of Action (MPOA) reporting. This report first briefly introduces the various concepts that inform sexual and reproductive health and rights on the continent, how the Maputo Plan of Action commitment evolved as a government solution, and how accountability and data can be used to improve Sexual and Reproductive Health and Rights (SRHR). In the second section of the report the data is presented and analysed in an easy-to-read manner and a way forward provides recommendations in the final closing section.

Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights (SRHR) are usually understood as the rights of all people, regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition these decisions do not infringe on the rights of others. This includes the right to access education and information, services and healthcare.

The World Health Organization's working definition of sexual rights includes a right to achieve "the highest attainable standard of sexual health, including access to sexual and reproductive health care standards".[i]

Some of the specific areas that sexual and reproductive health and rights cover is adolescent and ageing sexual and reproductive health, family planning and access to contraceptive services and supplies, counselling and treatment related to sexual coercion and violence, female genital operation (FGO) and other harmful practices, infertility, reproductive tract infections, sexually transmitted infections, and human immunodeficiency virus (HIV), safe, early and accessible abortion services without discrimination of fear of reprisal, pre, peri and post natal care and health, and information and empowerment campaigns that debate and challenge ideologies that support male superiority.

As much as SRHR are considered to be basic human rights and fundamental to development "conditions are devastating the African Continent: 25 million Africans infected with HIV, 12

million children orphaned due to deaths related to AIDS. 2 million deaths from AIDS each year, women increasingly affected with the feminization of the epidemic; 1 million maternal and new-born deaths annually, an African woman having a 1 in 16 chance of dying while giving birth; high, unmet need for family planning with rapid population growth often outstripping economic growth and the growth of basic social services (education and health), thus contributing to the vicious cycle of poverty and ill-health. Today, by any measure, less than one third of Africans have access to reproductive health (RH)".[ii]

In many parts of Africa considerable gender inequalities remain which play a highly significant role in jeopardizing women's access to SRHR. High levels of morbidity and mortality are attributable to a shortage both in breadth and quality of SRH services, which are usually easily preventable problems in developed countries. Conservative and restrictive environments often prevent women from making informed personal choices thus impacting negatively on the family, community and society.

Youth remain at risk and require both school and out-of school based family and sex education. Young women require access to sexually transmitted infections (STI) and HIV counselling and testing, psychological and medical treatment related to sexual coercion and violence, safe, accessible and early abortion services, as well as contraceptive services and supplies. It is only through special programs for adolescents that the continent will be able to ensure their secure future.

Government Commitments

The Maputo Plan of Action

As a result of the state of SRHR in Africa, various governments, regional economic communities such as the Southern African Development Community (SADC) and the African Union Commission (AUC) responded to the call to act with the development of policy on SRHR, not least of which was the International Conference on Population and Development (ICPD) in 1994. In 2005 the African Union Conference of Ministers of Health adopted the Continental Policy Framework on Sexual Reproductive Health and Rights (SRHR) and in 2006 adopted the Maputo Plan of Action for its implementation.

The Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework, commonly known as the Maputo Plan of Action (MPOA) or Maputo Plan, aims to achieve universal SRHR in Africa by 2015. It was a "short term plan for the period up to 2010 built on nine action areas: Integration of sexual and reproductive health (SRH) services in primary health care (PHC), repositioning family planning, youth-friendly services, unsafe abortion, quality safe motherhood, resource mobilization, commodity security and monitoring and evaluation."[iii]

The key elements of the MPOA were:

1. Integrating STI/HIV/AIDS, and SRHR programmes and services,
2. Repositioning family planning as an essential part of achieving the health Millennium Development Goals (MDGs);
3. Addressing the sexual and reproductive health needs of adolescents and youth as a key SRHR component;
4. Addressing the issue of unsafe abortion;
5. Delivering quality and affordable services in order to promote Safe Motherhood, child survival, maternal, new-born and child health; and
6. Strengthening African and south-south co-operation for the attainment of ICPD and MDG Goals in Africa.

In order to assess member states' progress in implementing this plan, the AUC administered a Progress Assessment Tool (PAT) - a questionnaire completed in 2010 for a 5 year review of the

Maputo Plan of Action. At their 15th Session, the AU Assembly requested the AUC to develop (and align with MDGs 4 and 5) a set of indicators for monitoring and reporting on the MPOA. The AUC has gone through a rigorous process of developing and piloting the indicators.

The MPOA Progress Assessment Tool (PAT)

In the 2010 round of reporting the following groups of indicators were used to gather data from countries.

1. Integration of HIV/STI, Malaria and SRH Services into PHC
2. Strengthening of Community based STI/HIV/AIDS and SRHR Services
3. Family Planning repositioning as key strategy for attainment of MDGs
4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being
5. Incidence of unsafe abortion reduced
6. Access to safe motherhood and child survival services increased
7. Resources for SRHR increased
8. SRH Commodity security strategies for all SRH components achieved
9. Monitoring, evaluation and coordination mechanism
10. Lessons learned
11. Country Profile

Overall 37 numerical data points and additional 101 data points of comments, challenges and recommendations were included in the 2010 round of reporting in the PAT.

Recent developments in PATS Indicators

In 2011 and 2012 the AUC has changed the indicators of the PAT and re-aligned them with the MDG indicators, as a means to avoiding duplication of reporting. These new PATS are currently being piloted in 7 African countries across the continent but budget and human resource constraints as well as capacity in country have played significant roles as barriers to the completion of this process. AAI is currently in discussions with the AUC with regard to how we can support this process.

Other SRHR commitments

The list below includes all government commitments on SRHR since 1979, but does not include national nor regional commitments. Although it is accurate to say that not all 194 countries have signed all of these commitments, and that fewer yet have ratified them, it would point to a pre-occupation with making promises, from all stakeholders. AAI strongly pushes for all stakeholders to focus on programming and implementation and consider existing commitments sufficient.

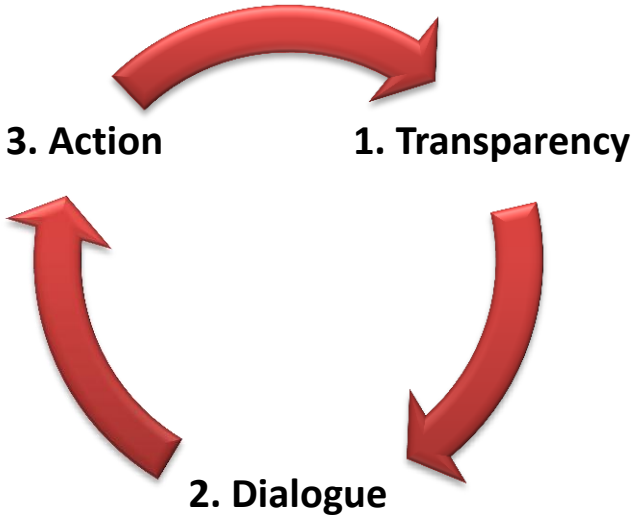
1. 1979 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), UN General Assembly
2. 1986 The African Charter on Human and Peoples' Rights (Banjul Charter)
3. 1990 African Charter on the Rights and Welfare of the Child (ACRWC or Children's Charter)
4. 1993 The World Conference on Human Rights (Vienna)
5. 1994 International Conference on Population and Development (Cairo)
6. 1995 Beijing Declaration, Fifth World Conference on Women
7. 1997 SADC Declaration on Gender & Development
8. 2000 Millennium Development Goals
9. 2001 Abuja Declaration on HIV/AIDS, TB and other related infectious diseases
10. 2001 UNGASS: Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session
11. 2003 Maseru Declaration on HIV and AIDS/ Maputo Declaration on Gender Mainstreaming/ Maputo Declaration on HIV/AIDS, TB, Malaria
12. 2003 The Protocol Relating to the Peace and Security Council (PSC) of the African Union (especially around violence)
13. 2004-2005 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Women Protocol)
14. 2004 Solemn Declaration on Gender Equality in Africa (SDGEA)
15. 2005 Continental Policy on Sexual and Reproductive Health and Rights, (Maputo Plan of Action related)
16. 2006 Maputo Plan of Action, Plan of Action on Sexual and Reproductive Health and Rights 2007-2010 (renewed till 2015)
17. 2007 High Level Meeting on Sexual and Reproductive Health Policies in Africa (Barcelona)
18. 2007 Africa Health Strategy: 2007 - 2015
19. 2008 Southern African Development Community Gender and Development (SADC–GAD)
20. 2008/2009 Campaign on Accelerated reduction of Maternal Mortality in Africa (CARMMA/MPOA)
21. 2009 African Union Gender Policy
22. 2010 UN Secretary-General's Global Strategy for Women's and Children's Health, (New York) General Assembly meeting
23. Various Regional Economic Communities (REC) commitments
24. Various national commitments



Increasing accountability and using data for advocacy

AIDS Accountability International (AAI) aims to build bridges between actors and institutions that collect and analyse primary data in the field of health and those who make use of this data in different contexts, such as policy makers and advocates. AAI provides these actors with a compass that points to new policy and programmatic directions and helps stimulate debate on the need for greater accountability and leadership.

However, in order for accountability to become a constructive governance principle in the response to health needs it cannot be reduced to a simplistic 'blame game' between government and stakeholders. AAI explains accountability as a governance 'mechanism' in three steps, as depicted in figure 1 below.



1. Transparency

The dialogue on accountability cannot start unless stakeholders have sufficient and equal access to the relevant data on the national response collected through national Monitoring and Evaluation (M&E) systems. Further, it is essential that this data is presented in a way that enables civil society stakeholders to engage with it and draw conclusions from it. It is important to note that the failure by governments to provide transparent access to the relevant data is sufficient grounds for legitimate demands for accountability. Thus the MPOA Scorecard increases transparency around MPOA & Accountability, by focusing on improving annual data collection for contributing to the annual reports to the AU Heads of State and Government

Summits until 2015. As well as to draw attention to the lack of reporting and under-reporting by government and demand government be accountable where applicable, and demand better data quality to better inform responses.

2. Dialogue

Government must commit to and engage in annual reviews of country performance in the response in relation to the relevant national or global targets for service coverage and governance principles with all relevant stakeholders. The reviews will give government opportunities to explain instances of poor performance, and civil society stakeholders can assess whether those explanations are acceptable or whether to demand political accountability. Obviously, the failure of government to participate in such reviews, or a politically biased engagement only with some civil society stakeholders, is sufficient grounds for demands for accountability. The MPOA Scorecard increase dialogue around the MPOA & Accountability, especially with regard to women, girls and other vulnerable groups, and creates an accessible, powerful, affective new evidence base for SRHR advocates and develop their capacity to open dialogue with other stakeholders on accountability.

3. Action

Access to data and dialogue between stakeholders are no ends in themselves but should determine which forms of action are necessary. Where stakeholders can agree with government that unified action is required in relation to potential funders or global agencies such action will increase the leverage of country demands. Where government accepts responsibility for poor performance in some aspect of the response it should take action to improve that performance. Where civil society actors do not accept government explanations for poor performance, or disagree with government plans to remedy poor performance, civil society stakeholders should take political action to try increase the leverage of their demands for political accountability. This MPOA Scorecard increases action around the MPOA & Accountability for women, girls and vulnerable groups, in terms of informing stakeholders that there is less need for making less new commitments but rather a gap in improving programming and performance on current commitments. It demands stronger leadership from all actors on SRHR issues and more programming and implementation of SRHR.

Using the MPOA Scorecard

The Scorecard has been developed on the previous experience of AAI in developing scorecards: the AIDS Accountability Country Scorecard and the AIDS Accountability Scorecard on Women, the Scorecard on LGBT.

The Elements

The AIDS Accountability MPOA Scorecard contains twelve elements each of which evaluates a different aspect of government response to SRHR.

These elements are:

1. Integration of HIV/STI, Malaria and SRH Services into PHC
2. Strengthening of Community based STI/HIV/AIDS and SRHR Services
3. Family Planning repositioning as key strategy for attainment of MDGs
4. Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being
5. Incidence of unsafe abortion reduced
6. Access to safe motherhood and child survival services increased
7. Resources for SRHR increased
8. SRH Commodity security strategies for all SRH components achieved
9. Monitoring, evaluation and coordination mechanism
10. Reporting*
11. Policy Environment *
12. Overall performance *

*These three elements are constructed on data from various data points, or on how much data was made available. See element section for more information.



AAI Scorecard Grades

AAI places countries in five broad 'grades', from A to E. The grade is based on the percentage reported by the country according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor). If a country has not reported on a particular element then the score will be marked as ND for No Data.

Score	Grade
81-100 %	A
61-80 %	B
41-60%	C
21-40%	D
0-20 %	E
No data submitted	ND

In order to calculate these grades one of two methods has been used in this scorecard.

