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EVALUATION OF THE CAMPAIGN FOR ACCELERATED REDUCTION OF MATERNAL MATERNITY IN AFRICA (CARMMA) 2009-2019

CARMMA

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ANC	Ante-natal care
AU	African Union
AUC	African Union Commission
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
DFID	UK Department for International Development
FAO	United Nations Food and Agriculture Organization
FP	Family planning
MDGs	Millennium Development Goals
MDSR	Maternal death surveillance and response
MNCH	Maternal, new-born and child health
MMR	Maternal mortality ratio
MPoA	Maputo Plan of Action
PMNCH	Partnership for Maternal, New-born and Child Health
REC'S	Regional Economic Communities
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
WHO	World Health Organization
UNAIDS	United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

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Executive summary

1 Africa has amongst the highest maternal, new-born and infant mortality rates in the world. Although a number of member states within some regions of Africa have halved maternal mortality levels since 1990, Eastern, Southern, Western and Central Africa still account for 62 per cent of global maternal deaths. In these four regions of Africa one of every 13 children dies before his or her fifth birthday, and these regions also have the second highest number of new-born deaths – 38 per cent of the global total [7]. In 2009 the African Union (AU) in 2009, responded to the crisis of high maternal deaths by placing maternal death firmly on its agenda and launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The campaign utilizes policy dialogue, advocacy and community mobilization to harness political commitment of member states towards improving maternal, child and newborn health (MNCH) and the survival of mothers and their newborns and children across the continent. The main objective of the campaign was to expand the availability and use of universally accessible quality health services, including those related to sexual and reproductive health (SRH), which are critical to reducing maternal mortality.

2 The transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) required a radical reappraisal of practices, programmes and policies in order maternal and child health and well-being in Africa to be sustainable. The evaluation of CARMMA campaign from the period May 2009 to December 2018 was commissioned by the African Union Commission (AUC), Department of Social Affairs to determine the relevance, effectiveness, impact and sustainability of the campaign and to make recommendations that would allow the campaign to further contribute to the reduction of maternal, newborn and child deaths and the achievement of the AU's 'Transformational Agenda 2063', the global sustainable Agenda 2030 and other global commitments. The evaluation comprised of a literature and data review, interviews with key stakeholders throughout Africa, an assessment of national MNCH indicators and a comparative analysis of the 48 African member states that had launched the CARMMA campaign by the end of 2017.

Launch and implementation

3 CARMMA was initially launched by eight high-burden member states that had very high maternal mortality rates these were: Chad, the Kingdom of Eswatini, Ghana, Malawi, Mozambique, Namibia, Nigeria and Rwanda. . As of the end of 2018 50 African Union member states to in Africa have launched the CARMMA campaign, 48 of whom were considered for the evaluation. In a number of member states of the AU, campaigns were launched by First Ladies, who then became CARMMA national champions. The CARMMA campaign received very strong support from the United Nations Population Fund (UNFPA), United Nations Children's Fund

(UNICEF) ,World Health Organization (WHO), and the United States Agency for International Development (USAID)

4 CARMMA engaged African leadership at the highest level to solicit and sustain political commitment. Events such as the CARMMA continental launch, national launches by member states and dedicated sessions of the AU Assembly on MNCH brought together Heads of State and Government, ministers, other senior government officials and partners, to discuss the lives of mothers and children and commit to action to improve MNCH. CARMMA national champions played a critical role in maintaining country focus on high-impact interventions that would reduce maternal, neonatal and child mortality. The evaluation reveals that member states that embraced the campaign at the highest political levels made significant improvement in their MNCH indicators.

5 Overall, the success of the CARMMA's Campaign was based on four key strengths:

- *Use of existing structures,* which minimized duplication, maximized resource efficiency and enhanced the status of MNCH on the political agenda of most countries

- *Use of innovations,* such as technology and community engagement to implement low-cost interventions

- *Use of high-profile and high-level personalities*, which increased national awareness and enhanced political commitment and leadership to improve MNCH

- Lastly, the campaign substantially *broadened and strengthened partnerships* to support CARMMA activities and prioritize MNCH. Strong national and regional-level partnerships helped to contextualize and domesticate the AU's MNCH agenda and allowed the campaign to be perceived as "home-grown", maximizing impact on the most pressing needs.

6 The campaign served as a useful platform for learning, sharing of information and strategies on MNCH. The campaign made use of various tools, events and publications. Additionally, a CARMMA website (http://www.carmma.org/) was established, newsletters and annual MNCH Status Reports covering the period 2012–2014 were developed. The adoption by the AU Assembly of Heads of State and Government (Assembly/AU/Decl.1(XI)) resulted in high level of buy-in of the CARMMA campaign. There were also CARMMA week commemorations held yearly from 2014–2017 providing an opportunity for governments and stakeholders to share experiences and good practices and to motivate member states to redouble their efforts to reduce their national incidence of maternal and child mortality. The first AU International Conference on MNCH in Africa was held in South Africa in August 2013. While the conference was planned to take place every two years, the second conference was delayed but was eventually held in Kenya in 2018. Not

all opportunities to focus on MNCH were sustained, for example the compendium of policy briefs and best practices (Assembly/AU/Dec.195 (XI)) was produced only once, in 2013. Similarly, MNCH Status Reports (Assembly/AU/Dec.494(XXII)), that were planned to be produced annually, were produced only 4 times (2012, 2013, 2014, 2017) during a six-year period.

7 In some member states, inadequate linkages with local priorities and lack of harmonization and coordination of multiple MNCH initiatives, made it difficult to scale up the campaign. A key gap was the limited involvement of the AU's recognized Regional Economic Communities (RECs) and the private sector in the campaign. Implementation also was limited as a result of gross understaffing: a campaign secretariat with sufficient staff and technical capacity was initially envisioned, but never put in place. Similarly, an MNCH taskforce was established in 2013, but was not fully operational – largely due to lack of financial resources. As a result of these limitations the AUC was not fully involved in the conduct and follow up of national-level campaigns. This undermined the AUC's ability to articulate CARMMA's goals, principles and expectations, including the need for the AUC to monitor the development of CARMMA post-launch roadmaps by member states. This would have enabled the Commission to routinely monitor, document and share the experiences of its member states. . Lack of budgets at the national level further constrained sustained implementation of the campaign by member states.

Key lessons of the CARMMA Campaign

Identifying entry points for MNCH to scale up and enhance reach: Political commitment and financial investment in health contributes to better results for MNCH, and is an essential ingredient, for an effective advocacy campaign such as the CARMMA Campaign. In some member states a focus on family planning was an important driver for improving women's health and became an entry point for the campaign. Multi-sectorial strategies with robust coordination mechanisms are also key drivers of success.

Targeted implementation of high-impact interventions for results: Ethiopia invested in community health programmes and recruited midwives to increase coverage and access to services. Rwanda invested in improving its supply chain management system to track commodities to the service-delivery level. Madagascar, invested in an electronic commodity system that has helped to ensure that reproductive commodities are available. Commitment to targeted implementation of high-impact interventions is another critical driver of success.

The importance of data use for decision making: To enhance data use, the results and impact of MNCH interventions should be presented in a clear and simple manner to enhance understanding by policy and decision makers and politicians. Where data was available and measurable, results demonstrated significant progress on key indicators.

Data was critical in placing focus on maternal mortality on the agenda of member states and in strengthening their capacity to identify areas for urgent attention. ,

Campaign monitoring

8 The weak direct link between the AUC and the member states driving the campaign at the national level and the absence of a mechanism to monitor implementation of the national campaigns resulted in the loss of critical opportunity for the AUC to hold African leaders directly accountable for their CARMMA commitments. To improve accountability, in 2017 the AUC developed a CARMMA scorecard, and increased the number of indicators on the CARMMA website.

9 The evaluation determined that:

- The majority of member states made tremendous progress in reducing their maternal mortality ratio (MMR); most reducing it by levels of between 7 and 1,300 maternal deaths per 100,000 live births. To attain the SDG target 3.1, member states are expected to reduce MMR to less than 70 maternal deaths per 100 000 live births by 2030.
- All member states took positive steps toward reducing neonatal mortality. Member states with the highest percentage reductions were Angola and Ethiopia, which both achieved a 22.9 per cent reduction between 2009 and 2016. To attain the SDG target of 12 deaths per 1,000 live births, most African member states must reduce current rates by between 20 and 90 per cent.
- All African member states made progress towards reducing under-five mortality, with the highest percentage point reduction realized in Angola: 35.2 per cent. By 2016 four countries had reached the SDG target of 25 or fewer deaths per 1,000 live births: Tunisia (13.6/1,000), Mauritius (13.7/1,000), Seychelles (14.3/1,000) and Cape Verde (21.4/1,000).

10 The main conclusions of the CARMMA evaluation are:

- The CARMMA campaign generated interest and contributed to sustaining the agenda for women's health and provided a vehicle for many other initiatives with similar focus
- The advocacy strategy implemented under the CARMMA campaign is still relevant for Africa, the conceptual design of the CARMMA advocacy and communication strategy was useful, and its successes can be built upon to galvanize efforts to improve the health of women, children and adolescents
- The CARMMA campaign generated significant successes that have resulted in the continued placement of women's, children and adolescent health high on political and global agendas

The evaluation makes the following recommendations:

i. Adequate resources should be mobilized to sustain the CARMMA campaign
ii. The CARMMA Secretariat should be established with adequate human resources
iii. Partnerships should be broaden with the specific objective of engaging the the private sector and the AU recognized regional economic communities
iv. Accountability mechanism of the campaign need to be sthrengthened at the national and regional level
v. The frequency and number of MNCH reports and meetings should be reviewed.
vi. The CARMMA campaign should be revised in line with the continental and global post 2015 commitments on MNCH and adolescent health

11 Specific Recommendations:

i. The political-will at the level of AU recognized Regional Economic Communities (RECS) needs to be strengthen in order that the AU recognized RECs more engaged with the CARMMA Initiative.
ii. Member states should also be encouraged to develop high impact and low cost roadmaps that leverage on multi-sectorial platforms.
iii. There is a need to advocate for appropriate and sustainable budget lines within government budgeting cycles. Funding should also be used to invest in integrated primary health care MNCHA and not stand alone programs.
iv. It is recommended that a CARMMA partnership framework (that includes the Regional Economic Communities) is developed, to support member states in focusing on high impact interventions.
v. A robust continental Accountability Framework needs to be developed, that takes in to account systems for improved data collection and knowledge management.
vi. The cost of maternal and child deaths should be linked with socio-economic development and the impact on a country's gross domestic product (GDP).
vii. The CARMMA Initiative should take advantage of relevant and existing reporting Frameworks and Initiatives including the NEPAD peer review mechanisms, the Conference of Finance Ministers and the Committee of the Africa Rights and Welfare of the Child, to strengthen member state reporting on MNCAH.
viii. The campaign should continue to focus on the unfinished MDG health agenda for women, newborns and children, and take into account the sustainable and transformative agendas of the global SDG's and Agenda 2063 for women and children with a specific focus on adolescent health.

