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GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH 2016-2030: IMPLEMENTATION IN THE AFRICAN REGION

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BACKGROUND

1. In the African Region, Member States have made several commitments to improve women's, children's and adolescents' (WCA) health. These include: the Maputo Plan of Action[1], which provides for delivery of quality and affordable health services to promote maternal, newborn and child health. Additional commitments were made through the Campaign for accelerating the reduction of maternal mortality in Africa (CARMMA) and Agenda 2063 of the African Union. Furthermore, in 2014, the first meeting of African Ministers of Health made commitments that were subsequently adopted by the Heads of State Summit in Malabo in June 2014, to end preventable maternal and child deaths by 2030.[2]

2. Although the African Region is home to only 14% of the global population, it accounts for the highest burden of maternal, newborn and child morbidity and mortality. The Region witnessed a 45% reduction in maternal mortality between 1990 and 2015.[3] During the same period, under-five mortality reduced by 54%, while neonatal mortality reduced only by 38%.[3] Despite these changes, by 2015 only twelve countries[4] had achieved the Millennium Development Goals (MDGs) target on child mortality reduction. Only two countries achieved the target on maternal mortality reduction, while no country achieved the targets on reproductive health.[3] The maternal mortality ratio and the under-five mortality rate in the Region remain high at 542 deaths per 100 000 live births and 81 deaths per 1000 live births respectively.[3] Mortality for adolescent girls aged 15–19 is over ten times higher in the African Region than in high-income countries.[5]

3. Based on the Health in 2030 Sustainable Development agenda, a Global Strategy for Women's, Children's and Adolescents' Health[6] (Global Strategy) was launched by the United Nations Secretary-General in September 2015. An operational plan (WHA69/16) to take forward this strategy was adopted by the World Health Assembly in May 2016 and supported by resolution WHA 69.2. The key changes introduced by the Global Strategy are the adoption of a health system-oriented, integrated, multisectoral approach to maternal, newborn, child and adolescent health programming. In addition, a five-year global operational framework as well as an indicator and monitoring framework have been developed to serve as guide for national governments and stakeholders in implementing the global strategy.

4. The Global Strategy proposes that, countries need to reduce maternal mortality to less than 70 deaths per 100 000 live births and newborn and under-five mortality to less than 12 and 25 per 1000 live births respectively by 2030.[6] Achieving these targets would entail as much as a seven-fold reduction of the current rates in the Region. Hence, significant and innovative efforts are urgently needed to increase the momentum of recent years and achieve better health outcomes. This has huge implications and would require addressing current issues and challenges that affect the efficient delivery of WCA services in the Region.

5. In line with the Global Strategy and its Operational Framework, this paper outlines the issues and challenges and proposes priority actions for implementation during the period 2016–2020.

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1 African Union Commission, *Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action) 2007-2010*: Addis Ababa, African Union Commission, 2006, pages 4 and 5.

2 UAC/WHO, *First meeting of African Ministers of Health jointly convened by AUC and WHO*, Luanda, African Union Commission/World Health Organisation, 2014.

3 WHO Regional Office for Africa, *Atlas of African Health Statistics 2016*: Brazzaville, World Health Organisation, 2016.

4 Eritrea, Ethiopia, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Senegal, Tanzania, Uganda, Zambia.

5 Patton GC, et al , "Global patterns of mortality in young people: a systematic analysis of population health data, The Lancet 374: 881–892, 2009.

6 Every Woman Every Child: *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) 2015:*

ISSUES AND CHALLENGES

6. **Inadequate implementation of commitments and national plans to achieve set targets.** Despite the many commitments, resolutions and decisions made by Member States to improve the health of women and children, only 12 countries achieved MDG Target 4,[4] while two countries achieved MDG Target 5A and none achieved MDG Target 5B on universal access to reproductive health. In most cases, commitments are often not matched with resources required to implement planned activities.

7. **Inadequate coordination of partners and initiatives supporting interventions for WCA in most Member States.** This results in patchy, unevenly distributed and unsustainable services that are often not aligned to the needs of Member States. The inadequate coordination also results in delivery of services that are not integrated or logically synchronised, hence reducing their potential effectiveness.