Direct coverage percentage: The PAT asks governments for a percentage of coverage achieved. An example would be: What percentage of Service Delivery Points (SDPs) (health facilities) (are) offering integrated SRHR/STI/HIV/AIDS and Malaria services. Data is then completed as a percentage. Countries are then graded directly on this number.

Degree of completion: The PAT asks governments whether particular actions have been done. It offers them three possible answers: "Done", "In Progress" or Not Done". If countries have "Done" everything they were required to do, AAI gives them 1 point. If their work has been marked as "In Progress" we give them half a point. Those countries that have not begun and mark "Not Done" we give no points on that action. Where several actions are required we simply add these points and half points together and get a final score which we then turn into a percentage and a grade.

For example: The PAT asks governments to report on 6 possible actions. The Democratic Republic of Congo (DRC) has completed 2 actions (1 point each), is "In Progress" on 2 actions (half a point each), and done nothing on 2 actions (no points). Thus their score is 1+1+0.5 +0.5 = 3 out of a possible total of 6. We then reflect that as a percentage by dividing 3 by 6 = 0.50 and then by multiplying that by 100 we get 50% (C Grade)

Where percentages are available they have been included in the Scorecard. Where percentages have been arrived at through the degree of completion points system percentages are not provided.

Data limitations

The MPOA SRHR database represents the largest data set on various aspects of country responses to SRHR for Africa. The AUC does not perform a verification and validation process to remove any inaccuracies. However, although the data may not always be absolutely correct, it remains a comprehensive, accurate, and significantly complete dataset which is aligned with the MDGS and is standardized for continental M&E comparisons.

Yet, further below, this scorecard report will discuss reasons why this data does not allow for straight-forward comparison between countries or other more rigorous and detailed forms of analyses.

The first limitation of data submitted to the AUC on the MPOA is that governments submit the data directly to the AUC and there may or may not be a verification process with other stakeholders. The inclusion of civil society is an attempt to improve the accuracy as well as breadth of the data, but this is not always enacted by government in completing the report. And indeed this inclusion of civil society may not always be best for marginalized people. AAI has conducted further research on these issues and more in the reporting process and the document can be found on our website at www.aidsaccountability.org.

The second limitation of the data refers to data quality. A variety of issues exist, including but not limited to data collection methods. Capacity around data collection in Africa is not yet of the quality that we would hope. It stands to reason that inaccurate, incomplete or biased data collection methods skew the results. This affects issues such as sample size, where a small number of interviews are said to reflect the experiences of a nation. Additionally, geographic coverage where research is only conducted in urban areas but is said to reflect the national experience neglects the rural differences and needs. Robust research methodologies should also include the income, race, religion, gender and class, thereby understanding various experiences of various people. For example, sometimes 100% coverage may indicate a methodological issue in the collection of the data. Very often these high figures represent the

percentage of people who, for example, attend a Voluntary Counselling and Testing clinic and who agree to be tested and receive their results rather than the real denominator which is supposed to be Number of most-at-risk population included in the sample of a Bio-Behavioural surveillance survey. Due to these, and other, limitations in data quality these statistics should be understood to be a snapshot of a country's situation and not a full-length documentary.

A third and important component of data reporting is that some countries are not able to provide data on all the indicators. This is usually for one of two reasons: the data point is deemed irrelevant (usually on the basis that the group is too small or not recognized, e.g. Lesbian, gay, bisexual and transgender people (LGBT)) or that the cost-benefit of collecting and collating data on that indicator is not justifiable. Bio-behavioural surveys are expensive and time-consuming and may not be the most appropriate use of limited government budgets in countries that are trying to roll out other health programs.

A further limitation of the data is that the AAI MPOA Scorecard methodology reflects a measure of government performance based on one indicator in one reporting process. For this reason a country may receive a top score (A) on a particular indicator yet activists may claim that this does not reflect the experience in the field. In providing national and global advocacy groups and other stakeholders with the scorecard analysis they are able to determine as experts in their field whether government decisions were well-based or indeed a sign of a lack of accountability.

Countries not included

Five countries are not included in this analysis, for various reasons:

1. Angola: Report submitted only dealt with issues as related to people with disabilities and as such is not comparable to other countries.
2. Mozambique: No report submitted to the knowledge of the AAI team.
3. Seychelles: No report submitted to the knowledge of the AAI team.
4. Swaziland: No report submitted to the knowledge of the AAI team.
5. Zimbabwe: The copy of the report that was made available to the AAI is illegible, and in order to avoid guess work a decision was taken to eliminate the report from this scorecard analysis.

Element 1: Integration of HIV and STIs, Malaria and SRH Services into PHC

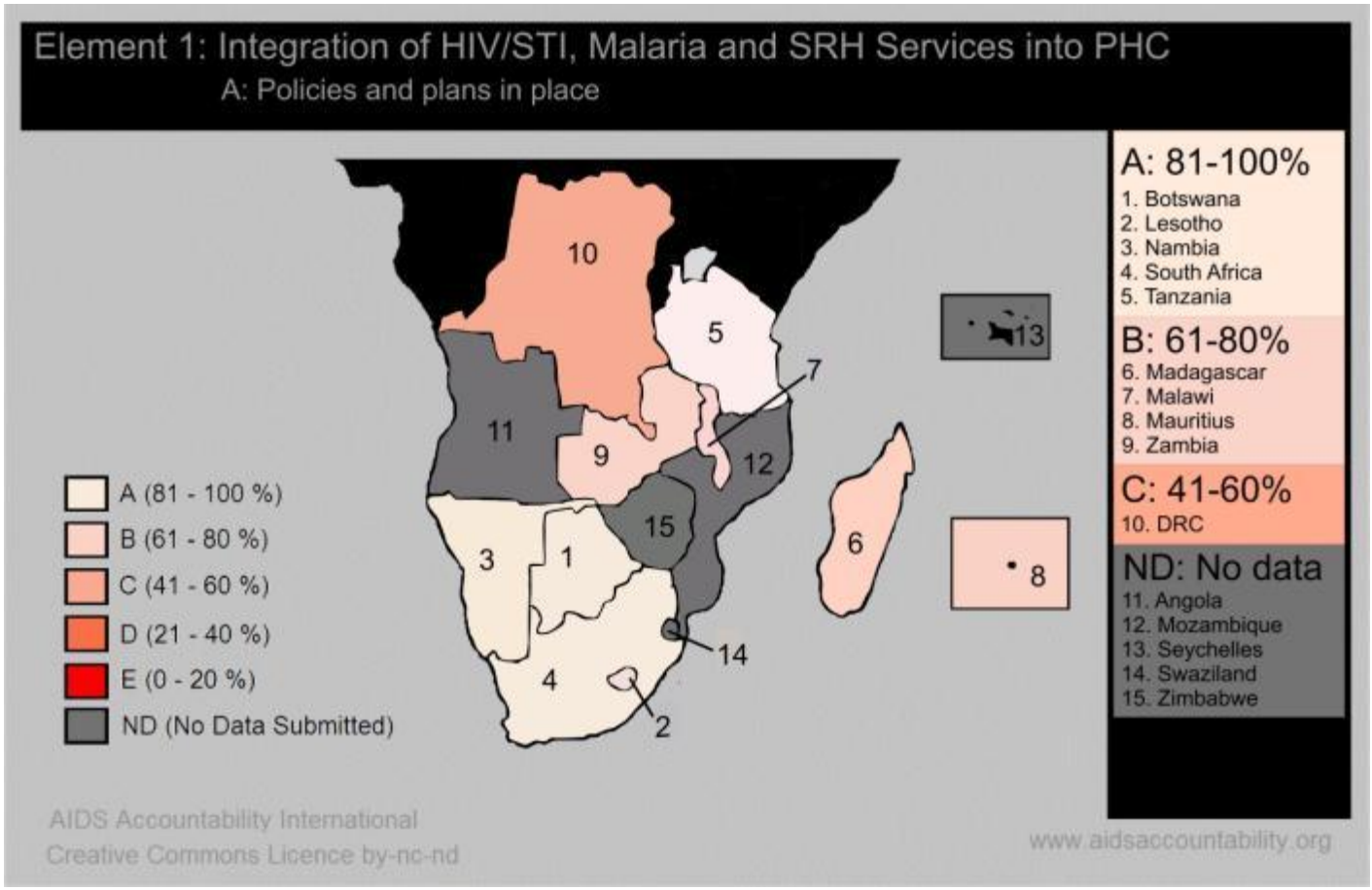
This element looks at the Integration of HIV/Sexually Transmitted Infections (STI), Malaria and Sexual and Reproductive Health (SRH) Services into Primary Health Care (PHC).

The PAT asks whether the following Actions have been "Done", are "In Progress" or Not Done":

1. Integrated SRHR/STI/HIV/AIDS and Malaria policy documents and / or national plans.
2. Multi-sectoral plans supporting SRHR.
3. Laws /legal instruments dealing with Gender Based Violence (GBV) in place.
4. Strategies dealing with GBV developed and implemented.
5. Policies and programmes that address harmful traditional practices.
6. Training institutions integrating STI/HIV/AIDS, nutrition with SRHR in their curricula.

Countries in the A category all achieved a 91.7% completion rate. All countries have completed Action 3 dealing with laws and legal instruments dealing with GBV. All countries, apart the DRC which is "In Progress", have completed Action 1 (integrating SRHR/STI/HIV/AIDS and Malaria policy documents and / or national plans). Difficulties exist in completing Actions 4 and 5 (GBV strategies developed and implemented and addressing harmful traditional practices) with only 3 and 4 countries respectively having completed this work.[iv] Only 4 of the 10 countries have completed integrating SRHR/STI/HIV/AIDS and Malaria services into PHC. Zambia is behind at 64%. DRC, Madagascar ad Mauritius gave different figures for SRHR/STI/HIV/AIDs and Malaria. Lesotho and Tanzania could not provide data and thus reflect the fact that they do not know how far integration has developed.

What is most important to identify is that countries are at various stages of the processes and that some countries are reporting better progress than others. Most importantly is the difference between having policies and plans in place and the actual implementation. It wold seem that most countries have managed to do the former but are still struggling to complete the latter. This is a common issue, and will become apparent throughout the MPOA Scorecard as a barrier to progress and thus meeting desired goals. What is also apparent is the greater lack of data on implementation, and the need for more monitoring to be done on actual service integration at primary health care level.