Next steps

12 The evaluation identifies several important actions for the CARMMA campaign as it strives to contribute to realization of SDG 3 and Africa's Agenda 2063, to end all preventable maternal, newborn, adolescent and child deaths by 2030. These include: (i) Scaling up what works and increased domestic resources for the adequate provision of maternal, newborn, child and adolescent programs. (ii) Increased accountability of the implementation of the CARMMA campaign (iii) Stronger partnerships for MNCH, that involves the AU recognized REC's and the private sector (iv) Strengthened data systems that provided accurate disaggregated data for improved reporting.

13 The vision, mission, objectives and strategic focus of the CARMMA campaign should be reviewed to reflect the changing reality reflected in the global sustainable Agenda 2030, and Africa's transformative Agenda 2063, the revised African Health Strategy 2016-2030 and the revised MPoA 2016-2030. The AUC's ability to effectively oversee and implement the campaign should be strengthened through increased human resource capacity, allowing the AUC to become the nerve centre of the campaign and drive monitoring efforts.

14 CARMMA's tenth anniversary in 2019 provides a timely benchmark for the AUC and members states to renew their commitment that "no woman should die while giving life" and to recommit to ending all preventable maternal deaths by 2030

CHAPTER ONE: INTRODUCTION AND BACKGROUND

Background and context

15 Some progress on maternal mortality indicators occurred globally during the last decade. For example, between 1990 and 2013 the global MMR fell by 45 per cent. An estimated 289,000 maternal deaths occurred in 2013, resulting in a global MMR of 210 maternal deaths per 100,000 live births in 183 countries according to the World Health Organization (WHO). The global adult lifetime risk of maternal mortality (that is, the probability that a 15-year-old woman will die eventually from a maternal cause) was 1 in 190 in 2013 [1]. WHO's 2015 report indicates a further reduction of nearly 44 per cent over the past 25 years, with global lifetime risk of maternal death at 1 in 73-to-1 in 180 [2]. These global figures, however, mask disparities. The estimated lifetime risk of maternal mortality in high-income countries is 1 in 3,300, compared to 1 in 41 in low-income countries [3]. In low- and middle-income countries, women in poorer income quintiles or living in rural areas experience several-fold higher rates of maternal death than their wealthier, urban-dwelling counterparts [4]. MMRs declined consistently in South, East and South-east Asia between 1990 and 2013, but *increased* in much of sub-Saharan Africa during the 1990s, in part to due to deaths from acquired immunodeficiency syndrome (AIDS). MMR was highest among oldest age groups, that is those aged 30 years or more, in both 1990 and 2013 [5].

16 Developing countries account for 99 per cent (286,000) of all maternal deaths globally. Africa (excluding North Africa) accounts for 62 per cent (179,000), followed by South Asia (69,000). Oceania had the fewest maternal deaths (510). Some countries have particularly high maternal mortality rates: two countries alone account for one third of global maternal deaths: India, at 17 per cent (50,000) and Nigeria, at 14 per cent (40,000). The 10 countries that accounted for 58 per cent of global maternal deaths reported in 2013 were: India and Nigeria, Democratic Republic of the Congo (21,000, 7 per cent); Ethiopia (13,000, 4 per cent); Indonesia (8,800, 3 per cent); Pakistan (7,900, 3 per cent); United Republic of Tanzania (7,900, 3 per cent); Kenya (6,300, 2 per cent); China (5,900, 2 per cent) and Uganda (5,900, 2 per cent) [1].

17 The main cause of maternal death were direct obstetric causes, which accounted for about 86 per cent of all maternal deaths globally in 2015, led by maternal haemorrhage (27.1 per cent), maternal hypertensive disorders (14.0 per cent), and sepsis (10·7 per cent). The rest were due to abortion (7·9 per cent), embolism (3·2 per cent) or other causes (9·6 per cent), with substantial regional variations.[5] Indirect causes, including human immunodeficiency virus (HIV), mental illness and diabetes aggravated by pregnancy accounted for 27·5 per cent of all deaths.[6] While marked progress has been made in decreasing maternal deaths from HIV, considerably less progress has occurred in relation to deaths from hemorrhage and hypertension. [4].

18 New-born' health and survival depends on maternal health status throughout pregnancy, childbirth and the early days of life. In process has been made in recent decade in reducing child mortality. The total number of under-five deaths dropped to 5.6 million in 2016 from 12.6 (12.4, 12.8) million in 1990; that is, 15,000 deaths every day, compared to 35,000 in 1990.[7] The under-five mortality rate dropped to 41 (39, 44) deaths per 1,000 live births in 2016 from 93 (92, 95) in 1990 – a 56 per cent (53, 58) decline. Globally, nearly 2.6 (2.5, 2.8) million new-born died in 2016: 7,000 every day. Neonatal deaths accounted for 46 per cent of all under-five deaths, an increase from 41 per cent in 2000. Regional estimates indicate that the largest number of new-born deaths occurred in South Asia (39 per cent), followed closely by sub-Saharan Africa (38 per cent). Five countries accounted for half of all new-born deaths: India, Pakistan, Nigeria, Democratic Republic of Congo (DRC) and Ethiopia. Great disparities in child survival exist across regions and countries: in sub-Saharan Africa approximately one child out of 13 dies before his or her fifth birthday, while in high-income countries the ratio is one in 189. Among new-born in sub-Saharan Africa, roughly one child in 36 dies in the first month, while in the world's high-income countries the ratio is 1 in 333. [7]

19 Most new-born deaths are attributable to infectious causes that are readily preventable or treatable with proven, cost-effective interventions. Infectious diseases and neonatal complications are responsible for most under-five deaths globally. In 2010, for example, of 7·6 million deaths of children younger than five years, 64 per cent (4,879 million) were attributable to infectious causes. Other causes included: pre-term birth complications (14·1 per cent, 1,078 million); intrapartum-related complications (9·4 per cent, 717 million); and sepsis or meningitis (5·2 per cent, 393 million). In older children, pneumonia (14·1 per cent; 1,071 million), diarrhea (9·9 per cent; 751 million) and malaria (7·4 per cent; 564 million) claimed the most lives [8]. The fact that one in four babies worldwide is born without skilled care [3] makes them vulnerable to preventable causes, most of which remain uncounted by national health information systems. [9]

20 Global efforts to end preventable maternal and new-born mortality have yielded various outcomes. The global community adopted a set of 17 Sustainable Development Goals in 2015 setting benchmark targets for global development between 2015 and 2030. These goals are intended to build on the momentum generated by the MDGs. The transition from the MDGs to the SDGs provides opportunities to expand the maternal health agenda. There is a concern however, that multiplicity and duplication of efforts and initiatives, competition for resources and weak governance structures for MNCH may limit success in reducing maternal deaths. More shall need to be done to improve governance for MNCH, and reduce the multiplicity of efforts and duplication, in order to achieve sustainable the goals and objectives set for MNCH. [10]

21 The past decade has seen a proliferation of global efforts for maternal health through at least 18 high-profile initiatives to mobilize increased funding or improve the provision of reproductive, maternal and new-born health care in low- and middle-income countries. Examples include Every Woman, Every Child; Women Deliver; and Family Planning 2020. Each initiative has slightly different goals and strategies. In 2005, the Partnership for Maternal, New-born and Child Health (PMNCH) was launched as an umbrella organization to foster strategic alignment among MNCH initiatives. Early, African-led continental initiatives included, Ministers of health and delegates from 48 African countries met in Maputo, Mozambique, in 2006, where they agreed unanimously that the right to health is under serious threat in Africa, and that poor access to sexual and reproductive health is a leading killer. The Minister of Health in Maputo, adopted the Maputo Plan of Action (MPoA) to address the need for universal access to comprehensive SRH services on the continent (EX.CL/Dec.249 (VIII)).

22 The Maputo Plan of Action, for the Operationalization of Continental Policy Frame work for Sexual and Reproductive Health and Rights has six key strategies, highlighted in Box 1, and was developed to bring the continent closer to its goal of universal access to comprehensive SRH services by 2015. It was designed as a short-term plan for the period 2006 to 2010, but was extended to 2015 (EX.CL/Dec. 568(XVII)) in line with the end of the MDG's. Following the expiry of the MPoA expiry in 2015 , a revised MPoA for 2016–2030 was developed and endorsed by the Assembly of Heads of State and Government in 2016 (Assembly/AU/ Dec.619 (XXVII)). The revised a costed MPoA (2016-2030) has 10 action areas outlined in box 2.

23 The 2016-2030 revised MPoA is in line with Agenda 2063 and its first 10-year implementation plan, the SDGs, Rio+20, ICPD+20 and the Global Strategy for Women's, Children's and Adolescent's Health, the Gaborone Declaration on the Roadmap towards Universal Access to Prevention, Treatment and Care, the Brazzaville Commitment on Scaling Up towards Universal Access to Health and the Abuja commitments on expenditure on health, among others. It takes into account best practices and high-impact interventions. The revised MPoA also recognizes the importance of creating an enabling environment, the relevance of community involvement, the need for women's empowerment and the role of men in access to SRHR services. The revised MPoA can be revised to suit the needs of each country.

Box 1: Six key strategies of the Maputo plan of action 2006

Integrating HIV/AIDS services into sexual and reproductive health and rights

Promoting family planning as a crucial factor in attaining the MDGs

Supporting the sexual and reproductive health needs of adolescents and young people as a key SRH component

Addressing unsafe abortions through family planning

Delivering quality and affordable health services to promote safe motherhood, child survival and maternal, new-born and child health

Adopting strategies that would ensure reproductive health commodity security

Box 2: Ten action areas for Maputo plan of action 2016-2030

Political commitment, leadership and governance

Health legislation

Gender equality, empowerment of girls and women and respect for human rights

Strategic communication

Investing in SRH needs of adolescents, youth and other vulnerable populations

Optimizing the functioning of health systems

Human resource development

Partnerships and collaboration

Monitoring, reporting and accountability

Increasing investments in health

CARMMA

24 The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an AUC high level advocacy campaign that aimed at promoting and advocating for renewed and intensified implementation of the 2006 Maputo Plan of Action to reduce maternal, new-born and child mortality in Africa. CARMMA was designed to bring MNCH issues to the forefront of the agenda of African member states. Launched on the 7th May 2009, during the 4th Session of the Conference of AU Ministers of Health (CAMH4) held in Addis Ababa, Ethiopia, the campaign's slogan was: 'Africa Cares: No Woman Should Die while Giving Life'. CARMMA serves as a platform for advocating in favor of improvements in MNCH. The campaign was designed to use **policy dialogue**, **advocacy** and **community mobilization** to secure political commitment, increase resources (particularly domestic financing and investment) and solicit societal and behavioral change in support of MNCH. It was a country -driven undertaking that AU member states were expected to launch and develop follow-up implementation plans to monitor progress.