8. **Inadequate financial resources from both domestic and external sources.** Inadequate and inefficient use of available resources limits scale up and sustainability of key interventions for WCA. By the end of 2015 only 22 countries in the Region had reached the set total health expenditure (THE) target of US$ 60 per capita or above,[7] and only six had implemented the 2001 Abuja Declaration target of "at least 15% of national budgets to the health sector."[8] In addition, household out-of-pocket expenditure constitutes more than 40% of the total health budget in 22 countries of the Region.[9] This puts the most vulnerable households at great risk of financial hardship and catastrophic health expenditure.[10] Furthermore, the amount and timing of external funds are often unpredictable, not well aligned and may distort the implementation of country plans.

9. **Inadequate human resources for health**. The Region continues to experience an acute shortage of skilled, equitably distributed (rural versus urban and hard-to-reach areas) and well-motivated human resources for health. In 2015, the Region was reported to have an average threshold of 15 doctors, nurses and midwives per 10,000 population.[11] Yet, to achieve the targeted 80% coverage rate for skilled birth attendance, it requires a minimum of 23 health workers per 10,000 population.[12] The current levels of staffing are further constrained by increase in population, recurrent outbreaks, epidemics, civil strife and natural disasters.

10. **Unreliable supply of and access to affordable essential medicines, vaccines and equipment**. Access to essential medicines and vaccines including the 13 United Nations life-saving commodities (WHA66.7), equipment and infrastructures for WCA health remains a challenge. This demotivates health workers and erodes the trust of communities, thereby hampering the utilization of health services. It also leads to direct loss of lives.

11. **Effects of cultural and socioeconomic conditions on access to services**: In most African countries, efforts to improve RMNCAH are constrained by a number of issues such as early marriage, harmful practices, gender inequity, stigma and low education that hinder the appropriate choices and

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7 WHO African Regional Office, *The African Health Monitor, Universal Health Coverage, Special issue March 2015* Brazzaville, World Health Organisation regional Office for Africa 2014.

8 Liberia, Malawi, Rwanda, Swaziland, Togo, Zambia.

9 WHO African Regional Office, *The Health of the People, What works*, *The African Regional Health Report 2014:* Brazzaville, World Health Organisation regional Office for Africa 2014.

10 Bigdeli et al, Medicines and Universal Health Coverage: Challenges and Opportunities**,** *Journal of Pharmaceutical Policy and Practice,* 8:8, 2015.

11 WHO, *World Health Statistics 2015*: Geneva, World Health Organisation, 2015.

12 WHO, *Working Together for Health: World Health Report 2006*: Geneva, World Health Organisation, 2006.

access to health services. The situation is aggravated by underlying risk factors, determinants of health and socioeconomic conditions that negatively affect the health of women and girls.

12. **Multisectoral approach to health not well articulated.** About half of the gains in the health of women, children and adolescents results from investments outside of the health sector such as education, agriculture, water supply, infrastructure, telecommunication and social protection, among others.[13] However, community participation and multisectoral engagement are suboptimal and this limits the potential synergies that would otherwise accrue from coordinated actions of the sectors.

13. **Gaps in the availability of reliable, accurate, disaggregated and timely data to guide decision-making.** In many Member States, data are collected separately according to disease programmes, thus creating multiple, parallel and fragmented systems. This further burdens the frontline health workers. Research and innovations are often externally driven and fall short of addressing context-specific bottlenecks that hamper effective and efficient delivery of services.

PROPOSED ACTIONS

To implement the Global Strategy and establish its implementation framework, the following priority actions are proposed for Member States with the support of WHO and partners. This will facilitate achievement of globally agreed targets[14] by 2030 in line with the Sustainable Development Goals.

14. **Ensure government ownership and leadership of programmes and initiatives**.

(a) Ensure that WCA issues are prioritized in national development and political agendas including at the level of Heads of State and Government, and parliamentarians.

(b) **Ensure that services are provided universally in a comprehensive, integrated and equitable manner, and sustained long enough to have impact on WCA**. Member States should establish/strengthen multi-stakeholder platforms for participatory and transparent planning and oversight of WCA. Translate the 17 SDG targets crucial to WCA health into country context, and develop and implement strategic plans for WCA that are aligned to the overall national health sector development plans.

(c) **Avail policies to improve the health of WCA** through adoption of appropriate policies and revision of those that adversely affect the health and well-being of WCA. The policies should take into consideration the role of men, communities and civil society in health service delivery.

(d) **Mobilize adequate resources** through conducting **resource mapping** to identify all existing and potential sources of funding, both domestic and external, for RMNCAH at national and subnational levels. Integrate RMNCAH financing into national health financing processes such as medium term expenditure frameworks and annual health sector budgeting at national and subnational levels as well as institutionalizing RMNCAH sub-accounts.