Element 1: Integration of HIV/STI, Malaria and SRH Services into PHC
A: Policies and plans in place
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
A: 81-100%
1. Botswana
2. Lesotho
3. Nambia
4. South Africa
5. Tanzania
B: 61-80%
6. Madagascar
7. Malawi
8. Mauritius
9. Zambia
C: 41-60%
10. DRC
ND: No data
11. Angola
12. Mozambique
13. Seychelles
14. Swaziland
15. Zimbabwe
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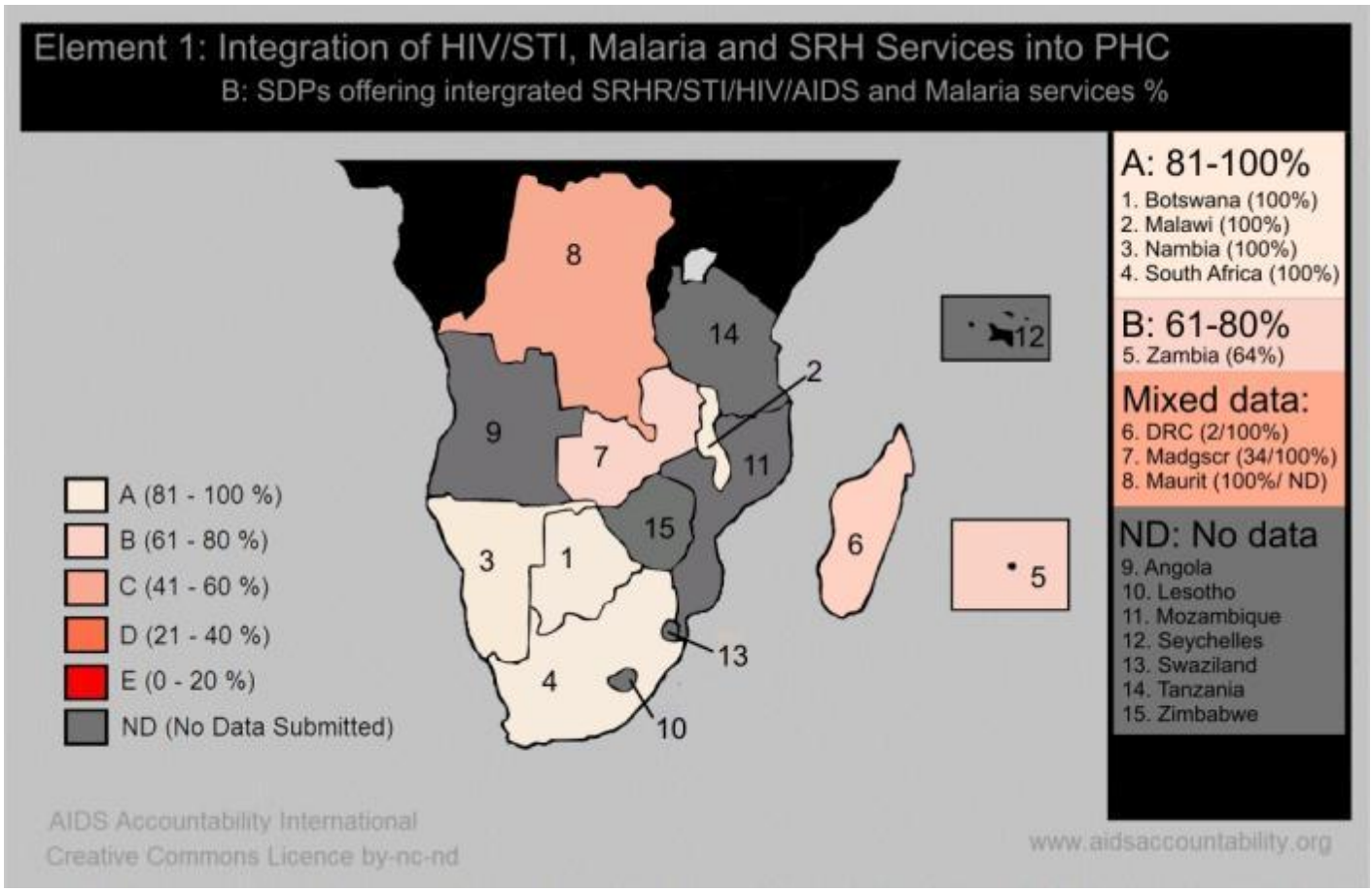
Element 1: Integration of HIV/STI, Malaria and SRH Services into PHC
B: SDPs offering intergrated SRHR/STI/HIV/AIDS and Malaria services %
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
A: 81-100%
1. Botswana (100%)
2. Malawi (100%)
3. Nambia (100%)
4. South Africa (100%)
B: 61-80%
5. Zambia (64%)
Mixed data:
6. DRC (2/100%)
7. Madgscr (34/100%)
8. Maurit (100%/ ND)
ND: No data
9. Angola
10. Lesotho
11. Mozambique
12. Seychelles
13. Swaziland
14. Tanzania
15. Zimbabwe
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Element 2: Strengthening of Community based STI/HIV/AIDS and SRHR Services

Community based health services are regarded are paramount in rolling out universal access to SRHR. Pathfinder International in their report *Improving Reproductive Health through Community-Based Services: 25 Years of Pathfinder International Experience*, states:

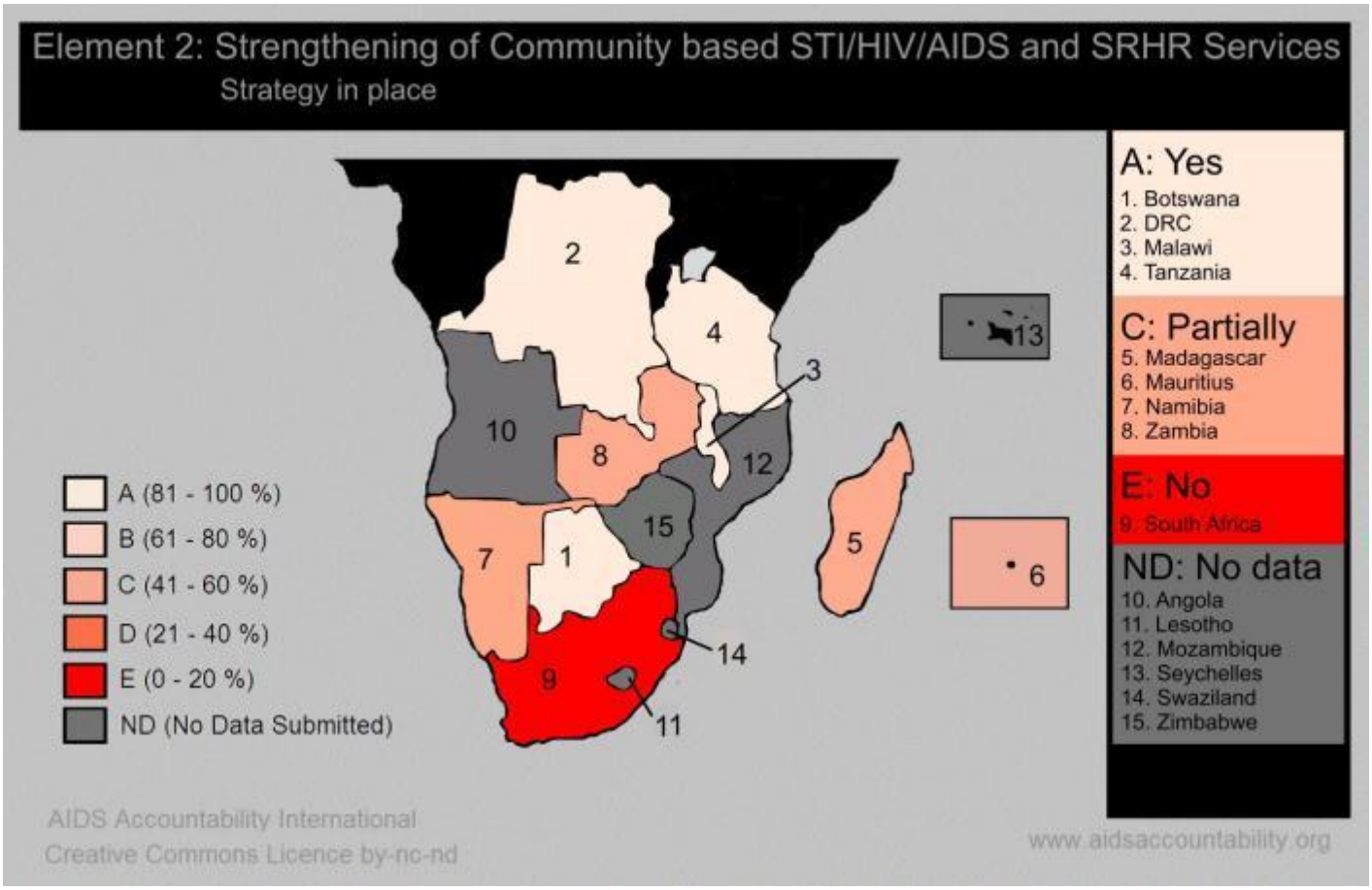
The support of local leaders and the community as a whole is important for ensuring access and sustainability, and stimulating substantial changes in community behavior. Building the capacity of communities and creating local partnerships is crucial to success. Moreover, community health workers (CHWs) improve "access, knowledge, and cultural acceptance of reproductive health" […] They serve as an important link between the community and health facilities by providing referrals and helping clients follow through with their prescribed care. Because CHWs hold the esteem of their peers, they are effective in promoting change and challenging stigma surrounding HIV/AIDS, harmful traditional practices, and prejudices against family planning. They are motivated by a sense of duty to care for others around them…"[v]

However, what is also obvious is that for community based services to have any effect is for the programming to go beyond policy and be fully implemented. However, the PAT only asks if the strategy is in place and for a reason for the success or failure of this. No question examines whether anything is being done to support the implementation and greater effectiveness of community based services. This is unlike many of the various other indicators, as it does not monitor implementation but only policy. This is in the opinion of the author problematic, especially as this report identifies policy being in place as less of a barrier to SRHR, but rather a lack of implementation posing a problem.

South Africa reports that the "package guiding the Primary Health Services is not inclusive of the community based SRHR" whereas various other countries report on the existence or development of various guidelines but no real and focussed strategy on community based services, but rather a conglomeration of policies and guidelines. Considering the importance of community health workers and their role in primary health care and universal access, this element needs greater focus from advocacy campaigns, both within governments and from civil society and funding partners.

Mauritius acts as a good example of how a country which was under-developed at independence in 1968, but which now is considered an upper middle income country, improving socio-economic conditions in huge strides in every year. Maternal mortality, infant mortality have decreased, communicable diseases are managed effectively, and life expectancy have all increased. In recent years Mauritius has reinforced its healthcare system by improving infrastructure in primary health care facilities, including the roll out of usually ignored health issues such as diabetes mellitus and mental health care to primary health care facilities. These improvements extend to better quality and more health care worker training institutions being created, and highly accountable budget lines being allocated for programmed activities.[vi]

Malawi too is quickly reinforcing the use of what are called Health Surveillance Assistants (HSA), in 2012 the Ministry of Health promoting the role and importance of HSAs in being "frontline health workers at the community level"[vii] working with Village Health Committees (VHCs), which looks health needs at both individual village need as well at the needs of a collection of villages in an area. HSAs are provided with 12 weeks of training, bicycles and drug kits and are employed by the Ministry of Health.[viii] Other elements in the MPOA Scorecard also underline the importance of community based health services.



Element 3: Family Planning repositioning as key strategy for attainment of MDGs

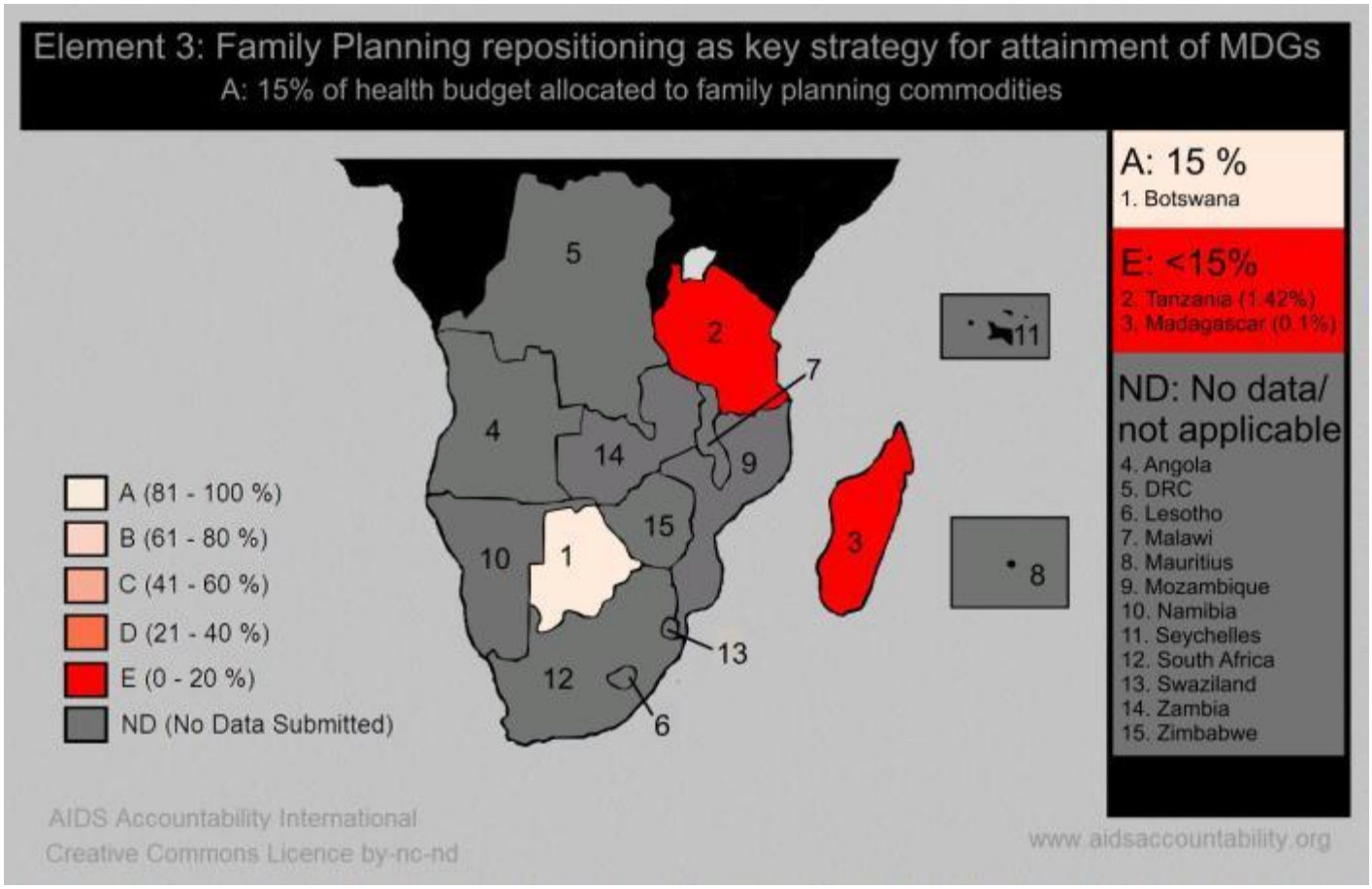
Allocating sufficient resources to family planning commodities is seen as a means to measure government's desire to reposition family planning. Leaders committed to allocating 15% of the health budget to family planning commodities as a means of attaining the relevant MDGs as well. Only one country has reported that they achieved this commitment.