25 In each of the member states key stakeholders and influential personalities were involved in the national launches as an effort to obtain very high political commitment. Key stakeholders of the campaign included the AUC; national governments (presidents, first ladies, ministers, parliamentarians); birth attendants; community health workers, doctors, nurses and midwives. Other stakeholders included several UN agencies – WHO, UNICEF, UNFPA, the joint United Nations Programme on HIV and AIDS, United Nations Development Fund for Women and the World Bank – as well as bilateral partners (United States Agency for International Development (USAID), Department for International Development (DFID), civil society organizations (International Planned Parenthood Federation, White Ribbon Alliance), academia, community and religious leaders, professional associations, artists, media, the private sector and society at large.

26 The expectation was that the national launches would trigger concerted and increased action to improve MNCH and survival across the continent. The campaign's vision was to build on existing MNCH efforts across Africa, particularly through the sharing of best practices, generation and sharing data on MNCH, advocacy for increased political commitment and the mobilization of domestic resources and investment in support of MNCH. It was additionally, expected that the campaign would mobilize, wider African public and inspire them into action for MNCH. The campaign was anchored on three communication pillars:

1. Positive messaging
2. Sharing good practices and lessons learned
3. Scaled-up programme and communication activities

27 The main objective of the campaign was to expand the availability and use of universally accessible quality health services, including those related to SRH that are critical for the reduction of maternal and child mortality. The focus was not on developing new strategies and plans, but rather on ensuring coordination and effective implementation of existing ones to renew and strengthen efforts to save women's lives. The campaign called for ensuring accountability: every single loss of a mother's or child's life should be accounted for. CARMMA's main focus areas were:

a) Building on existing efforts, particularly best practices
b) Generating and providing data on maternal, new-born and child health
c) Soliciting stakeholder goodwill, increasing political commitment and mobilizing domestic resources in support of MNCH
d) Accelerating actions to reduce maternal and infant mortality in Africa.

28 Since the initial launch of the CARMMA in 2009 fifty (50) AU member states have launched the campaign by 2018.

Communication and strategic design of the CARMMA initiative

29 The AUC designed a communication and resource mobilization strategy to guide CARMMA implementation. The framework was designed to be participatory and results-focused. Key elements of the strategy included:

✓ Policy, programme and media advocacy

✓ Behavior-change communication aimed at increased knowledge, community efficacy and behavior change

✓ Social mobilization for enhanced stakeholder involvement, community empowerment and social change

✓ Resource mobilization to attract funding for the campaign.

The expected programmatic campaign results are outlined in box 3. The main outputs were to be:

✓ Develop and disseminate advocacy kits

✓ Develop a CARMMA pre-launch road map

Box 3: Expected Campaign Results

✓ Meeting technical needs of member states' national MNCH programmes

✓ Establishment of maternal death review committees/systems in member states

✓ Meeting technical needs of regional economic communities

✓ Sustained implementation of the MPoA in member states

✓ Integration of MPoA in reproductive health programmes of all member states

✓ Increased SRH resources in AU member states

- ✓ Launch and post-launch implementation in all member states
- ✓ Ensure that best practices in SRHR are shared among member states and cooperating stakeholders
- ✓ Develop an information centre and MNCH/CARMMA database.

30 The main target audiences for CARMMA advocacy included: policy and decision makers at the national, regional and global levels; institutions and communities; media professionals; women and adolescent girls directly affected by the risks of pregnancy and childbirth; service providers and programme managers. Secondary audiences were peers, community leaders, religious leaders and the media, which indirectly influences pregnant women and adolescent girls.

31 The advocacy campaign was based on behavior and social change initiatives underpinned by several behavioral models, such as the: health beliefs model, theory of reasoned action, social ecological model, diffusion of innovations, social learning theory, theory of gender and power and the trans- theoretical model or stages of change. CARMMA deliberately incorporated several social change communication and development theories, concepts, approaches and methodologies.

32 The CARMMA campaign aimed to address the multiple levels of influence recognized by the socio-ecological model; that is, individual, interpersonal, organizational, community and public policy (Figure 1). At the individual level, CARMMA sought to engage national counterparts, especially ministries of health, to raise awareness, increase knowledge, influence attitudes, challenge incorrect and inappropriate beliefs and motivate people to adopt desired behavioral changes. At the interpersonal level, CARMMA sought to engage counterparts in member states to influence change at the interpersonal or family level.

33 At the organizational level, CARMMA was to engage country counterparts and other institutional partners for resource support and organizational behavior change. At the local level, by working through member states CARMMA aimed to mobilize community resources and encourage the adoption of behaviors leading to improved MNCH and lower maternal and child mortality.

34 Finally, in the public domain CARMMA was to engage country counterparts to develop and implement policies that support the campaign.

Figure 1 Ecological model used to drive the CARMMA campaign:

CHAPTER TWO: PURPOSE, METHODS AND SCOPE OF EVALUATION

35 The purpose of this evaluation is to determine the **relevance**, **appropriateness**, **effectiveness**, **efficiency**, **impact** and **sustainability** of the CARMMA campaign. In addition, the evaluation is intended to determine how the campaign should move forward in the context of Africa's transformative Agenda 2063, the global sustainable Agenda 2030, the UN Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health and other related global initiatives.

Specific objectives

36 The specific objectives of the CARMMA evaluation are to:

i. Determine whether campaign objectives, outcomes and impact were achieved

ii. Assess the effectiveness of the campaign's focus, structure, ownership and coordination arrangements

iii. Detail the opportunities, challenges and lessons learnt in implementing the campaign at the continental, regional and country levels

iv. Assess the policy and practice implications of the campaign at the continental, regional and country levels

v. Make recommendations on technical and structural adjustments to the campaign to effectively contribute to the attainment of Agenda 2063, Agenda 2030, the UN Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health and other global commitments.

Methods

37 A mixed-method approach, involving both quantitative and qualitative research, was used for this evaluation. Methods included document review, secondary analysis of existing data and key informant interviews. The process was guided by the following research questions:

i. To what extent have campaign objectives, outcomes and impacts been achieved?

ii. How effective were the campaign's focus, structure, ownership and coordination arrangements for implementation of the initiative?

iii. What are the lessons learnt, opportunities and challenges for implementing the campaign at the continental, regional and country levels?

iv. What are the key policy and practice implications of the campaign that can contribute towards informing future strategies, including Agenda 2063, Agenda 2030, the UN Secretary-General's Global Strategy on Women's, Children's and Adolescents Health and other global commitments?

38 For each evaluation objective, the following information was sought:

Objective 1: Determine whether campaign objectives, outcomes and impact were achieved

a) The main outputs, outcomes and impacts that can be attributed to the campaign
b) New information, evidence gathered or generated by the campaign
c) How the campaign strengthened AU work in MNCH
d) How appropriate were the implemented activities in addressing the campaign purpose, objective and outputs?

Objective 2: Determine the effectiveness of the campaign focus, structure, ownership and coordination arrangements

a) How appropriate were the campaign's management tools for meeting existing challenges?
b) How appropriate were the campaign's coordination and governance structures for meeting its objectives? What could be improved?

c) Assess the various organizations' roles and performance as implementation agencies

Objective 3: Detail the opportunities, challenges and lessons learnt in implementing the campaign at continental, regional and country levels

a) What were the main challenges to implementing the campaign?
b) What were the opportunities?
c) Lessons learnt and best practices

Objective 4: Determine the policy and practice implications of the campaign at continental, regional and country levels

a) Was new ground broken in terms of policy, practice or influence on member states and key partners relevant to the campaign?
b) Were campaign structures adequate to influence MNCH policy and practice on the continent?

Objective 5: To make recommendations on technical and structural adjustments to the campaign to effectively contribute to the attainment of Agenda 2063, Agenda 2030, UN Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health as well as any other global commitments.

a) Changes that need to be made in campaign design and implementation to be in line with Agenda 2063, AU health policy documents and other global commitments
b) Recommendations for future continental campaigns.

Document review

39 A review of documents was conducted to enable an assessment of CARMMA initiative implementation, using seven main sets of documents.

i. AUC continental policies, including CARMMA programme documents that provided insights related to the campaign's design, strategic direction, objectives, aim and mission
ii. Launch reports and previous reviews of CARMMA, including M&E documents and work plan for the campaign, which provided information on country-specific launches, individual country focus and progress to date.
iii. Other global or regional policy instruments and initiatives (including MNCH and related programme initiatives, such as the AU Campaign to End Child Marriage, Every Woman Every Child and the PMNCH, among others). Policy instruments included Agenda 2063, the African Health Strategy and the MPoA SRHR continental policy framework, African Regional Nutrition Strategy, Pharmaceutical Manufacturing Plan for Africa, Catalytic framework to end AIDS and TB and eliminate malaria by 2030, along with other relevant AU health policy instruments and global MNCH commitments
iv. Health status reports, which enabled an assessment of health system indicators that are not generated using routine data systems

v. Quantitative datasets from various sources, including demographic and health survey (DHS) reports, World Bank reports and estimates from various countries. Data were validated by contacting ministries of health to provide the latest estimates, where appropriate.
vi. Review of published literature on MNCH, to place the issues in context. The literature helped to identify the current state of MNCH on the continent and potential focus areas for the next phase of the campaign
vii. AU decisions made through various assemblies. Sixty-eight decisions made since 1963 were reviewed, 30 of which were health-related and seven directly linked to the MNCH, with implications for the CARMMA campaign. A synthesis of these decisions was useful for tracking progress made, action points in support of the campaign and administrative decisions made regarding MNCH for the African continent. A summary of these decisions is presented in Annex 1.

40 Where appropriate, a document review template was used to extract relevant information synthesized for this report.

Review of secondary data and analysis

41 To assess progress and impact of the CARMMA initiative, a core list of indicators was used to generate data used for the evaluation. The list is based on internal consensus within the AUC on how to monitor progress for various initiatives. Annex 2 provides a summary of core indicators, some of which were used for this report. Most of the indicators were used in the CARMMA dashboard and cut across various programme areas. They are clustered around the three main areas presented in table 1 (Annex).

42 A series of reviews were carried out on the data available from public sources, such as DHS, AUC online data platform and international databases compiled by partners such as the World Bank and UNFPA. The data was subjected to a validation process by countries for their concurrence, and analyzed to provide a description of the status of indicators across countries. A comparative analysis of the 48 African countries that are part of the CARMMA initiative was conducted. Although causal linkage was not designed for this analysis, the evaluation provides a description of status, compared with set SDG targets where applicable, combined with stakeholder views on the initiative's impact, which helped to gauge the campaign's contribution to MNCH status on the continent.

Key informant interviews

43 To fill gaps of the literature and data review, interviews with key personnel were conducted, including: three current and four former AU staff, UNFPA regional and country office staff and ministry of health officials from selected member states (taking into account the 5 regions of Africa) as well as strategic persons and institutions on the African continent who possess vital information on the progress and lessons that can be generated for future design of the campaign.

44 Key informant interviews were also carried out with the management of the AU's Department of Social Affairs, including both its current and former commissioners and the director and head of the division, to obtain first-hand information on the campaign's background, experiences, successes, failures, lessons and future.