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[13] Kumanan Rasanathan et al. *Ensuring multisectoral action on the determinants of reproductive, maternal, newborn, child, and adolescent health in the post-2015 era,* BMJ351:Suppl1 pp36.

[14] Reduce child mortality to 25 or fewer deaths per 1000 live births, reduce newborn mortality to 12 or fewer deaths per 1000 live births, reduce maternal mortality in all countries to a global ratio of less than 70 per 100 000 live births, meet a minimum of 75% of demand for modern contraceptive methods.

(e) **Institute national and subnational accountability processes for periodic review and monitoring of progress towards agreed national targets**. Member States should develop accountability frameworks. These will involve monitoring frameworks with specific national and subnational targets and indicators, participatory review mechanisms and inclusive decision-making processes.

15. **Institute measures for health systems strengthening.**

(a) **Ensure high coverage of effective and high impact reproductive, maternal, newborn, child and adolescent health interventions (refer to annex 2)**. This can be achieved through packaging and targeting RMNCAH for efficient delivery, aiming at reducing inequities. Emphasis should be on reaching the most vulnerable groups such as newborns, adolescents and populations living in rural, hard-to-reach and humanitarian settings. Innovative mechanisms should be considered to help improve availability of quality care.

(b) **Sustainable investment for health workforce.** Improve quality of pre-service training as a more sustainable approach to having a competent health workforce. This can be done through regular review and design of training programmes, timely provision of technical updates and technologies to training institutions in collaboration with the regulatory authorities. Recruit and distribute in an equitable manner more skilled health workers and institute measures for retention in collaboration with professional associations and the private sector.

(c) **Improve availability of essential medicines, supplies, infrastructure and equipment,** through investing in local production and manufacturing of medicines, vaccines and health equipment; strengthening capacity for supply chain management including building capacity of technical programme officers to play their roles in quantification and timely ordering. Improve rational use of medicines through adoption and use of clinical protocols and application of prescription standards for both government and private health facilities. Ensure availability and functionality of essential infrastructure including water, source of energy and communication in health facilities

(d) **Improve availability of quality data to inform decision-making,** through strengthening health management information systems, regular conduct of service availability and readiness assessments and programme reviews. Member States need to operationalize universal civil registration and vital statistics systems, implement or strengthen maternal and child deaths surveillance and response, invest in, guide and conduct research focusing on implementation to provide evidence-based solutions for overcoming bottlenecks in the programmes that are context-specific.

(e) **Address the critical social, behavioural, economic and environmental determinants of health.** Member States should strive to provide universal quality education for girls and boys. This should include measures to address special needs and bottlenecks that prevent girls from achieving their full potential. Put in place policies and programmes to empower adolescents such as life skills building programmes. Ensure involvement and participation of men as they are major players in the affairs that impact on the health of WCA.

16. **Enhance mechanisms for multisectoral action.** Commit to and strengthen coordination of actions of relevant sectors for joint accountability of results. Develop consensus and jointly monitor indicators on key determinants of WCA health across relevant sectors, particularly: education, agriculture, water, sanitation, welfare, social protection, youth, justice, labour and

trade. Countries should promote involvement of communities, civil society, and the private sector; and strengthen South-South cooperation.