In the AUC Report, *MPOA Progress Review*, it is reported that: "Only 16 (37.2%) countries reported on the proportion of their health budget that is allocated to family planning commodities. Among these, four (25%) said they do not specifically budget for family planning, as support to this area is derived from the global health budget. Seven (43.8%) countries indicated that they allocate 1–5% of the health budget to family planning commodities, while four (25.2%) others allocate 10–15%. Only one (6.3%) country reserves 16% of its budget to family planning (indicator 9)."[ix]

Thus it is clear that this area needs considerable advocacy efforts in order to improve the response from governments, not only in the SADC region but across the continent. Moreover the AUC Reports states that, "Many countries have supportive FP protocols and guidelines, but need to implement them more effectively and to reach all communities in need. […]Policies and strategies have been articulated and adopted in most countries, but their effective operation is still a problem".[x]

This is obvious when one analyses the second image below. Nine countries achieved an A with regard to whether Supportive protocols and guidelines are in place, yet only one, Botswana, has actually implemented this policy in reality. This area needs to be carefully monitored by civil society in their advocacy work.

Several countries report unmet family planning needs as challenges, as well as stock outs, increase in backstreet abortions, as well as scarcity of adequately trained health care workers as barriers in this section. Countries report community education as a means to improve demand for family planning commodities, but that better planning, more budget allocation and better supply chain management are vital to rolling out universal access to quality family planning in the region.


Element 3: Family Planning repositioning as key strategy for attainment of MDGs
A: 15% of health budget allocated to family planning commodities
A: 15 %
1. Botswana
E: <15%
2. Tanzania (1.42%)
3. Madagascar (0.1%)
ND: No data/ not applicable
4. Angola
5. DRC
6. Lesotho
7. Malawi
8. Mauritius
9. Mozambique
10. Namibia
11. Seychelles
12. South Africa
13. Swaziland
14. Zambia
15. Zimbabwe
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
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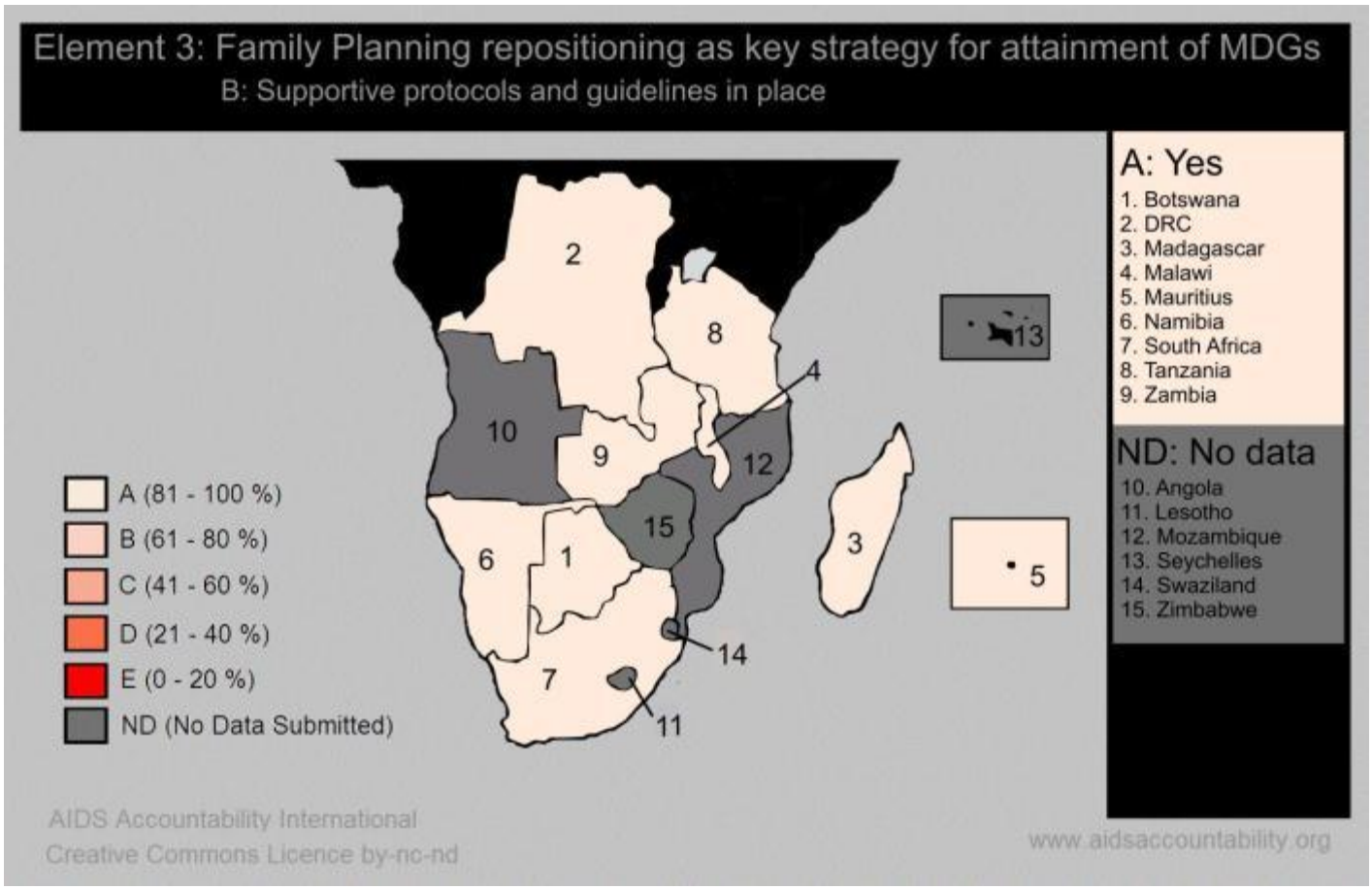
Element 3: Family Planning repositioning as key strategy for attainment of MDGs
B: Supportive protocols and guidelines in place
A: Yes
1. Botswana
2. DRC
3. Madagascar
4. Malawi
5. Mauritius
6. Namibia
7. South Africa
8. Tanzania
9. Zambia
ND: No data
10. Angola
11. Lesotho
12. Mozambique
13. Seychelles
14. Swaziland
15. Zimbabwe
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
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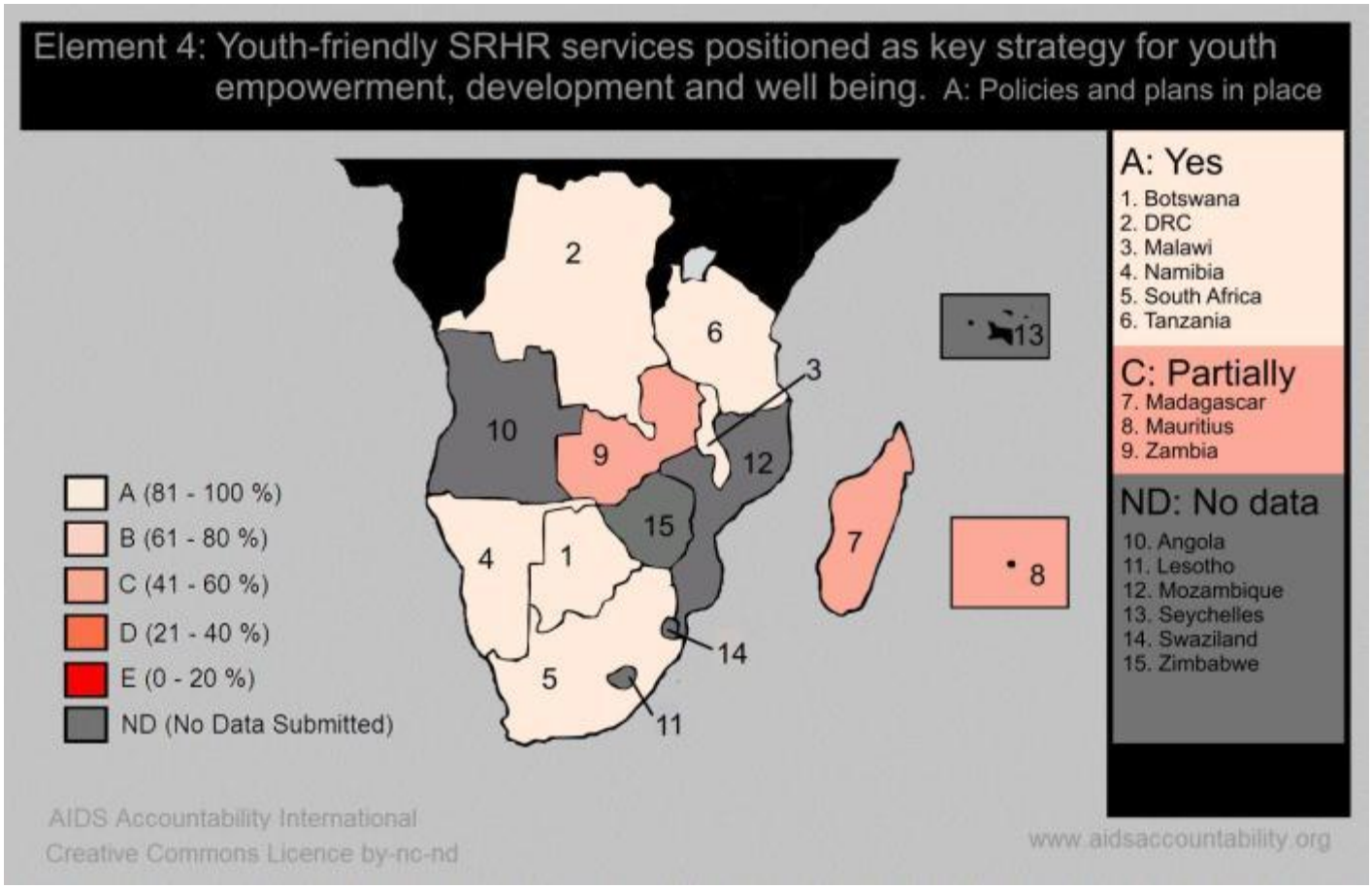
Element 4: Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being

Youth are quite obviously a key population for SRHR services and thus this indicator is an excellent measure of what the future will hold for adults in the region with regard to SRHR. The youth bulge, which sees a proportionately large percentage of the population in the youth bracket is a phenomenon around which there has been significant debate.

The youth bulge is a common phenomenon in many developing countries, and in particular, in the least developed countries. It is often due to a stage of development where a country achieves success in reducing infant mortality but mothers still have a high fertility rate. The result is that a large share of the population is comprised of children and young adults, and today's children are tomorrow's young adults.[xi] This analysis suggests that as governments begin to achieve the MDGs and reduce infant mortality an additional (some say unforeseen) circumstance was the large youth proportion of a country's population. Although this may create exaggerated needs on an under developed health system, some suggest that this is a "window of opportunity" in which countries can respond by working with youth as part of the solution rather than a source of the problem.

The MPOA data shows that countries once again have policies and plans in place but that yet again it has yet to reach the community level. Various countries recognise that cultural and religious beliefs act as barriers to both youth uptake as well as health care workers sensitively and in some cases legally allowing youth access to their SRH rights. Common recommendations from country reports are more budget allocation to training of health care workers, as well as national alignment in programming with regional and national commitments to offering these services to youth. Another common problem is in accessing out of school youth to not only educate them on safe sex, but access to family planning, abortion, post abortion care and other services. In an era of social media and in areas where private enterprises are able to reach these youth, public private partnerships offer possible opportunities to improving the situation. What is also obvious is that health care for youth is necessary not only from a human rights or epidemiological perspective but from a socio-economic development as well as security perspective and needs to be urgently addressed.