45 Interviews were also conducted with key partners, such as UNFPA, in regional offices as they were instrumental in supporting country teams and ministries of health. The cluster of interviews was grouped into three main regions:

i. West and Central Africa: Three interviews with key informants were conducted to represent the region, including interviews member states

ii. North Africa: Three interviews with key informants, including interviews with one member state

iii. Eastern and Southern Africa: Ten interviews with key informants, representing both partners and member states

iv. Interviews were conducted via phone calls, Skype or face-to-face. They were conducted either in UNFPA regional offices, coupled with collection of secondary data, or on Skype or phone calls from various locations. The tools used for this assessment are presented in Annex 3. Table 2 presents a summary of the key informants interviewed.

Data management and analysis

46 The data and information gathered from document reviews, multi-country data sets and key informants was collated, and where applicable verified for accuracy before analysis. Quantitative data was analyzed using Stata 14. A descriptive analysis of the indicators by thematic area was carried out to illustrate progress made by member countries with respect to the indicators. Specifically, comparative analysis was used to compare maternal mortality between 2009 and 2016 to illustrate strides made.

47 Qualitative data was organized using NVIVO 11 software and analyzed thematically. Analysis of qualitative data entailed managing the text data through use of audio recorders that were transcribed and typed into Microsoft Word software. Informal analysis was conducted, and summaries of the collected data were drafted after each session for clarification or follow-up. Preliminary analysis entailed open coding and progressive categorization of issues based on inductive (where analytical categories derived gradually from the data) and deductive approaches (where ideas from the interview schedule will shape the coding scheme). These categories (themes) were further modified as more issues were examined using the data. The iterative approach involved successively more focused rounds of coding text, followed by writing memos to explore themes and identify relations among themes or categories and linking themes to building analytical models. Categories derived

from the data were further analyzed through the development of analysis charts. At this stage, triangulation of data was enhanced through comparisons of analysis charts within and across regions to look for similarities and differences to support identification of key issues around the focus of the assessment. Final analysis was organized around a description of the main issues identified. A range of analysis was prepared to examine experience within and across sites. Key experiences and lessons learnt were also documented as part of the evaluation report.

CHAPTER THREE: KEY FINDINGS

The Implementation of the CARMMA CAMPAIGN

1. Campaign activities and outputs

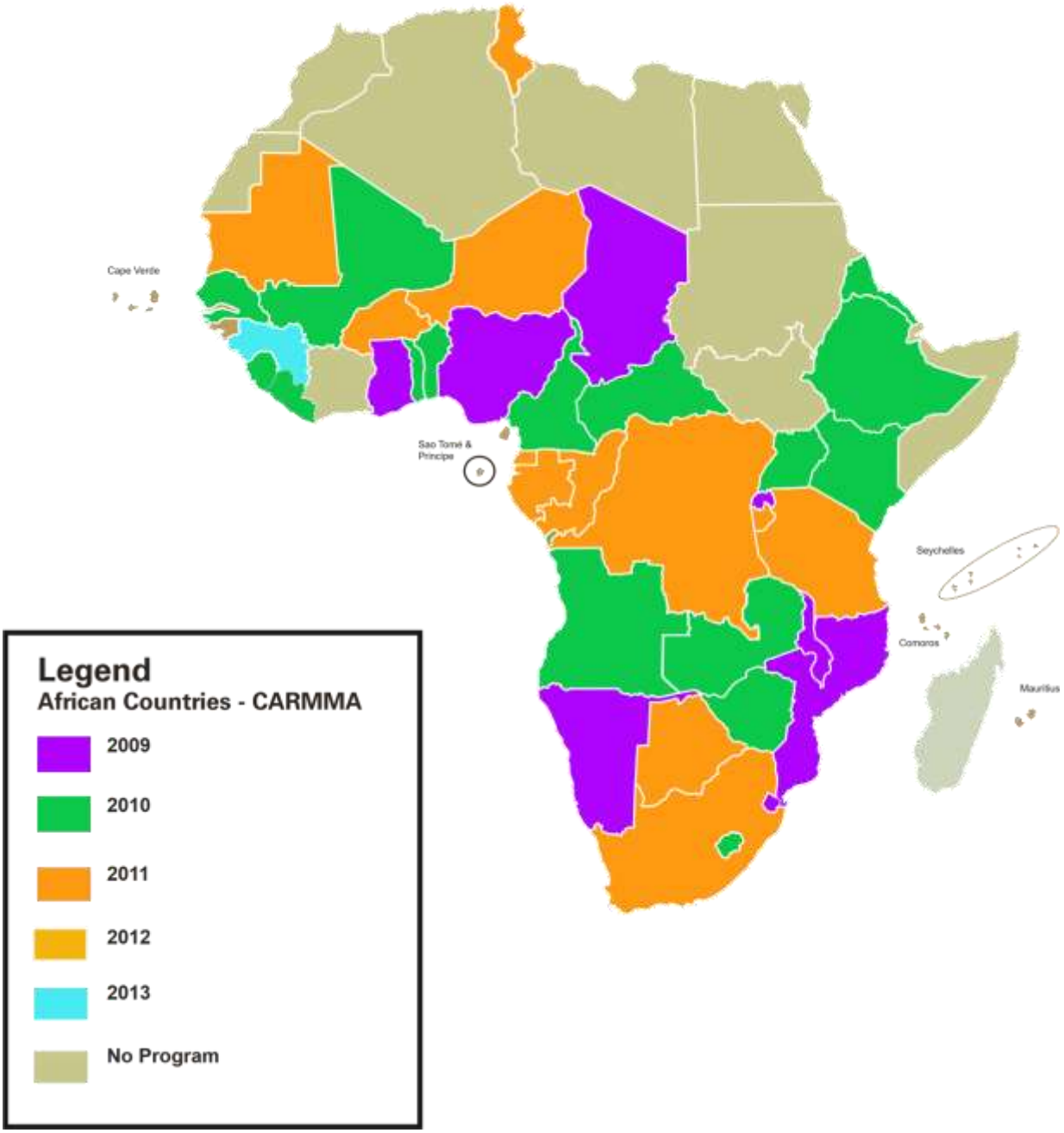
i. Actions to reduce maternal and infant mortality in Africa at national level

48 The CARMMA initiative was launched in 2009, in eight high-burden member states with very high maternal mortality rates (Chad, The Kingdom of Eswatini, Ghana, Malawi, Mozambique, Namibia, Nigeria, and Rwanda). These countries were selected for the initial launch of the campaign as a priority. The criteria for selection included high mortality rates; low gender development indexes; high political commitment, that was measured by resource allocation and leadership; Selection was also from the five regions of the Africa Union, in order to ensure regional balance, as was the strong presence of UNFPA country offices and other agencies with the capacity to support country-driven efforts to accelerate maternal mortality reduction.

49 In 2010, nineteen (19) member states launched CARMMA (Angola, Benin, Cameroon, Central African Republic, Eritrea, Ethiopia, Gambia, Guinea Bissau, Kenya, Lesotho, Liberia, Mali, Republic of Congo, Senegal, Sierra Leone, Togo, Uganda, Zambia and Zimbabwe).

50 Eleven (11) more member states launched the campaign in 2011 (Burkina Faso, Burundi, Botswana, DRC, Equatorial Guinea, Gabon, Mauritania, Niger, South Africa, Tanzania and Tunisia). In 2013 three (3) Comoros, Côte d'Ivoire, Guinea and Seychelles launched CARMMA. Madagascar and Somalia, launched in 2014, Djibouti in 2015 and Mauritius in 2016, Sudan and Cape Verde, launched in 2017 and Algeria and the Saharawi Arab Democratic Republic, launched in 2018. The Saharawi Arab Democratic Republic being the 50th member state of the Africa Union to launch the initiative. Figure 2 provides a graphic view of when countries launched the initiative.

Figure 2. Years and Countries that launched CARMMA-



51 Discussion with key informants indicated that the motivation behind establishing CARMMA was to provide a platform for placing maternal and child health issues on political agendas. One informant noted: "*The motivation was to provide a basis to showcase the importance for maternal health and how that benefits countries. It showed that the government should be at the driving seat." (*Key informant 1) The underlying philosophy of the initiative was "*to motivate us to ensure that a*

*woman giving birth to another life should not die, and I feel we have tried to put it there". (*Key informant 2)

52 Essentially, the idea of the CARMMA campaign was to ensure that the health system was strengthened to support the provision of maternal health services, as articulated by an informant: "*We cannot continue with the status quo and this does not cost a lot. It's a matter of organization to put in place quality services with human resource, you know qualified human resource have the skill that a midwife need, but also an enabling environment. Putting this together can help us, you know, reduce but also accelerate the reduction of mortality. Because it is doable, it is possible other countries have done it, why not ours?" (*Key informant 3)

53 In the initial stages, one success of the campaign was the national launches. After the launch, member states implemented several initiatives, some of which fell within their strategic policies, while in other cases the launch provided political leverage needed to spearhead MNCH issues. Governments were expected to commit resources for maternal health programmes aligned to contextual challenges.

54 In the DRC, the launch of CARMMA included mini-launches in four regions and provided an advocacy platform to reprioritize planning and the implementation of the DRC roadmap for MNCH

55 Chad, Malawi, Nigeria, Rwanda and Zambia launched CARMMA in all districts/ states in country. Chad leveraged the launch of CARMMA to coincide with activities of the Campaign to End Violence against Women, and to raise funds for maternal mortality reduction through pledges. Malawi adopted district hospitals for health system strengthening in partnership with the private sector. In Rwanda, with support from UNFPA and the White Ribbon Alliance, the Ministry of Health launched CARMMA in seven districts in 2010. In Zambia, CARMMA was launched in more than 23 districts and 50 parliamentarians were sensitized on maternal health issues, and lobbied to allocate at least 15 per cent of the national budget for health. This resulted in Zambian parliamentarians agreeing to a motion to establish of an HIV/AIDS Fund because of the link between HIV and maternal deaths.

56 Examples from other member states include:

- Angola focused on the automation of data to track maternal deaths. The Angola government established CARMMA committees that had both political and technical membership that meet twice a year to review progress. The technical team is led by the minister of health. The CARMMA committees were established to ensure that maternal deaths were reported maternal death within 24 hours. Activities of the committee also included training and advocacy at the provincial and national level to offer support in conducting maternal death reviews.

- The Central African Republic organized follow-up meetings after the launch with various stakeholder groups (journalists, women leaders and others) to develop action plans for accelerated responses and ensure widespread engagement in maternal mortality reduction efforts.
- Ethiopia focused on developing human resources for health to alleviate the skilled birth attendance challenge by training more midwives, task shifting and recruiting community health volunteers, which contributed to some improvement in skilled delivery –resulting in lower maternal mortality over time.
- In Eritrea, the use of maternity waiting homes, coupled with training and the use of ambulances improved access to skilled birth services. The Kingdom of Eswatini institutionalized maternal mortality sensitive monitoring indicators during the launch of CARMMA. The Kingdom of Eswatini also conducted national sensitization campaigns and training on CARMMA for traditional healers, religious leaders and nurse managers. The supervision of health care workers in the execution of their duties related to maternal health was strengthened. In addition an advocacy officer was recruited to facilitate the implementation of Her Royal Highness' advocacy for CARMMA.
- In Sierra Leone it was agreed to provide free medical services for pregnant mothers and infants; district-by-district launches were planned and an additional component supported by UNFPA ('baby packs') were distributed to pregnant women. The baby packs consists of baby wrappers, baby under wears, soap, Vaseline, baby oil, napkins among others to encourage women to deliver at hospitals.