17. The Regional Committee is hereby requested to consider and endorse the proposed actions.

ANNEX 1: AT A GLANCE: THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH

<table>
<tr><th>VISION</th><th>GUIDING PRINCIPLES</th></tr>
<tr><td>By 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.
Implementing the Global Strategy, with increased and sustained financing, would yield tremendous returns by 2030:
– An end to preventable maternal, newborn, child and adolescent deaths and stillbirths
– At least a 10-fold return on investments through better educational attainments, workforce participation and social contributions
– At least US$ 100 billion in demographic dividends from investments in early childhood and adolescent health and development
– A "grand convergence" in health, giving all women, children and adolescents an equal chance to survive and thrive</td><td>– Country-led
– Universal
– Sustainable
– Human rights-based
– Equity-driven
– Gender-responsive
– Evidence-informed
– Partnership-driven
– People-centred
– Community-owned
– Accountable
– Aligned with development effectiveness and humanitarian norms</td></tr>
<tr><th colspan="2">OBJECTIVES AND TARGETS
(aligned with the Sustainable Development Goals to be achieved by 2030)</th></tr>
<tr><td colspan="2"><table>
<tr><th>SURVIVE
End preventable deaths</th><th>THRIVE
Ensure health and well-being</th><th>TRANSFORM
Expand enabling environments</th></tr>
<tr><td>Reduce global maternal mortality to less than 70 per 100 000 live births
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country
Reduce under-five mortality to at least as low as 25 per 1000 live births in every country
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
Reduce by one third premature mortality from noncommunicable diseases and promote mental health and well-being</td><td>End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
Ensure universal access to sexual and reproductive health care services (including for family planning) and rights
Ensure that all girls and boys have access to good-quality early childhood development
Substantially reduce pollution-related deaths and illnesses
Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines</td><td>Eradicate extreme poverty
Ensure that all girls and boys complete primary and secondary education
Eliminate all harmful practices, discrimination and violence against women and girls
Achieve universal access to safe and affordable drinking water and to sanitation and hygiene
Enhance scientific research, upgrade technological capabilities and encourage innovation
Provide legal identity for all, including birth registration
Enhance the global partnership for sustainable development</td></tr>
</table></td></tr>
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ACTION AREAS (based on evidence of what is required to reach the objectives)	
1. Country leadership	Reinforce leadership and management links and capacities at all levels; promote collective action.
2. Financing for health	Mobilize resources; ensure value for money; adopt integrative and innovative approaches.
3. Health system resilience	Provide good-quality care in all settings; prepare for emergencies; ensure universal health coverage.
4. Individual potential	Invest in individuals' development; support people as agents of change; address barriers with legal frameworks.
5. Community engagement	Promote enabling laws, policies and norms; strengthen community action; ensure inclusive participation.
6. Multisectoral action	Adopt a multisectoral approach; facilitate cross-sector collaboration; monitor impact.
7. Humanitarian and fragile settings	Assess risks, human rights and gender needs; integrate emergency response; address gaps in the transition to sustainable development.
8. Research and innovation	Invest in a range of research and build country capacity; link evidence to policy and practice; test and scale up innovations.
9. Accountability	Harmonize monitoring and reporting; improve civil registration and vital statistics; promote independent review and multi-stakeholder engagement.

Adopted from Every Woman Every Child, *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) 2015* p.7.

ANNEX 2: EXAMPLES OF EVIDENCE-BASED INTERVENTIONS FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH

LIFE COURSE	*INTERVENTION PACKAGES*
Women's health	• *sexual and reproductive health information and services including Family Planning and management of Sexually Transmitted Infections;* • *nutrition;* • *management of communicable and non-communicable diseases;* • *screening and management of cervical and breast cancer;* • *gender-based violence prevention and response;* • *pre-pregnancy risk detection and management* • *Infertility*
Pregnancy, childbirth and postnatal care	• *antenatal care,* • *childbirth care;* • *safe abortion and post-abortion care;* • *prevention of mother-to-child transmission of HIV and congenital syphilis ;* • *management of maternal and newborn complications;* • *postnatal care for mother and baby;* • *extra care for small and sick babies*
Child health and development	• *breastfeeding (early and exclusive breastfeeding);* • *infant and young child feeding;* • *responsive caregiving and stimulation;* • *immunization;* • *prevention and management of childhood illness and malnutrition;* • *treatment and rehabilitation of congenital abnormalities and disabilities*
Adolescent health and development	• *health education;* • *supportive parenting;* • *nutrition;* • *immunization;* • *psychosocial support;* • *prevention of injuries, violence, harmful practices such as FGM and early marriage and substance abuse;* • *sexual and reproductive health information and services;* • *management of communicable and non-communicable diseases*

ENABLING ENVIRONMENT

HEALTH SYSTEM ENABLERS

- *policies for universal health coverage; sufficient and sustainable financing;*
- *health workforce supported to provide good-quality care everywhere;*
- *commodity supply;*
- *health facility infrastructure; community engagement;*
- *mainstreaming emergency preparedness;*
- *human rights-, equity- and gender- based approaches in programming;*
- *accountability at all levels*

MULTISECTOR ENABLERS

- *policies and interventions in key sectors: finance and social protection;*
- *education;*
- *gender;*
- *protection— registration, law and justice; water and sanitation;*
- *agriculture and nutrition;*
- *environment and energy;*
- *labour and trade;*
- *infrastructure, including facilities and roads;*
- *information and communication technologies;*
- *and transport*