Element 4: Youth-friendly SRHR services positioned as key strategy for youth empowerment, development and well being. A: Policies and plans in place
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
A: Yes
1. Botswana
2. DRC
3. Malawi
4. Namibia
5. South Africa
6. Tanzania
C: Partially
7. Madagascar
8. Mauritius
9. Zambia
ND: No data
10. Angola
11. Lesotho
12. Mozambique
13. Seychelles
14. Swaziland
15. Zimbabwe
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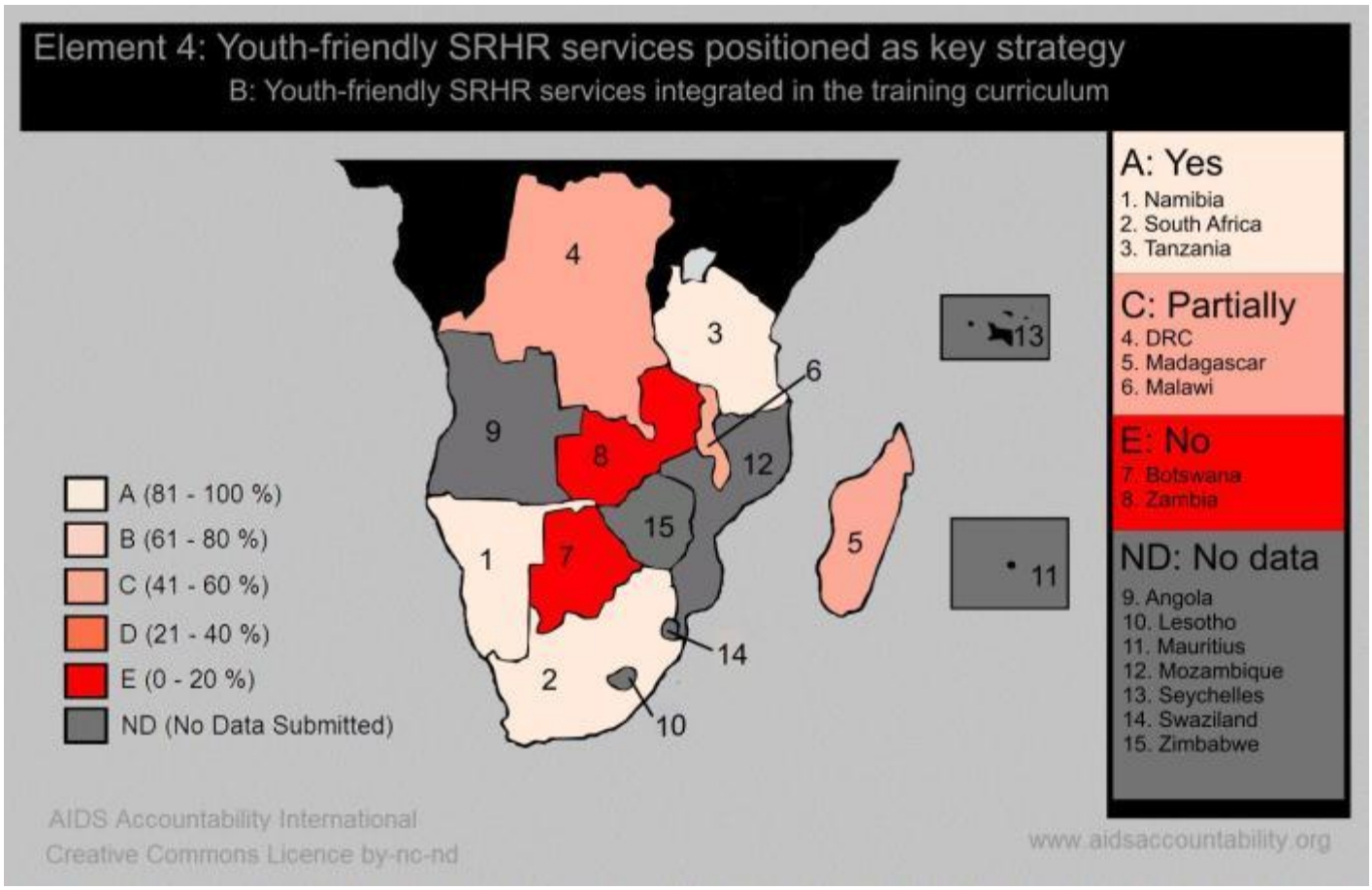
Element 4: Youth-friendly SRHR services positioned as key strategy
B: Youth-friendly SRHR services integrated in the training curriculum
A (81 - 100 %)
B (61 - 80 %)
C (41 - 60 %)
D (21 - 40 %)
E (0 - 20 %)
ND (No Data Submitted)
A: Yes
1. Namibia
2. South Africa
3. Tanzania
C: Partially
4. DRC
5. Madagascar
6. Malawi
E: No
7. Botswana
8. Zambia
ND: No data
9. Angola
10. Lesotho
11. Mauritius
12. Mozambique
13. Seychelles
14. Swaziland
15. Zimbabwe
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Element 5: Incidence of unsafe abortion reduced

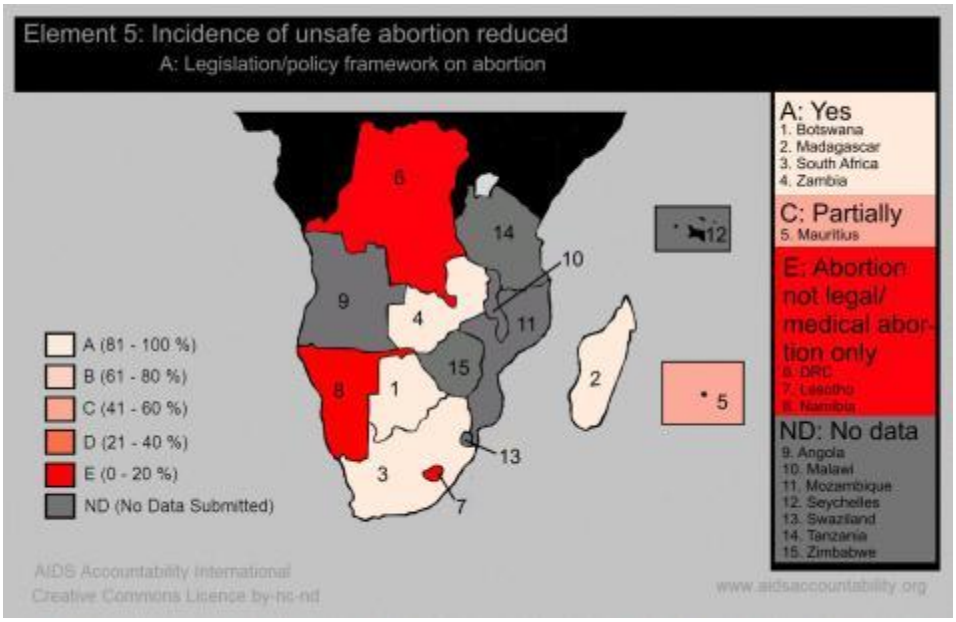
What is universally understood to be true is that countries in which abortion is restricted or illegal spend significant amounts of money on treating post-abortion complications. In a laudable move the government of Zimbabwe in August 2012, issued a new policy that health care workers no longer have to report women seeking post-abortion care to the police. The obvious impact of this is that in the bid to lower maternal mortality the Zimbabwean government will make access to post abortion health care easier for all women and the men supporting them.

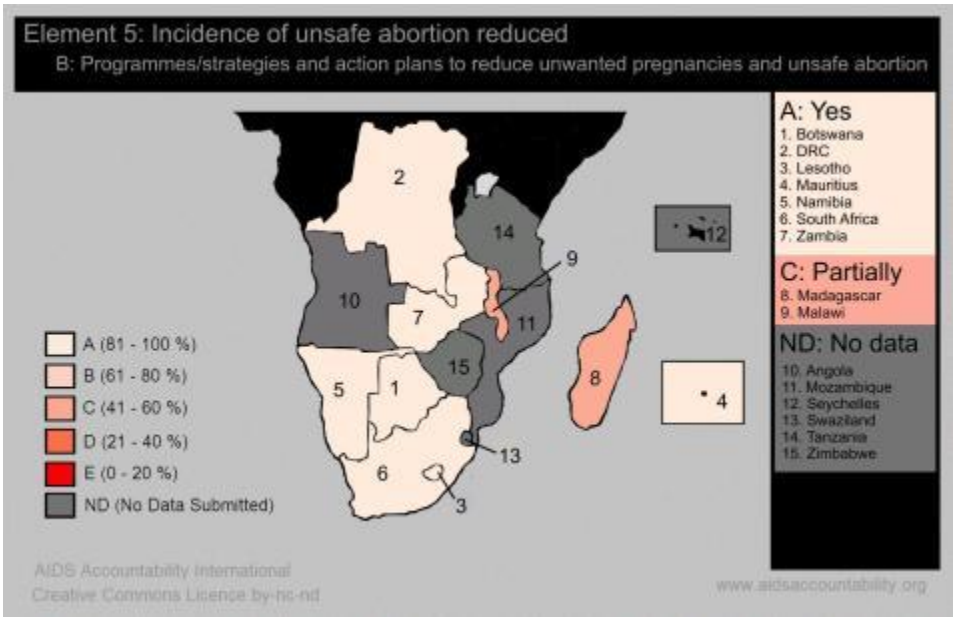
In Malawi, where a government and IPAS report found that 70 000 women sought abortions in 2009 alone, it is estimated that 17% of maternal mortalities are related to unsafe abortions. In the 2012 preliminary report on 'Health System Costs of Providing Post Abortion Care in Malawi', estimates show that basic post-abortion care costs around $45, which is a significant cost to state. The report states, "Public health facilities in Malawi that provide post-abortion care spend approximately $1.06 million annually to treat women with complications of unsafe abortion". It continues: "If safe abortion services were made available to women, approximately $435,000 would become available in public health care facilities each year to divert to other health care needs."[xii]

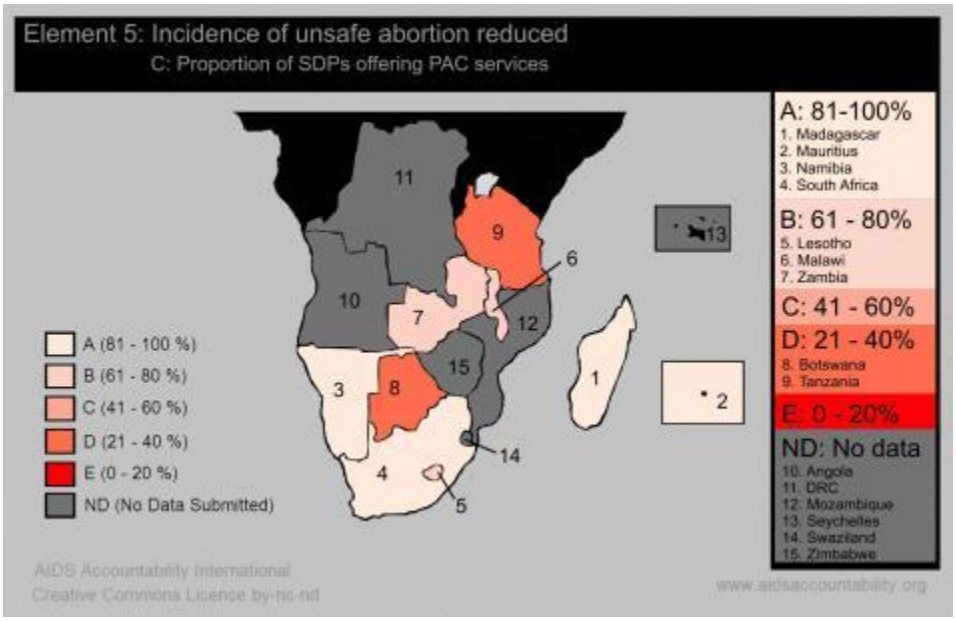
What is apparent from the MPOA data section on challenges and recommendations is that cultural and religious beliefs hinder progress towards providing access to legalizing abortion for all women, including teenagers and young girls, however all countries are facing illegal abortions and an increase in baby abandonment, often termed "baby dumping" by media. (noted in the Namibian report) demonstrating that the population faced with unwanted pregnancies are so desperate as to commit a crime in order to avoid unwanted pregnancies and parenthood. Governments need to show accountability to the women most affected by these circumstances and protect them both by meeting unmet needs for family planning but in addition de-criminalizing abortions and offering quality abortion in quality health care facilities. Access to emergency contraception as well as extensive campaigning around sexual and reproductive rights is essential to both women and men as they make decisions around intercourse and parenthood.

Indeed what the MPOA Scorecard shows is that countries have gone to great lengths to put programmes and policies in place to reduce unwanted pregnancies and unsafe abortion, yet abortions remain illegal or limited to only legal or medical abortions (only performed if there is a risk to the mother's mental or physical health) in too many countries.

South Africa offers an example of a country in which abortion is legal, and PAC services are offered and yet maternal deaths, illegal abortions and baby abandonment continue. This must demonstrate a need for targeted campaigns at the public to educate them, as well as to ensure that non-judgemental services are being provided. Training of HCWs and the public on timely referral and timely management are key in this circumstance.