57 In countries with low maternal mortality, the focus was on ensuring that no mother dies during childbirth and reducing inequities associated with accessing care. A good example was in Mauritius, where MMR ratios are low (53 per 100 000 live births) and CARMMA focused on ensuring that no maternal deaths were experienced: "*Mauritius, with very low maternal mortality ratio, the lowest in our region but we look at it in terms of one death is too many deaths"*. *(*Key informant 1)

More details of country-specific activities are provided in Annex 4.

Box 4 highlights an example from South Africa, where the campaign was integrated into the national strategic plan for MNCH and Nutrition. Part of the national strategy was a

revised contraceptive policy and complementary clinical guidelines to strengthen service delivery as part of universal health coverage.

Box 4 Core focus areas for South Africa under CARMMA

Strengthen and promote access to comprehensive SRHR services, with specific focus on family planning services. Advocacy and health promotion for early antenatal care and attendance/booking

- ✓ Improving implementation of key family practices, including diarrhoea management at home
- ✓ Intensifying management of HIV-positive mothers and children by:
  - Improving access to treatment for both mothers and children
  - Improving management of co-infections and
  - Eliminating mother-to-child transmission of HIV
- ✓ Improve child survival by:
  - Promoting and supporting exclusive breastfeeding for at least six months
  - Providing facilities for lactating mothers (boarder mothers) in health facilities where children are admitted.
  - Promotion of Kangaroo Mother Care for stable low- birth weight babies at all levels of care
  - Advocacy for appropriate care and support for pregnant women and lactating mothers in the workplace
  - Improving immunization and vitamin A coverage
  - Intensifying management of severe malnutrition in health facilities.
  - Intensifying case management of sick children
- ✓ Strengthening human resources for maternal and child health by:
  - Providing training on essential steps in management of obstetric
  - emergencies to doctors and midwives
  - Intensifying midwifery education and training
- ✓ Improve access to skilled birth attendants by:
  - Allocating dedicated obstetric ambulances to every sub-district to ensure prompt transfer of women in labor and women and children with obstetric and neonatal emergencies to the appropriate level of care
  - Establishing maternity waiting homes

Box 5 illustrates the launch and post-launch experience of CARMMA in Equatorial Guinea.

58 The evaluation revealed that countries not only launched the CARMMA campaign

Box 5. Country launch in Equatorial Guinea

The Government and the First Lady of Equatorial Guinea organized the launch of CARMMA at a luncheon event before the OAFLAs 10th ordinary General Assembly in June 2011, in the context of the 17th ordinary session of the AU Assembly held in Malabo. The launch was officiated by the UNFPA's Executive Director, as one of three keynote speakers, along with the Minister of Health and the First Lady. The event attracted more than 500 people representing government, civil society organizations, the private sector and international NGOs. It was a wake-up call and a reminder to all of the road map for improving maternal and child health.

Post-launch efforts indicated that the Government budgeted more than US$2 million to implement the roadmap. Also, in 2016 the Government (through Decree number 41/2016 dated March 11), adopted short- and medium-term measures for the implementation of some social actions . Among them, the declaration of free maternity services for pregnant women in all public hospitals and health centres at the national level; this benefit extends from regular pre-natal consultations until 30 days after delivery, including Caesarean section, if necessary.

but more importantly, implemented post-launch activities that contributed to improve maternal and child health. Post-launch interventions took place at both at the policy and programmatic levels, and leveraged existing national structures and mechanisms, while also learning from experience and best practices from across the continent.

59 Although AU member states did not all implement standard interventions, AU policy instruments and commitments seem to have shaped the prioritization of interventions and their subsequent adaption to the country context. While some member states did not develop post-launch roadmaps as envisaged by CARMMA, adaptation of the MPoA and review of national policies and plans provided the necessary framework to support the implementation of post-launch activities.

60 The evaluation also found that the AUC was not directly involved in the planning and execution of national CARMMA launches in member states; instead, UN agencies (UNFPA, UNICEF and WHO) supported member states to launch CARMMA. While support from partners in an important campaign such as CARMMA is welcome, the positioning of the African Union at the periphery of the campaign in some member states limited the Commission's ability to articulate the goals, principles and expectations of the campaign – including the need for member states to prepare post-launch roadmaps to enable the Commission to routinely monitor, document and share experiences as part of its campaign mandate. This was further by compounded by the additional difficulty of the Commission to track the national-level implementation of CARMMA campaign due to the lean staffing of the AUC team leading the campaign and all the associated cost. Evidence gathered during this evaluation strongly suggests that member states that embraced the campaign and enjoyed political leadership and commitment made tremendous improvements

in their maternal and child health indicators. CARMMA national champions played a very critical role in maintaining the national focus on high-impact interventions to reduce maternal and child mortality. The case study presented in box 6 demonstrates how involving high-level champions led to the implementation of maternal death surveillance and response (MDSR) in Sierra Leone.

Box 6: Case study on MDSR implementation in Sierra Leone

Sierra Leone's Maternal Survival Action Network was established in May 2013 and a meeting was convened a year later, hosted by the Office of the First Lady. Strategic partners included the First Lady, UNAIDS, the Global Fund, the RCH Directorate and programme, Internal Rescue Committee, Health for All Coalition, Safe Blood Services and national MDR committee representatives. The meeting discussed potential actions based on MDR recommendations, including strengthening blood services to enable prompt access to safe blood transfusion. The meeting arrived at several recommendations, including some related to earmarking specific funding for blood services, drawing up comprehensive plans for services and advocacy, advocating for legislation and other implementation issues. Action Network activities also included helping the Office of the First Lady to set up district-level CARMMA communities to ensure action and response to MDR findings, as well as to promote better use of clinics and reporting of community maternal deaths. The implementation of MDSR was revitalized at the onset of the Ebola outbreak. Sierra Leone's national MDSR framework previously focused on facility-based MDR. A review of processes and challenges identified opportunities to strengthen MDRs and make better use of findings in facilities. The intention was to strengthen the system by identifying context-specific barriers and enablers to the use of MDR findings for quality of care improvements. In addition, in August 2015, the Ministry of Health and Sanitation launched 'National Maternal Death Surveillance and Response Technical Guidelines', broadening the focus and providing practical guidance for moving from the current focus on maternal death reviews to surveillance and response. The national MDSR committee was inaugurated in February 2016, and an orientation meeting took place that month. Key champions of maternal and neonatal health in Sierra Leone established an Action Network that is hosted by the CARMMA Initiative under the Office of the First Lady, for which Evidence for Action provided backend coordination and technical support. This network, championed by the First Lady herself, aimed to act as a catalyst for facilitating change and overcoming bottlenecks in areas where inadequate progress was being made on actions from MDR recommendations. By convening influencers and opinion-makers, the Network aimed to share national evidence, advocate for resource mobilization and ensure that other relevant high-impact interventions from MDR recommendations are carried out. (Details available online http://mdsr-action.net-case studies/maternal-survival-action-network for Sierra-Leone)

ii. Increasing political commitment and leadership and broadening partnerships for maternal and child health

61 CARMMA engaged African leaders at the highest level in a bid to solicit and sustain high-level political leadership and commitment to improve maternal and child health.

Political engagement at the highest level included the following:

62 The CARMMA continental launch in 2009, National launches by member states, the 15th Ordinary Session of the AU Assembly in 2010, held under the theme *'Maternal, Newborn and Child Health and Development in Africa by 2015'*. On the sidelines of the January 2013, 20th ordinary session of the Assembly of

Heads of State and Government, there was a luncheon event on CARMMA held under the theme 'Reinforcing the Campaign on Accelerated Reduction of Maternal Mortality in Africa'.

63 Other political platforms included the 4th, 5th and 6th Conference Of Health Minister's Sessions which were held in 2009, 2011 and 2013 respectively; the 1st and 2nd sessions of the Specialized Technical Committee on Health, Population and Drug Control which took place in 2015 and 2017 respectively (held under the themes 'Challenges for inclusive and universal access and 'Youth, health and development: overcoming the challenges towards harnessing the demographic dividend' respectively); the Abuja +12 extra-ordinary session of the AU Assembly in 2013 (held under the theme 'Ownership, Accountability and Sustainability of HIV/AIDS, Tuberculosis and Malaria Response in Africa: Past, Present and the Future'); the 2013 (held under the theme 'A call to Action') and 2018 (held under the theme 'Maintaining momentum and focus towards ending preventable maternal, child and adolescent deaths by 2030 – a sustainable path towards Africa's transformation' respectively) International Conference on MNCH in Africa.

64 Other platforms that brought together Heads of State and Governments, ministers, other senior officials and partners to discuss the status of MNCH on the continent and commit to taking action to improve the lives of mothers and children and the annual CARMMA Week celebrations are some of the activities that brought together Heads of State and Governments, ministers, other senior officials and partners to discuss the status of MNCH on the continent and commit to taking action to improve the lives of mothers and children.

65 These three high-level events provided African Heads of State and Government an opportunity to deliberate on progress in maternal and child health, identify challenges and share experiences. African leaders committed, among other things, to provide national leadership and stewardship, implement high-impact interventions, put in place measures to ensure that the death of mothers and children are accounted for and sustainably increase financial resources for health. The meetings were attended by the highest office-holders on the African continent, which helped to explain the popularity enjoyed by the campaign across the continent. These forums drew the attention of government leaders to the poor health status of African mothers and children and the importance of taking the lead and acting decisively to improve this situation. A key achievement of the forums was the collective voice, commitment and leadership of African leaders to improve maternal and child health.

66 While some African leaders followed through on their commitments and championed implementation of interventions, to reduce maternal and child mortality, in their respective countries, others did little. Lack of a monitoring mechanism meant that the Commission could not assess implementation levels. The AUC thus lost an important opportunity to hold African leaders to account for their commitment to accelerate improvements in health across the continent.

a. The CARMMA launches

67 The continental CARMMA launch was in 2009, followed by national launches that spanned a period of over eight years. Many of these launches were attended by many of Africa's most eminent and influential personalities . The CARMMA champions are highly respected sons and daughters of the continent that wield enormous power and influence on critical issues affecting Africa. By supporting CARMMA, the champions made a bold statement that the continent was ready to address the high maternal, new-born and child mortality. At the national level, some launches were officiated by First Ladies, who subsequently became CARMMA national champions. By voicing their support for CARMMA, the First Ladies (considered in most countries as the mothers of the nation) sent a very strong signal of national resolve to address maternal, new-born and child deaths. The success recorded by CARMMA's national activities is in part attributable to the concerted effort by First Ladies to champion improved access to health services and fight social against injustice suffered by women, children and adolescents.

b. Conference of African Union Ministers of Health, the Sessions of Specialized Technical Committee on Health, Population and Drug Control Joint and 1st Joint AUC and WHO African Ministers of Health meeting.

68 The campaign was launched during the 4th Session of the Conference of African Union Ministers of Health and discussed during the 5th and 6th sessions, convened in 2011 and 2013 respectively. Ministers on both occasions deliberated on the continent's maternal, neonatal and child health situation and made recommendations, aimed at improving the health status of mothers, new-born and children. One of the key recommendations arising from these sessions was the inclusion of new-born and child health as part of the campaign(EX.CL/Dec.743(XXII))

69 Restructuring of the AU in 2014 resulted in the Conference of African Union Ministers of Health, replaced by the Specialized Technical Committee on Health, Population and Drug control (STC-HPDC) Assembly/AU/Dec.365(XVII). Following the restructuring, the Commission held its first and second sessions of the new STC-HPDC in (2015 and 2017) respectively and MNCH was on the agenda. The ministerial meetings happened at a very crucial period, when the continent was transitioning from the MDGs to the SDGs. The sessions provided the ministers with a unique opportunity to review progress made in achieving the MDGs

in general; particularly MDGs 4, 5 and 6. Although the continent did not broadly and collectively achieve MDGs 4 and 5, the ministers noted that tremendous improvements in maternal, new-born and child health had been registered. They also noted that maternal, new-born, child and adolescent health remained unfinished business in Africa, and that much needed to be done to achieve the SDGs. The ministers adopted the revised African Union health policy instruments and extended the campaign to 2030, in line with the SDGs EX.CL/Dec.970(XXXI).

70 The WHO African Ministers of Health meeting held in Luanda, Angola, in 2014 is an excellent example of effective partnership for enhanced coherence, synergy and efficiency. The meeting resulted in a draft known as the Luanda Declaration (AUC/WHO/2014/Doc.4) in which ministers of health too ending preventable maternal and child deaths in Africa by 2030. In addition, Ministers of Health deliberated on a mechanism to assess the implementation of declarations and other commitments made by African Ministers of Health, culminating in a commitment to establish an accountability mechanism. The accountability mechanism aimed to contribute to improving the effectiveness, efficiency, impact and sustainability of commitments made by African Ministers of Health. The joint ministerial meeting was a welcome initiative that should be encouraged, as the meeting brought together two critical institutions with mandates to champion health in Africa (The AUC and WHO). The evaluation established that this joint meeting, scheduled to be convened every two years, was not held in 2016. The AUC, however continued to make progress in establishing an accountability mechanism for the monitoring its health policy instruments.

71 Ministerial meetings are considered one of the most appropriate forums to discuss maternal, new-born and child health, as commitments and decisions made at these meetings have a high probability of being implemented. The first joint AU/WHO ministerial meeting, that took place in 2014, in Luanda, Angola, presented a good opportunity for collective decisions and actions on matters relating to women's and children's health. The evaluation found that STC-HPDC meetings had poor representation at the ministerial level, further limiting the ability for African ministers of Health to collectively take decisions on matters related to the MNCH agenda.

72 The CARMMA campaign can however, be credited for the national ownership of the campaign and for substantially broadening and strengthening partnerships to improve maternal and child health at both the continental and national levels. The AUC worked closely with a range of partners, including UN agencies and international and local NGOs, and other partners in implementing CARMMA at the national level. This is a best practice that is emphasized, as the campaign seeks to contribute towards the achievement of the global sustainable development commitments and Africa's Transformational Agenda 2063, particularly those on health and of women, children and adolescents in particular. A key gap

of the campaign, however, was the low-key involvement of AU recognized RECs and the private sector. Failure to include RECs may be attributable to lack of adequate coordination between the AUC campaign team and RECs, varying interest of the RECs and the challenging political landscape facing REC's. However, as the campaign opens a new chapter these critical partners should be taken on board, as initially intended, and a mechanism for their engagement defined – as this would reduce the logistical effort required to coordinate the campaign in the region.

A. Sharing of experiences and best practices

73 A key CARMMA deliverable was to advocate for and facilitate the sharing of experiences and best practices across the continent. The campaign employed several approaches and acted as an important platform for learning and sharing of information on maternal and child health, not only for political leaders, but also the public. The following achievements can be cited:

a) CARMMA website and social media

75 The CARMMA website www.carmma.org launched in 2012 has served as a critical communication and advocacy tool promoting maternal and newborn survival strategies and providing evidence on the progress toward achieving the targets set by African leaders. It is an important go-to website for information on what is happening across the continent, with regard to maternal and child health. The evaluation could not ascertain figures on traffic to the websites, as data on website analytics was not available, although information from key informants did indicate that the site was popular across the continent. However, the evaluation found that the website is not regularly updated: some outdated information remains on the site and some recent information is missing. It was also noted that the site experiences some downtime, as it was not always available.

76 The use of social media tools such as Facebook (CARMMAfrica) and Twitter @CARMMAfrica were also documented by the evaluation. Both CARMMA accounts were active at the time of the evaluation. The tools are linked to the website; however the evaluation could not ascertain the number of followers or the effectiveness of the tools in sharing experiences and best practices.

b) Platforms for MNCH

i. The Maternal Newborn and Child Health(MNCH) Task Force

77 In 2013, the Commission established the MNCH Taskforce, the MNCH Taskforce plays a pivotal role in guiding the MNCH activities of the campaign. It spearheaded the finalization of the indicators for monitoring implementation of the MPoA and CARMMA.

The taskforce identified a total of 34 indicators for monitoring the MPoA, 13 indicators for monitoring CARMMA and 10 indicators for the MNCH scorecard.The evaluation could not document any other meeting of the taskforce other than the inaugural meeting in 2013. The taskforce was not fully operational at both the technical and political largely due to lack of financial resources.

ii. CARMMA Week commemorations

78 CARMMA Week commemorations endorsed by Executive Council(EX.CL/Dec.649(XIX)) and AU Assembly (Assembly/AU/Dec.680(XXX)) decisions have been commemorated since 2011, the week-long events are celebrated in the month of November.

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79 Available data indicates that CARMMA Week was commemorated in 2014, 2015, 2016, 2017 and 2018. The event has helped to sustain campaign momentum at both the continental and national levels. CARMMA week commemorations have also been used to launch CARMMA at the national level with a focus on campaign objectives of the CARMMA campaign. For example, In 2011, the CARMMA week celebrated in Tunisia provided a platform to strengthen South-South cooperation and experience sharing at the ministerial level amongst member states, in 2014 the event was used to launch the online health data platform in Addis Ababa, and in 2016 the launch of CARMMA in Mauritius brought together all the Island states to discuss their progress and challenges as Island states. In 2017, the week was celebrated in Ghana and the focus was a twin city event that was held in the cities of Accra (the capital) and Kumasi (Ghana's second city). The event was used to bring together academia, cultural, religious and traditional leaders, civil society to focus on the issue of maternal, newborn, child stand adolescent health. The Ghana CARMMA week commemoration was also used in Accra, to highlight Female Genital Mutilation a harmful practice that contributes to maternal mortality. In 2018, the celebration was a twin country event that was celebrated in Algeria and the Saharawi Arab Democratic Republic. Algeria used the opportunity to launch CARMMA and showcase the progress it had made in the provision of MNCH at the national and community level, while the Saharawi Arab Democratic Republic becoming the 50th country to launch CARMMA, used the opportunity of its launch of CARMMA to show case the progress it had made in spite of the challenges of providing MNCH services in challenging circumstances.

80 Existing evidence clearly indicates that continent-wide, CARMMA Week commemorations spearheaded by the Commission, partners and the host member state provided an exceptional opportunity to share experiences and best practices, motivating countries to double their efforts to reduce maternal and child

mortality. In addition, the event also encourages member states that have not launched CARMMA to do so. The evaluation, however, did not find documentation on national -level events commemorating CARMMA Week. This was a missed opportunity that could have enhanced experience-sharing nationally and between member states and potentially sustained momentum on the campaign, resulting in better health outcomes for mothers and children. Moving forward perhaps the week could be organized around themes related to the indicators being tracked for progress to gain meaningful impact in member states.

iii. International Conference on Maternal, New-born and Child Health in Africa(IMNCH)

78 The International Conference on Maternal, New-born and Child Health in Africa was the perhaps the most significant event dedicated to discussing MNCH issues. It is also a strong reminder of what can be achieved when member states take centre stage in the implementation of AU initiatives. The first international multi-sectorial and action-oriented event, hosted by the Commission and the Government of South Africa in 2013 , brought together heads of state and government, policy makers and experts from AU member states, UN agencies, multilateral and bilateral development partners and civil society organizations. The first IMNCH conference took stock of the progress made in addressing MNCH issues; highlighted prevailing challenges and forged collective resolve in preparation for the post-2015 development agenda. The conference also launch the Mama Afrika Award, designed to recognize key personalities and organizations that have made a significant contribution to reducing maternal, new born and child morbidity and mortality. The conference ended with an action plan for 'Ending Preventable Maternal, New-born and Child Mortality'.

79 Analysis of the three-day IMNCH conference revealed a very dense agenda, with four parallel sessions per day and several plenary sessions. This packed agenda may not have allowed time for insightful discussions. In addition, a very broad agenda risks losing specificity and focus. Despite these risks, the conference resulted in an action plan. Though actionable, the plan was very broad and did not pinpoint critical issues that would have a strong impact on maternal and child mortality. Although the Commission initially tried to monitor implementation of the plan, in the end there was little to show since member states and other key stakeholders did not share reports with the Commission, as required. Evidence available shows that the conference was supposed to be held every two years. The second conference was eventually held in Nairobi, Kenya in October 2018. The conference which was well attended concluded with the need for an accountability framework to monitor and follow up on progress of member states. The inability to convene the second conference in 2015 and keep to the time schedules, denied the Commission the opportunity to share experiences and showcase gains on the continent on a regular basis.

80 Moving forward member states will need to agree on reasonable timelines for the hosting of the MNCH Task Force and the International conference on maternal newborn and child health.

c) CARMMA reports, Compendium of policy briefs and best practices and Newsletters

The Maternal Newborn and Child Health (MNCH) Status Report

81 Pursuant to the declaration of the 15th ordinary session of the AU Assembly (Assembly/AU/Decl.1(XI)), the AUC prepared three annual MNCH status reports, for 2012, 2013 and 2014. The reports detail the maternal and child health situation on the continent and make recommendations for improvements. The status reports also documents the challenges, experiences and lessons learned on the continent. Consideration of the reports by ministers, and their eventual adoption by Heads of state and Government, ensures the highest endorsement of the reports. These reports are also available on the CARMMA website, making them available to the wider African public. The Status Reports have resulted in recommendations for improved MNCH at the highest level. Discussions and recommendations around high-impact, low-cost MNCH interventions can be traced to the MNCH status reports.

82 Two national CARMMA reports were produced and published and a third edition of the report was in draft form at the time of this evaluation. The CARMMA national reports document experiences in maternal and child health and highlight some best practices. Although efforts were made to produce the report regularly, it was not possible, mainly due to lack of financial resources.