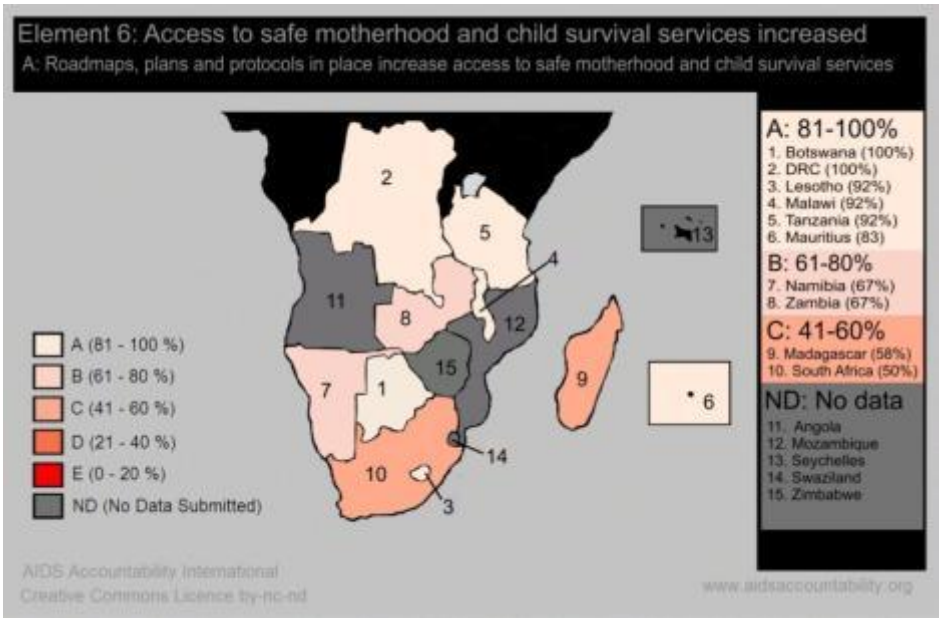
Element 6: Access to safe motherhood and child survival services increased

In 2011 at the UN High Level Meeting on AIDS, globally leaders committed to the *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive.* This plan demonstrates that no technical barriers stand in the way of giving babies and mothers a chance at surviving. PMTCT or Prevention of mother to child transmission stands at between 15-45 per cent without interventions, but can be reduced to less than 5 per cent with timely management and access to ARVs. The very possibility of a Born HIV generation is around the corner and by 2015 the target is achievable with enormous financial support being offered by funding partners, accountable leadership from governments, and support and advocacy from civil society.

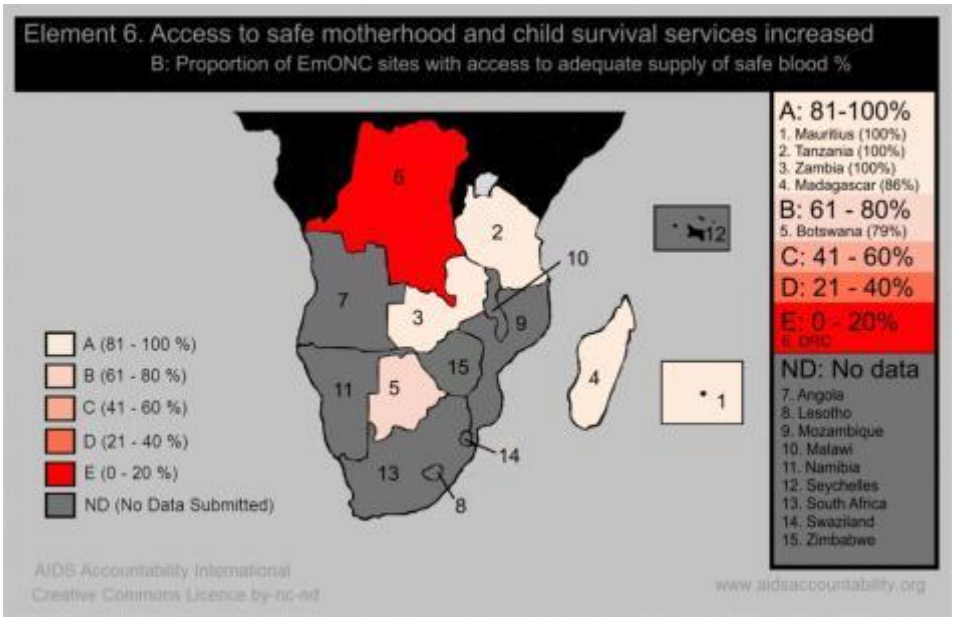
However, for all the facts and science showing the possibilities of the elimination of PMTCT, real access to PMTCT remains elusive in many countries, most obviously of which in the MPOA Scorecard is the Democratic Republic of Congo. In a country which reports 68 million people, 1,2 million of which are estimated to be living with HIV, the percentage of HIV positive mothers who have delivered and are receiving ARVs sits at a shocking 2 per cent. Other countries too report low numbers but none as low as the DRC. Since reporting on the first round of the MPOA a few of these countries have reported improved figures, such as South Africa which now claims fewer than 4 per cent.[xiii]

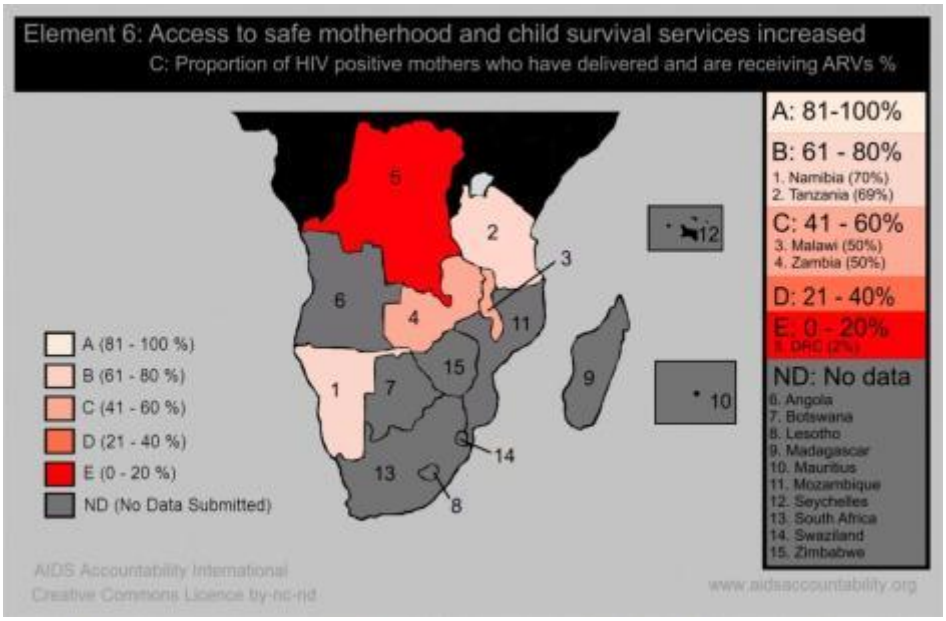
The EMTCT Plan was developed by representatives of more than 30 countries and the 22 countries with the highest burden of HIV have all signed onto implementing the plan as well as been part of its development. Corporate, bi-lateral as well as multi-lateral funding has been dedicated to EMTCT and the 2015 targets, yet issues of timely access to pre-natal care and HIV testing, stock-outs of HIV testing kits, as well as follow up of both mother and baby post-partum remain barriers, especially in those countries with vast geographical areas and low population numbers such as Namibia. If HCWs are able to spend sufficient time with mothers that present at clinics and compete full health checks, including HIV testing, as well as diagnose high blood pressure problems many of the factors increasing maternal mortality could be cheaply addressed. Of course, remaining barriers include patient adherence, whether it be to ARV treatment, or blood pressure medication. However, community based programmes such as Community Antiretroviral-Therapy Groups, or CAGs, (groups of patients who meet to talk about

their health issues and other aspects of their lives, offering moral and mental support as well as taking turns to collect medicine for the group) are becoming useful tools which improve adherence and can be applied to other issues facing mothers and their babies.



What is interesting however is the number of countries that do not report any data on the proportion of Emergency Obstetric and New-born Care (EmONC) sites with access to adequate supply of safe blood. With sepsis and haemorrhaging (blood loss) featuring as direct yet avoidable causes of maternal mortality, yet reasonably cheap and simple to diagnose and treat, governments need to urgently address hygiene, correct diagnosis and management, as well as access to cheap effective medications.





Element 7: Resources for SRHR increased

When countries commit to allocating budget to particular development areas it shows the decision to "put their money where their mouth is" and allocating resources, especially financial, is a huge step towards going beyond policy and programming, towards implementation and thus real impact on the public access to health. Thus in promising to allocate 15 per cent of national budget to health, the SADC countries reinforced their commitment to health development. However, sadly in the MPOA Scorecard only Botswana has demonstrated the actual follow through on the promise.

The data is however limited in this section as several countries reported figures reaching 15 per cent: Malawi (12 per cent), Mauritius (8 per cent), Namibia (12 per cent), Tanzania (10 per cent), Zambia (11,55 per cent), whilst South Africa reported No, 15 per cent was not allocated yet South Africa's health budget forms 12,2 % of the national budget. This serves of an example where the data provided by the report is incomplete, inaccurate or not useful. What should be remembered too is that in the South African example for instance, that health forms 121 billion South African Rand of the trillion rand budget, but that 51.2 billion Rand was still allocated to the defence budget, signalling a space for budget allocation to still be reviewed with regard to health needs in the country. This data should therefore be used as a guideline only, and reviewed in coordination with local budget experts as a means to better understand budget monitoring and development.

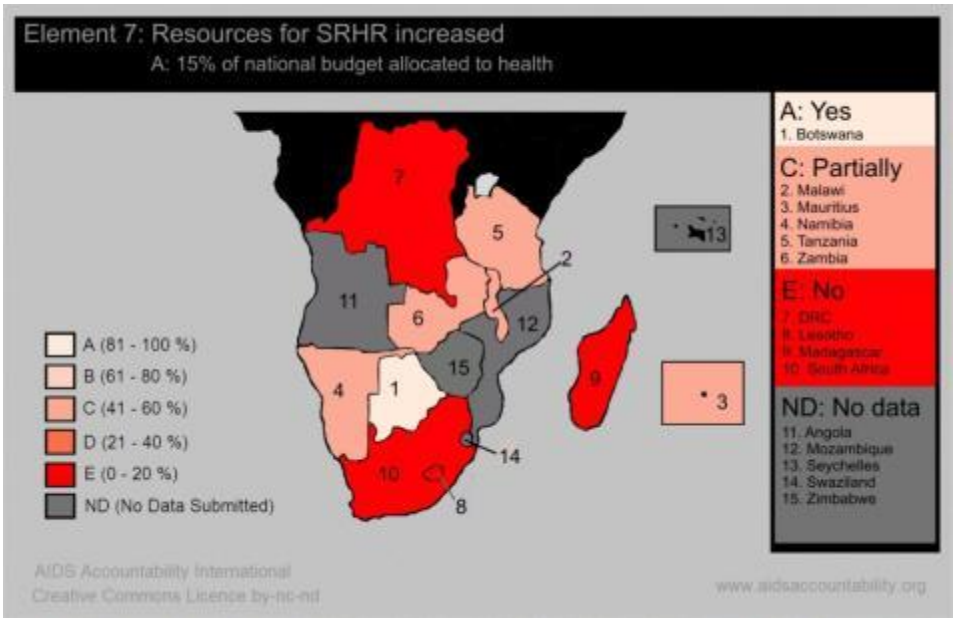
In the second map we see that once again our governments have put policy and planning in place. This trend can be seen throughout the MPOA Scorecard and is once again demonstrated in this section on resources for SRHR. Because putting policy in lace can be viewed as the first step this may be promising yet the implementation data consistently proves otherwise.