83 The Compendium of Policy Briefs and Best Practices is one of the activities that sought to directly enhance the sharing of best practices of member states across the continent. Although efforts to document best practices are laudable, the document was only produced in 2013 and there was no indication that subsequent reports were produced. As the curtain was drawn on the MDGs, the compendium of best practices would have been very handy to guide the continent on what worked, and should therefore be encouraged during the SDG period.

84 CARMMA monthly newsletters have been produced since CARMMA was launched, although not necessarily every month. The newsletter is published on the CARMMA website and widely disseminated to stakeholders electronically. Although newsletters are information products rather than avenues for sharing best practices, they still played a role in keeping the advocacy campaign vibrant.

85 The frequency of MNCH status reports was a key challenge. Although it is a good way to track progress, the timing between reports should be reviewed to ensure that they do not represent an administrative burden. For meaningful change, perhaps a minimum of three-to-five years would be ideal for generating the reports,

d) Generating and providing data on maternal, new-born and child health

86 The process of developing the M&E framework for the campaign began in 2011. In 2012 the process was completed and an 'Indicator Reference Guide' was developed, along with tools to facilitate monitoring and evaluation of the MPoA – and by extension the campaign.

87 In The MNCH Taskforce, spearheaded finalization of the indicators for monitoring implementation of the MPoA and CARMMA. The taskforce identified 34 indicators for monitoring the MPoA, 13 for monitoring CARMMA and 10 for the MNCH scorecard. A summary of the indicators is provided in table 3.

88 Based on these indicators, and cognizant of the need to prepare a broader and more comprehensive data platform, the Commission decided to include the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, TB and Malaria Services Indicators (Assembly/AU/Dec.291(XV)). Development of the online platform was completed and launched in 2014. The online health data platform 'African Health Stats' (www.africanhealthstats.org) a one-stop site for information on maternal, new-born and child health, HIV&AIDS, tuberculosis, malaria and health financing for all AU member states. The evaluation found that the site is active and shares information in a handy, simple and user-friendly format. Available evidence indicated that the platform was utilized by the Commission to assess expiring health policy documents and draft MNCH status reports. The evaluation also documented use of the platform by the media to inform the public.

89 The platform has become an important tool that provides data on the 55 African Union member states in a single portal. However, it does not have current data, some of which is dates back to 2008. Lack of recent data is likely to affect utilization of the platform, thereby limiting its great potential to act as an accountability and advocacy tool to catalyze action. In addition, platform indicators need to be updated and new indicators added to adequately monitor implementation of the SDGs.

90 The evaluation was informed of an ongoing process to harmonize health statistics in Africa as part of the broader 'strategy for harmonization of statistics in Africa'. Establishment of a health sub-group of the Specialized

Technical Group on Demography, Migration, Health, Human Development, Social Protection and Gender and a draft indicator reference manual for monitoring the African health strategy were the key outputs of this process. Harmonization of health statistics is a very important initiative that should be fully supported by the Commission and its partners.

Political decisions and their implications for the campaign

91 The evaluation also examined Assembly decisions of the Africa Union and the impact on the campaign. These include:

a) **Assembly of the African Union, Eleventh ordinary session, Sharm El-Sheikh, Egypt, 30 June–1 July 2008 (Assembly/AU/Dec.195 (XI)).** The session addressed the report on promoting MNCH in Africa. The Assembly reaffirmed its commitment to intensifying its leadership role and keeping the promotion of MNCH high on the continental agenda. It encouraged member states to institutionalize enquiries into maternal, infant and child deaths and submit periodic reports to the Commission, RECs and other relevant partners for assessment and analysis of progress and sharing of best practices. This Assembly set the standard for reporting on maternal deaths and audits.

b) **Assembly of the African Union, Twelfth ordinary session, Addis Ababa, Ethiopia, 1-3 February 2009 (Assembly/AU/Dec.216(XII))**. The assembly examined a report on the implementation status of the decision to promote MNCH in Africa. Among the resolutions passed was one reiterating the need for commitment to keeping maternal, infant and child health high on Africa's agenda for sustainable development through the implementation of all relevant national, regional, continental and global initiatives (such as International Conference on Population and Development Programmes of Action), the MDGs and the African health strategy (EX.CL/Dec.436 (XIII)), as well as the MPoA on sexual and reproductive health and rights (EX.CL/Dec.327(X)Rev.1).The decision refers to all past initiatives, maintaining the pace of the MNCH agenda.

c) **Assembly of the African Union, Twentieth ordinary session, Addis Ababa, Ethiopia, 27–28 January 2013 (Assembly/AU/Dec.461(XX)).** The decision on the reduction of maternal, new-born and child mortality and morbidity in Africa continued to reaffirm previous AU commitments, while underscoring those contained in the Maputo Plan of Action (MPoA); CARMMA; the Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and Other Related Infectious Diseases; and universal access to prevention, treatment and support services. It also reaffirmed commitments to redouble efforts to improve the health of African women and children, as spelled out in the

document ‘Actions on Maternal, New-born and Child Health and Development in Africa’. The decision also urged health ministers to examine progress toward maternal, new-born and child health; to map out concrete and innovative strategies at a larger scale to adequately address the health needs of African women and children; and to submit a report to the 21st ordinary session of the Assembly. The Assembly resulted in a useful role in ensuring that the CARMMA advocacy campaign remained central to African political leaders.

d) **Assembly of the African Union, Twenty-First ordinary session, Addis Ababa, Ethiopia, 26-27 May 2013 (Assembly/AU/Dec.477(XXI)).** This Assembly focused on effective implementation of the ‘Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa’ and reporting on progress made. A decision was made to include indicators for AIDS, TB and malaria and for MNCH in the African peer review mechanism, as part of accountability for the implementation of commitments undertaken. The session also requested the Commission to convene a meeting of the pharmaceutical manufacturing plan for Africa (PMPA) consortium, including Africa’s pharmaceutical private sector, during the Abuja+12 Special Summit on HIV/AIDS, TB & Malaria planned for Abuja, Nigeria, in July of that year. The relevance of this Assembly was twofold: it placed MNCH indicators on the continental platform for accountability and began to consolidate efforts to ensure that sufficient commodities are available through partnership with manufacturers and the private sector.

e) **Assembly of the African Union, Twenty-second ordinary session Addis Ababa, Ethiopia, 30-31 January 2014 (Assembly/AU/Dec.494(XXII)).** The Assembly on MNCH progress focused on the 2013 annual report on the status of MNCH in Africa and the report on the International Conference on Maternal, New-born and Child Health in Africa held in Johannesburg, South Africa, from 1 to 3 August 2013. As well as endorsing the recommendations contained in the 2013 annual report and action plan for ending preventable maternal, new-born and child mortality, the session endorsed the establishment of an annual award to recognize significant contributions or actions by individuals, organizations and governments in Africa to ending preventable maternal, new-born and child mortality and enhancing their survival and well-being. This session suggested that the award be named the ‘Mama Afrika Award’, in honor of Miriam Makeba.

f) **Assembly of the African Union, Twenty-third ordinary session, Malabo, Equatorial Guinea, 26-27 June 2014 (Assembly AU DECL 2 (XXIII)).** The Assembly focused on a report by AIDS Watch Africa discussing the progress report on implementation of the Pharmaceutical Manufacturing Plan for Africa (PMPA) business plan. Discussion also focused on the need to accelerate effective implementation of the Abuja Commitments on

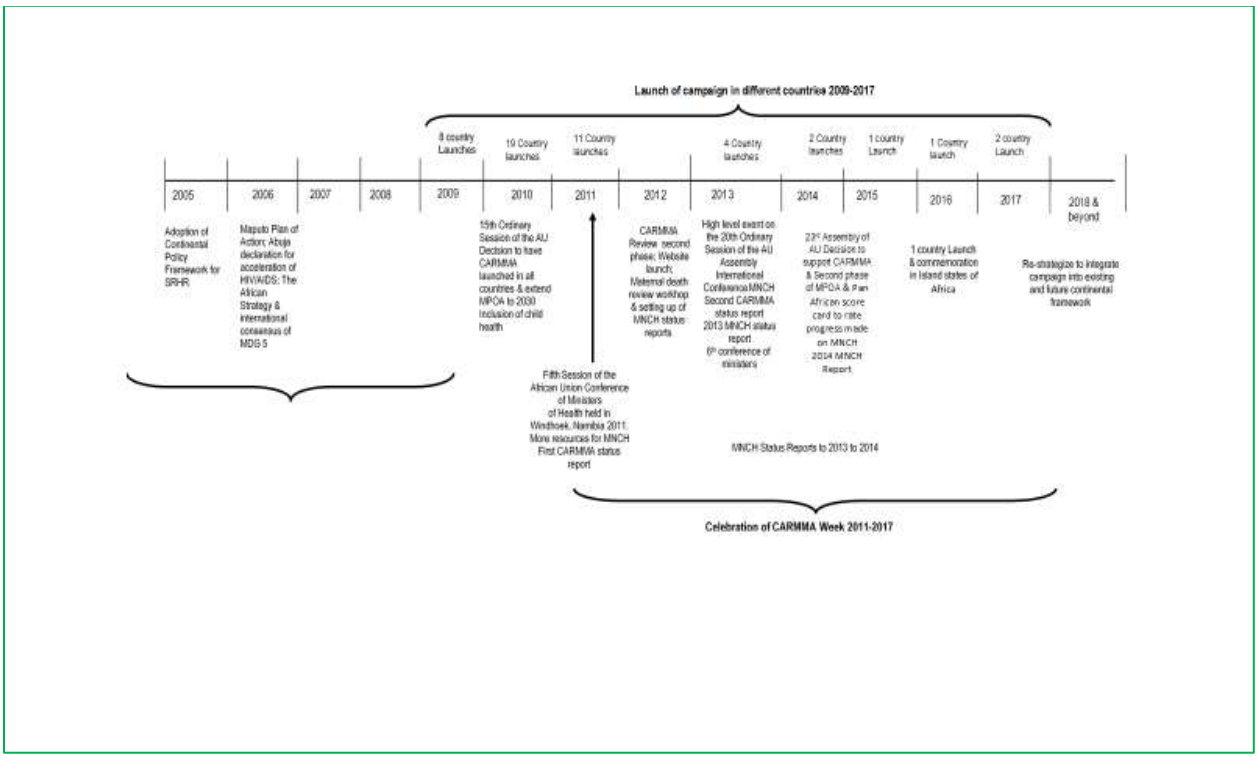
HIV/AIDS, TB & Malaria and all co-infections and on the AU Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa. The Assembly reaffirmed its commitment to accelerating domestic financing, including innovative mechanisms with annual increases in domestic funding and allocations to health. In terms of MNCH, the Assembly declared the need to end preventable child and maternal deaths by 2030, in line with Post-2015 Framework on Sustainable Development.

92 This was a significant decision as it led to the second-revised MPoA (2016-2030). There was mention of going beyond the health sector and investing in multi-sectorial programmes (such as education; empowerment of women and girls, climate change and water and sanitation) as well as supporting the development and adoption of a Pan-African MNCH scorecard to help the AU gauge and rate member states " progress on MNCH and to collaborate with RECs in following up on implementation of country roadmaps and reporting on achievements to the Assembly. The Assembly and the resulting decisions played a significant role in ensuring that the Africa MNCH was in line with new global initiatives.