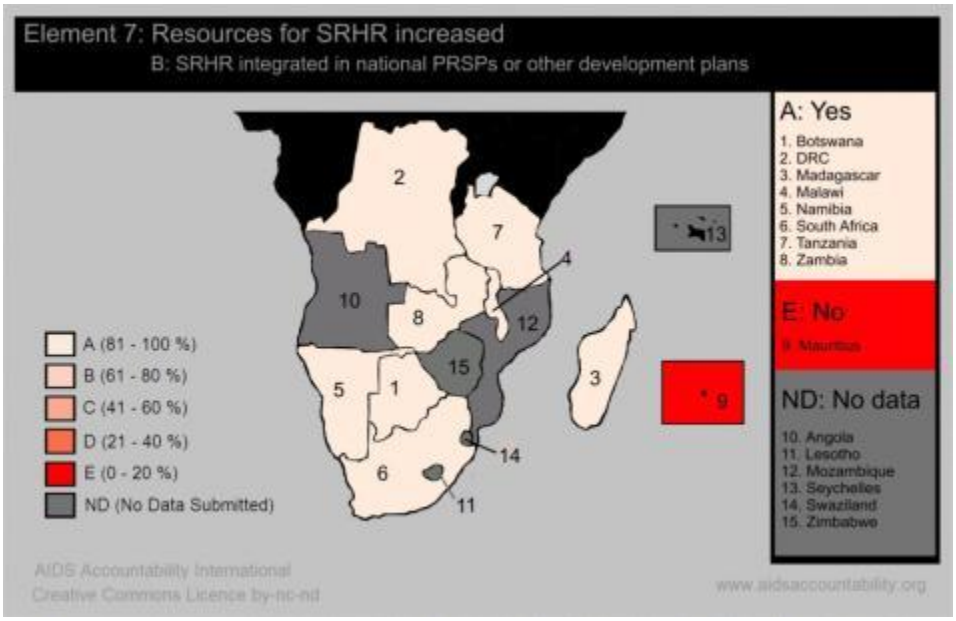
With regard to midwives per population, it is necessary, in order to fully understand the data in this section, to compare the numbers with other non-SADC countries. Number of midwives per 10 000 in Norway is the highest in the world at 319. Next is Finland with 240. The figures in the MPOA Scorecard however, when compared to the global average of 28, are remarkably low. Mauritius, Namibia and Tanzania reported 2, 14 and 4 respectively. The rest of the countries did not report at all. So as to measure performance on this element, we can use the 2004 Joint Learning Initiative report, Human Resources for Health, which used three categories to identify

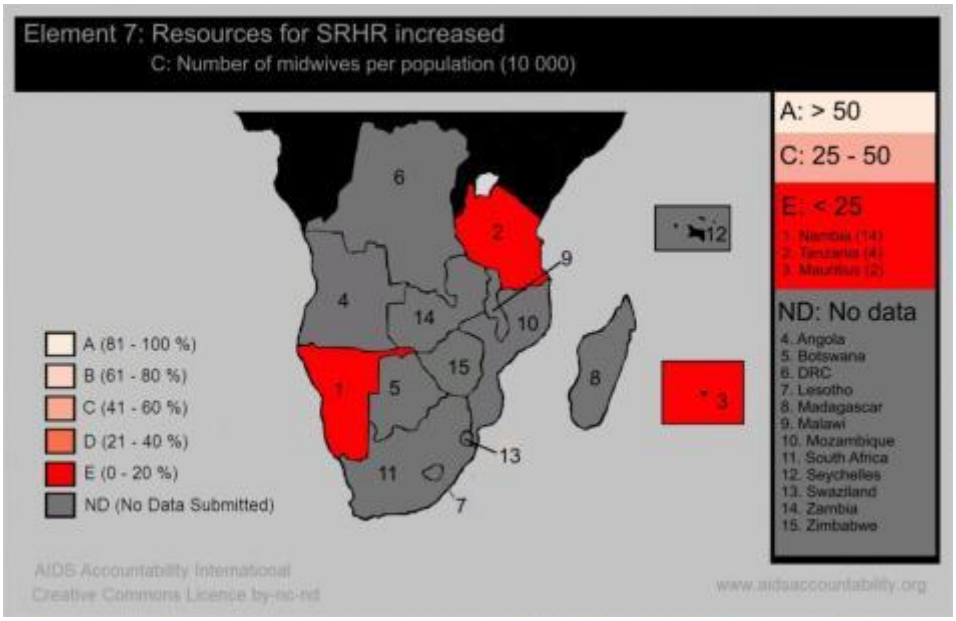
low, medium and high density of health workers in health settings as a means to accurately engaging with such forms of data.

The report classifies the number of midwives as follows: less than 25, 25-50 and 50 or more health workers respectively per 10 000 population, as low, medium and high density clusters. [xiv] This shows all countries to be in the low cluster.

Attrition of health care workers is an enormous problem in the continent and innovative plans that put the cost at the doors of developing countries which employ African HCWs abroad are being developed. Plans to bring retired midwives back into the system and train larger numbers of new ones should also be urgently put in place, as they form the backbone of SRHR services.

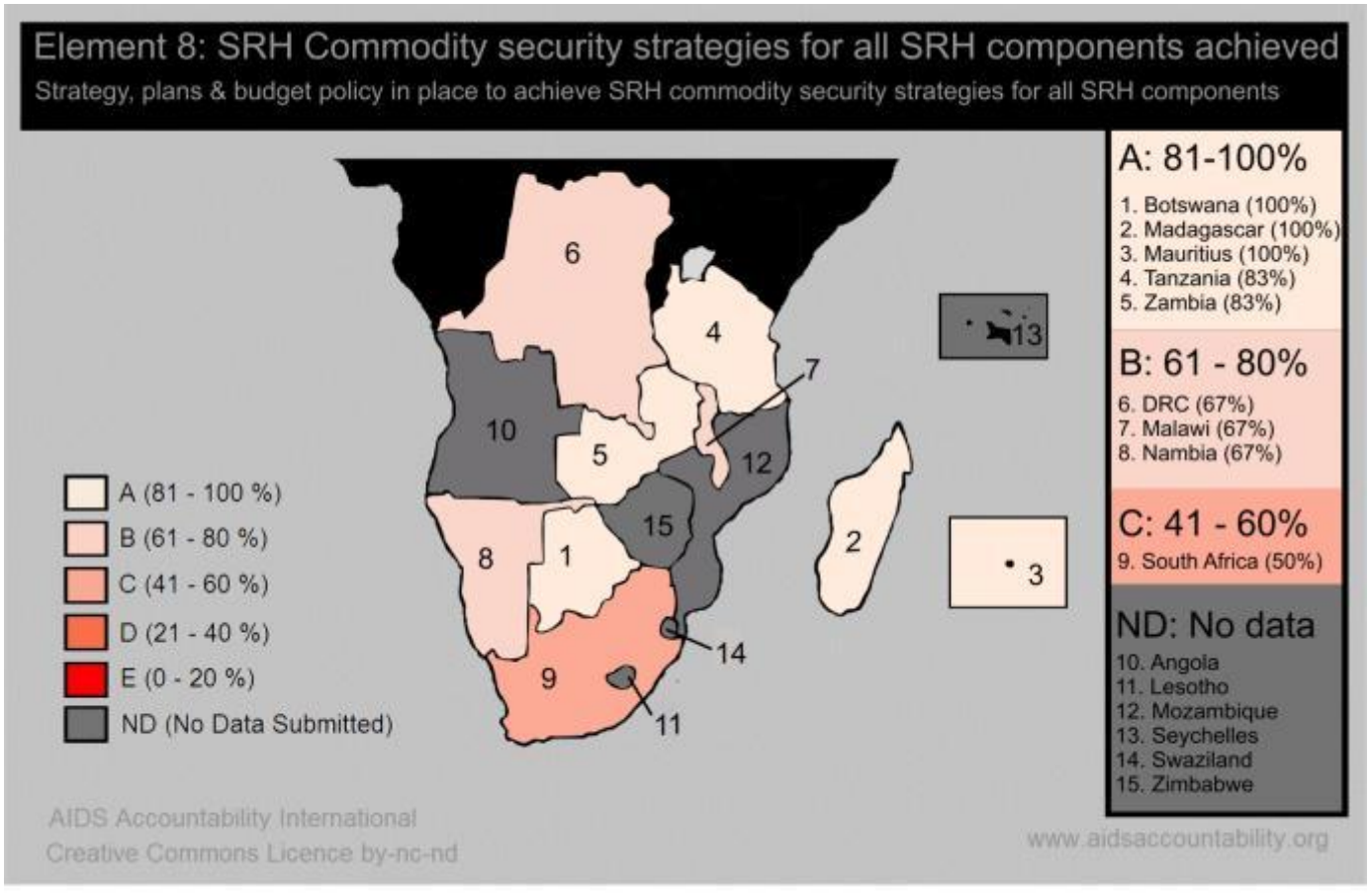






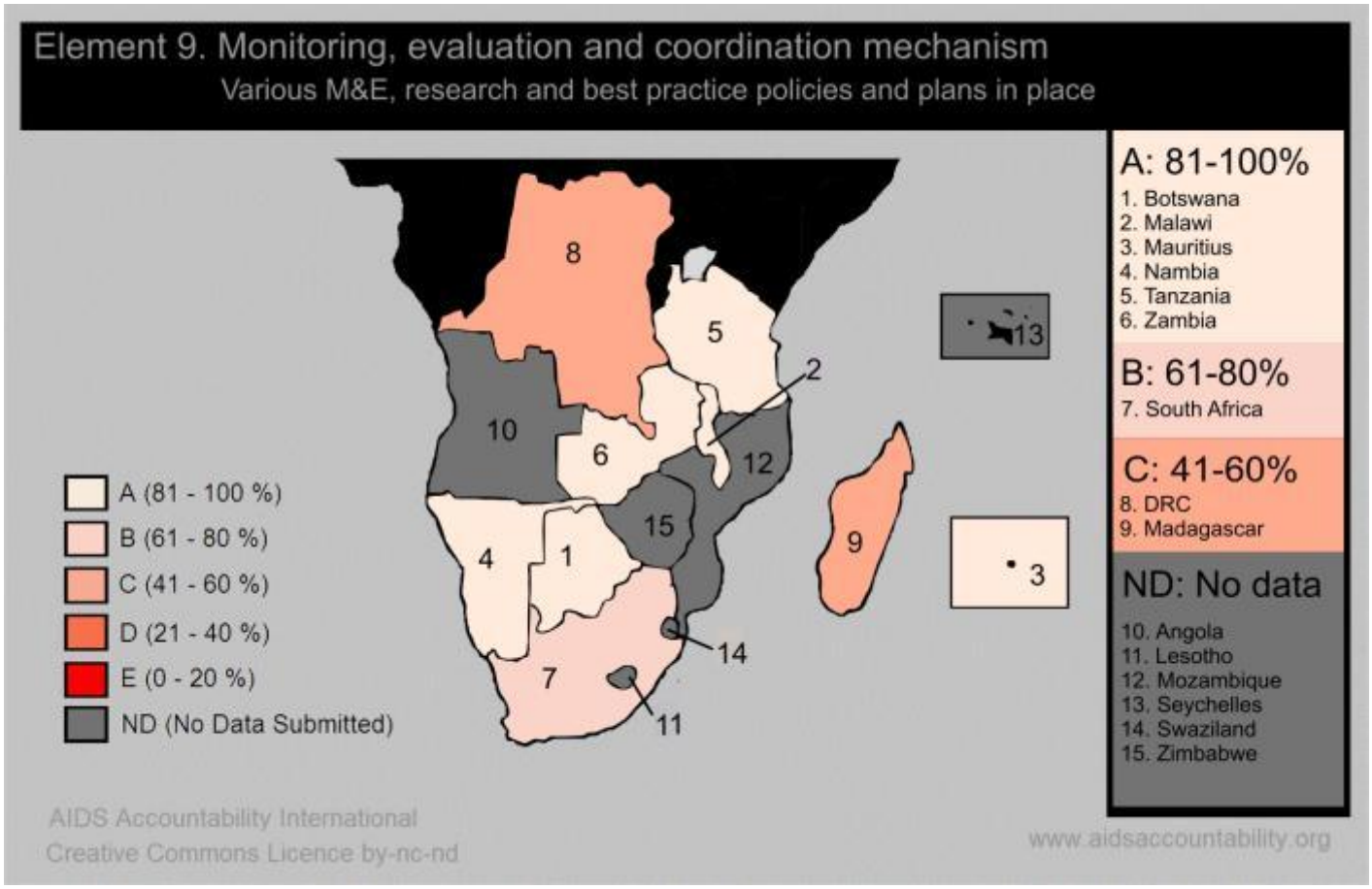
Element 8: SRH Commodity security strategies for all SRH components achieved

Element 8 assesses whether governments have prioritised SRH commodities security. Most countries have managed to put policies and plans in place and demonstrated accountability in this aspect of SRH response. However, when reviewing the remaining data of Element 8, when assessing SRH commodity stock outs the picture appears rather different. Botswana, Malawi, South Africa, Tanzania and Zambia all report experiencing stock outs of commodities in this section of the PAT. Only Namibia reports that stock outs are never a problem, whilst other countries do not report or advise that this question is “not applicable” to their country, a circumstance which needs further investigation as stock outs can be understood to be applicable to every country, as either occurring or not, and thus transparency should be demonstrated when completing this indicator. Private-public partnerships need to be further utilised in this area. As often discussed it is the Coke versus condom debate, where beverage companies are able to deliver beers or soft drinks to the most rural areas on a regular basis yet government cannot ensure SRH commodities to the same locations. The public sector needs to draw on the experience, knowledge and existing infrastructure that corporates already have.



Element 9: Monitoring, evaluation and coordination mechanism

This section evaluates governments' response in terms of monitoring and evaluating the work being done on SRHR, and demonstrates a willingness to "know the demand, know the response" yet much remains to be done. Unfortunately in an environment where civil society duplicates efforts by government, develops their own M&E tools and often does not fully coordinate with government in terms of supporting and delivering in the areas where work is most needed, M&E is left on the side-lines, or CSOs develop their own way of monitoring rather than sharing their knowledge with government and perhaps offering training to government staff here necessary. Challenges and recommendations in this section point largely to a lack of capacity amongst government staff which can be readily supported by civil society in a bid to bolster and develop the skills held in health ministries. The value of quality data collection, in a timely, consistent manner needs to be understood by all stakeholders and the role it plays in determining what actions need to be taken, needs to be constantly reinforced so that funding partners, as well as civil society play a bigger role in this area.



Element 10: Reporting

Of the 53 countries on the African continent at the time of the first round of the MPOA reporting, 33 submitted reports, demonstrating a 60 per cent response rate. This is a good result for the first round considering that in other reporting tools such as UNGASS, the first rounds solicited much lower response rates. It does however leave space for improvement and does not speak to the quality of the reporting itself.

In the SADC region, which the MPOA Scorecard focusses on, 12 of the 15 countries submitted reports. Swaziland, Seychelles and Mozambique did not submit a report to the knowledge of the AAI.

The report submitted by Angola only dealt with issues as related to people with disabilities and as such is not comparable to other countries. The Zimbabwean report has not been included in this analysis because the copy of the report that was made available to the AAI is illegible, and in order to avoid guess work a decision was taken to eliminate the report from this scorecard analysis.

Madagascar has the most compete report with 85 per cent of the possible total of 61 numerical indicators having data competed in the submitted report, whilst Lesotho was at the lowest completion rate at 59 per cent. The average overall for SADC was 83 per cent, also a commendable figure considering it was the first round and very little capacity support was able to be offered at country level in terms of the “how to” of completing the PAT.

Percentage of numerical responses in PAT

A	B	C	D	E
81-100%	**61-80%**	**41-60%**	**21-40%**	**1-20%**
Madagascar (92%)	Botswana (73%)	Lesotho (59%)		
Tanzania (90%)	Namibia (80%)			
DRC (89%)	South Africa (80%)			
Malawi (89%)	Mauritius (79%)			
Zambia (89%)				

Element 11: Policy Environment

This section is a brief analysis of how many of the possible 37 policies, plans and protocols that governments already have in place. Botswana comes out as the leader as the country that has completed the most of its policy work. Botswana reported that 87 per cent of their policies were in place, whereas Lesotho reported only having as little as 37 per cent. The average overall for SADC was 61 per cent, which demonstrates a need for this part of the process to still be completed.

Incredibly, many countries begin developing and writing their own policies from a blank slate as opposed to using templates or examples from neighbouring countries, without referring to best practice and lessons learnt in the region, and do not sufficiently draw on the expertise of regional experts. This need to improve the sharing of knowledge is referred to in a variety of the PAT reports in the recommendations sections and highlights how improvements are being held up at this point of the process. Funds need to be made available for the greater sharing of experiences between countries with regard to developing policy, getting stakeholder buy-in, and moving the SRHR agenda forward.

Moreover, policies always need to reflect government commitments to addressing SRHR issues, and so those pushing for equitable and safe access to termination of pregnancy, reduction in maternal mortality, and access to family planning need to be prioritised and completed and implementation begun as a matter of urgency.

Percentage of policies in place

A	B	C	D	E
81-100%	**61-80%**	**41-60%**	**21-40%**	**1-20%**
Botswana (87%)	Tanzania (73%)	DRC (60%)	Lesotho (37%)	
	Namibia (70%)	South Africa (60%)		
	Malawi (67%)	Zambia (50%)		
	Mauritius (67%)	Madagascar (43%)		

Element 12: Performance

The Performance Element analyses 13 percentile coverage indicators that reflect performance or implementation. This is necessary to measure what governments have done post creating the policy. It is designed to be an overall and general score of how well a country is performing on implementation.

The 13 indicators used were:

1. Proportion of SDPs providing PAC Services %
2. Proportion of EmONC sites with access to adequate supply of safe blood %
3. Proportion of HIV positive mothers who have delivered and are receiving ARVs %
4. No. of midwives per population %
5. Proportion of births attended by skilled health personnel
6. Antenatal care coverage (one visit)
7. Antenatal care coverage (four visits
8. Contraceptive prevalence rate (any method)
9. Contraceptive prevalence rate (modern method)
10. Immunization Rate
11. Insecticide Treated bed-Nets(ITN) coverage (under five)
12. Insecticide Treated bed-Nets(ITN) coverage (pregnant women)
13. Intermittent Presumptive Treatment (IPT) of malaria in pregnancy coverage

All of the 13 indicators were equally weighed and only those data points that had values reported were included for each country. A percentage was then generated thus hoping to reflect a countries performance in one quick snap shot. It is only one measure of a country's performance yet seems to accurately reflect many of the other findings of this report in other more detailed elements.

Mauritius comes out the clear winner at 77 per cent, although still only in the B category, reflecting that the best that countries are actually achieving overall is 77% of what is needed. DRC ranks lowest at 29 per cent which is not an unexpected finding considering the discussions and numbers reflected in earlier elements of this report.

What is however interesting is that Lesotho, which ranks in the lowest group of the policy element, ranks in the highest group in the performance element. Moreover Botswana, who ranks highly in the policy environment, ranks at only 55 per cent in the performance group. However if the statistics relating to malaria are removed, Botswana reaches a performance of 63 per cent, which may reflect the contradictory evidence around malaria in Botswana (14 000 cases with the Ministry of Health reporting only 2 deaths from malaria in recent years.) This needs to be further examined local experts in their use of this tool.

Lesotho on the other hand gains from this methodology as a country where abortion remains illegal, yet performs in the highest performing group, it may reflect that efforts at policy may be better spent at implementing basic training and commodities supply rather than working and re-working documents that take time to implement. This too needs further investigation.

What is however apparent, across all countries is that these performance indicators should all be in the upper nineties, all data should be available and not just a few of the indicators and that governments should have more information on which to base their decisions if they hope at all to respond accurately.

Civil society in these countries needs to be aware of why these figures are so low, and what can be done to most efficiently and effectively improve the performance of governments in their countries. There would seem to be enormous political will to improve SRHR in the region, with massive strides already being taken, but it remains obvious that much work has still to be done.

Performance

A	B	C	D	E
81-100%	**61-80%**	**41-60%**	**21-40%**	**1-20%**
	Mauritius (77%)	Malawi (58%)	DRC (29%)	
	South Africa (68%)	Zambia (58%)		
	Lesotho (65%)	Botswana (55%)		
		Namibia (54%)		
		Madagascar (51%)		
		Tanzania (48%)		

Moving forward

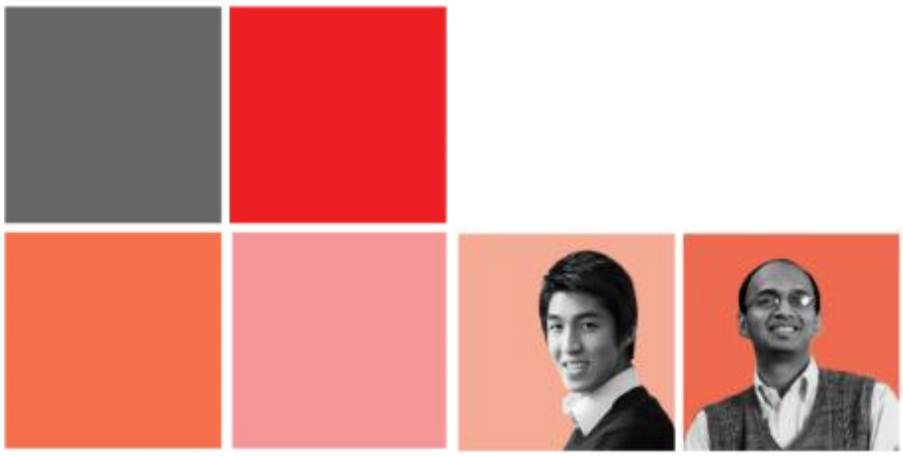
AIDS Accountability International sees the following points as vital issues in addressing SRHR and the commitments made in the Maputo Plan of Action:

1. The AUC needs to prioritise completing the piloting of the revised PAT, and needs support from funding partners and civil society in the pilot countries in order to be able to do this important work.
2. A second round of MPOA Reporting needs to be done before the end of 2013. The time delay between the first and second round poses a possible threat to undermining the importance of this work.
3. All African countries, especially those in the SADC region where the burden of HIV and AIDS are largest and where SRHR issues are heavily affected by this, need to report in the upcoming rounds.
4. Reporting needs to be bi-annual and not annual. The task, if quality work is expected, requires time and resources and annual reporting is too large a demand on overworked health departments.
5. Completion of the PAT needs to be the responsibility of the top leadership of the ministry of health and its staff. Allocating the task to staff is necessary but final accountability needs to be shared at the top echelons of health ministries.
6. Collaborative completion of the PAT with experts from civil society, multi and bi-laterals, as well as funding partners will ensure a PAT that truly reflects the statistics of a country, the challenges being faced and a collective set of recommendations. Health ministries should not outsource the reporting to consultants but rather ensure a collaborative process which brings all stakeholders around the table to work together.
7. The quality of reporting needs to be improved. Data collection methods need to be improved, methodological considerations, sources of data, and statistical considerations need to be part of the PAT report. Funding partners potentially play an enormous role here in funding better data collection.
8. Marginalised groups such as men who have sex with men need to be included in the PAT report so as to accurately reflect the health rights needs of all people, and so that governments can plan with full information and knowledge of what is happening at community level.

9. Civil society organisations need to engage more fully with the MPOA process. They need to familiarise themselves with the original intent of the Maputo Declaration and work with their governments to fulfil their obligations, in time for the assigned deadlines. Where government excludes them civil society needs to lobby for inclusion or rally for a change of leadership, and increased accountability.
10. The MPOA Scorecard needs to be repeated with every round to monitor the progress of countries, or lack thereof, and commend and share best practice and hold under-performing leaders to account to the people. Lessons learnt and best practices are vital to this work.
11. All stakeholders need to engage with the actual data and commit to refrain from silo work, duplication of government work but rather to collaborate with governments to support where they are most able to.
12. Accountability needs to be increasingly on the agenda, and the use of data to advocate for improved leadership responses so that an ethical answerability becomes a larger force in national, regional and continental dialogue, and a lens for various groups and organizations through which to do their work.

References

i Defining sexual health. Report of a technical consultation on sexual health, WHO. 28–31 January 2002, Geneva.
ii Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007-2010, African Union, September 2006.
iii Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007-2010, African Union, September 2006.
iv Mauritius reported "9999" (No Data available) for Question 1.6a (Training institutions integrating STI/HIV/AIDS, nutrition with SRHR in their curricula). We thus did not include this data point in our calculations. Mauritius reported "100% for SRHR/STI. HIV/AIDs is being integrated now." For Question 1.7a. We thus gave Mauritius 50% for the HIV integration.
v Improving Reproductive Health through Community-Based Services: 25 Years of Pathfinder International Experience, Mary K. Burket, Pathfinder International, October 2006.
vi WHO Country Cooperation Strategy 2008-2013. Mauritius, WHO Regional Office for Africa, 2009
vii Malawi's primary health care through community participation, E. M. F l Nkhono, Ministry of Health, Malawi, 2012
viii Malawi's primary health care through community participation, E. M. F l Nkhono, Ministry of Health, Malawi, 2012
ix MPOA Progress Review, African Union Commission, 2010.
x MPOA Progress Review, African Union Commission, 2010.
xi Youth Bulge: A Demographic Dividend or a Demographic Bomb in Developing Countries? Justin Yifu Lin, on Let's talk Development, a blog osted by the World Bank Chief Economist. Accessed May 2012.
http://blogs.worldbank.org/developmenttalk/youth-bulge-a-demographic-dividend-or-a-demographic-bomb-in-developing-countries
xii Health System Costs of Providing Post Abortion Care in Malawi', IPAS and the Government of Malawi, 2012
xiii Goga A et al. Impact of the national prevention of mother to child transmission (PMTCT) program on mother-to-child transmission of HIV (MTCT), South Africa, 2010. 6th International AIDS Society conference, abstract MOAC0206, Rome, 2011.
xiv Human Resources for Health, Joint learning Initiative, 2004, The President and Fellows of Harvard College



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