93 While it is evident that the Assembly of AU Heads of State and Government provided a forum for ensuring that the campaign agenda was repeatedly emphasized, and that initiatives to improve its outcomes were discussed and passed, there was no clear process for monitoring the implementation of ministerial and assembly decisions that had been passed

Figure 3 provides highlights of the key activities that were implemented over the period under review, including the AU assembly meetings described above.

Figure 3. Key implementation milestones of CARMMA


Launch of campaign in different countries 2009-2017
8 country Launches
19 Country launches
11 Country launches
4 Country launches
2 Country launches
1 country Launch
1 Country launch
2 country Launch
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018 & beyond
Adoption of Continental Policy Framework for SRHR
Maputo Plan of Action; Abuja declaration for acceleration of HIV/AIDS; The African Strategy & international consensus of MDG 5
15th Ordinary Session of the AU Decision to have CARMMA launched in all countries & extend MPOA to 2030 inclusion of child health
CARMMA Review second phase; Website launch; Maternal death review workhop & setting up of MNCH status reports
High level event on the 20th Ordinary Session of the AU Assembly International Conference MNCH Second CARMMA status report 2013 MNCH status report 6th conference of ministers
22nd Assembly of AU Decision to support CARMMA & Second phase of MPOA & Pan African score card to rate progress made on MNCH 2014 MNCH Report
1 country Launch & commemoration in Island states of Africa
Re-strategize to integrate campaign into existing and future continental framework
Fifth Session of the African Union Conference of Ministers of Health held in Windhoek, Namibia 2011. More resources for MNCH First CARMMA status report
MNCH Status Reports to 2013 to 2014
Celebration of CARMMA Week 2011-2017

Output areas	Evidence of achievements	Implication for future initiative
Output 1: Increasing political commitment on MNCH issues, especially maternal mortality and child health		
i). Increased involvement of high- level political players at country level	Several member states (such as Chad, Ethiopia, the Kingdom of Eswatini, Ghana, Malawi Mozambique, Namibia , Nigeria, Rwanda, Senegal) provided examples of high-level commitment and national initiatives to address MNCH	Involvement of high-level political offices has a positive effect on ensuring that MNCH issues are placed on government agendas, as they are critical facilitators for political gains
ii). Domestication of campaign using local structures	In most member states there was evidence of using government structures and existing strategic policy documents	Use of local structures increases the potential for sustainability and national ownership
iii). Provided a vehicle to place MNCH back on regional and global agendas	There was evidence that CARMMA catalyzed issues of newborn and maternal health and acted as a vehicle for advocacy for other global and regional initiatives	Future endeavors require that advocacy be anchored in existing political structures and platforms in order to achieve positive MNCH outcomes
Output 2: Effective research, assessments, publications and dissemination		
i). Documentation of several country status reports for all AU member states	The AUC documented several country status reports from 2013-2017 in line with the campaign design	Although the reports are useful for demonstrating progress, use of the reports to improve implementation of MNCH interventions will need to be strengthened at the country level. This could form the focus for advocacy in the next phase. Strategies to ensure effective implementation need to be developed by AUC member states as part of a co-design process with the Commission.

ii). Improved reporting structures within country	Setting up dashboards and websites helped to improve the compilation of data from countries	Management and streamlining data from member states is necessary to showcase improvement, but needs to be developed further to: -Ensure that action and decision-making are based on the data generated -Frequency of data reporting from member states is limited to between 2-5 years for ease of administration and to ensure enough time to record changes - Ensure inclusion of data on adolescents
Output 3: Mobilized communities and constituencies to support development of materials for advocacy, social mobilization and behavior change		
i). Limited evidence of involvement by communities in materials development for advocacy	Apart from member state launches and involvement of communities at different levels, there was limited evidence of how local communities have been involved in MNCH advocacy activities, especially in the development of materials	During the next phase, clear guidance should be provided on how countries engage communities for social change and report on such mechanisms, including platforms for action and effectiveness of advocacy materials
ii). Mobilization of additional partners to support MNCH	In some member states (such as Angola, Republic of Congo, Democratic Republic of Congo, Kenya, Malawi and Zambia) the launches attracted new partners to MNCH	Future campaign should endeavor to develop mechanisms for coordinating partners at both the regional and national levels to undertake effective advocacy
Output 4: Communication and resource mobilization capacities of member states strengthened		

Limited access to resources at country level to support MNCH advocacy activities	An area that showed limited evidence of success. Lack of resources was a major hindrance for implementing MNCH advocacy activities at the country level, with countries stating that with competing interests limited resources were available for advocacy	Member states may need to develop clear structures for funding advocacy through normal budget allocations at both the country and regional levels
Output 5: Effective monitoring, evaluation, reporting and follow-up systems in place		
i). CARMMA provided opportunities to bring success stories into the public domain & increased the visibility of MNCH	Member States utilized success stories of launches to energize health sector priorities and showcase areas of focus for MNCH	Future endeavors will need to anchor success and impact on the existing data platform, but this will need to capture human stories, beyond statistics
ii). Development of data bases and African online platform for key indicators	CARMMA website was launched and the an online database set up for tracking progress of key indicators	The database is a unique resource for generating evidence for action. However, it may need clear linkages with data use and action points for countries to base their efforts towards improving MNCH
Output 6: Partnerships and networks developed and maintained		
Partnership with civil society and other partners increased political commitment on maternal mortality issues	Working with development partners, NGOs facilitated implementation of planned strategies for MNCH and improved partnership & coordination in some countries	There is a need to strengthen linkages with partners at the country level, develop strong coordination mechanisms and ensure alignment of partner priorities with country needs for effective implementation and synergy of high- impact MNCH interventions

Key outputs of CARMMA

Table 4 summarizes the outputs of the CARMMA campaign and notes implications for future initiatives.

Table 4. Key outputs of CARMMA

a. Attributed CARMMA outcomes and impact

94 To examine whether the campaign contributed to desired outcomes and impacts, the evaluation linked key campaign outputs to the documented changes seen in the 13 CARMMA indicators. The evaluation did not perform a statistical analysis to ascertain a relationship between the activities and outputs on one end and outcome and impact on the other. Nevertheless it is apparent that the campaign had a substantial influence on the policy and service delivery environment regarding maternal and child health and a potentially positive impact on the health outcomes of African mothers and children. The campaign therefore contributed to the progress recorded by the continent in improving maternal and child health outcomes.

b. Progress and status of maternal health

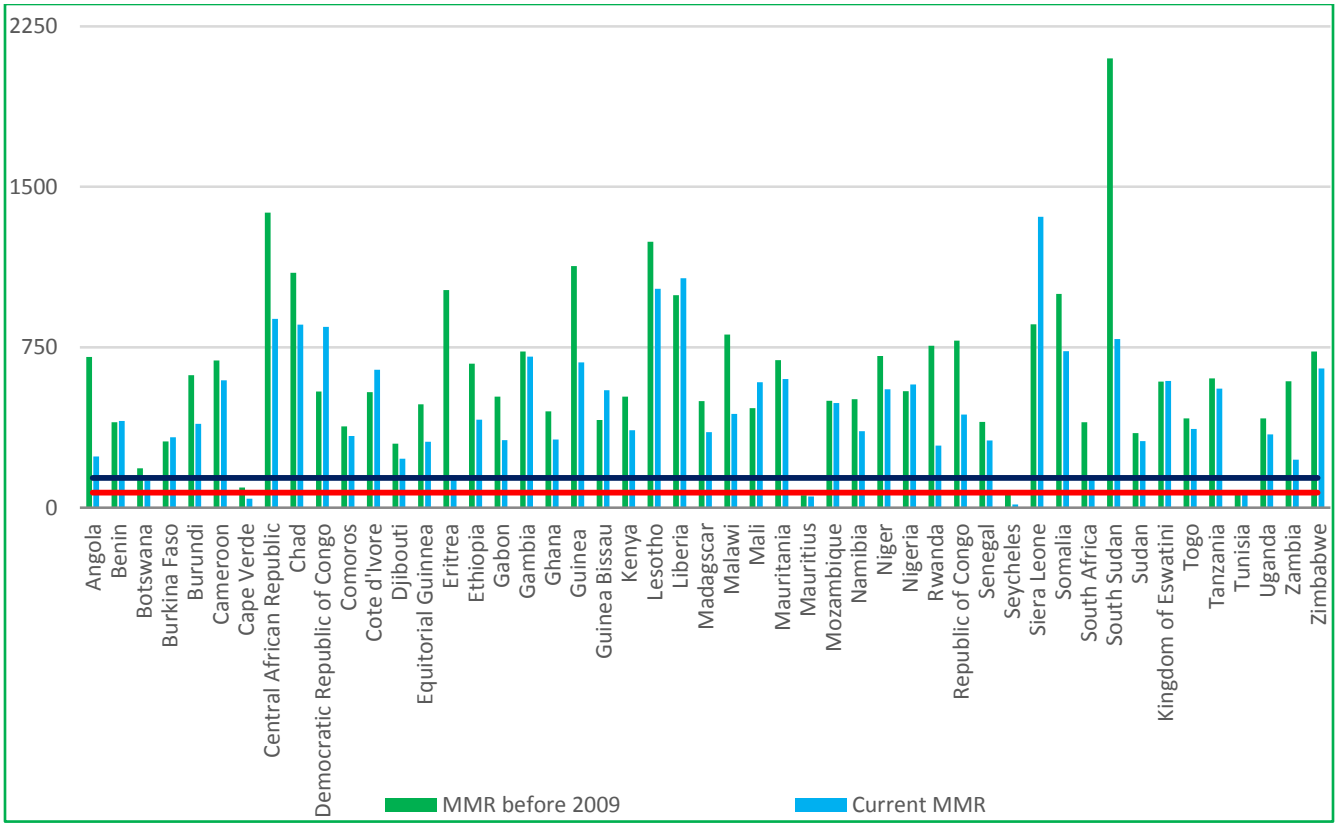
95 This section summarizes the status of key indicators for maternal health, including mortality rate per 100,000; percentage of births attended by skilled personnel; percentage of pregnant women who attended four ANC visits; percentage of women receiving postpartum care by a skilled health personnel within two days of childbirth; percentage of new borns who received postpartum care from skilled birth attendant within two days after delivery; contraceptive prevalence rates (per cent); unmet needs for family planning (per cent); proportion of unsafe abortions in a country per 1,000 women aged 15–49 years; and adolescent fertility rate. Although the status of these indicators cannot be attributed to CARMMA alone, it is plausible to suggest that changes in country contexts – including interventions implemented, some of which were reignited through the CARMMA initiative – are likely to have contributed to the changes seen in member states. Where appropriate, key outcomes from before the campaign launch (2009) are compared with the most recent data and the 2030 SDG targets. The latter helps to estimate gaps remaining to reach the targets.

c. Maternal mortality

96 Improved maternal mortality rates illustrate progress by member states in increasing access to quality, safe motherhood services. Figure 4 compares maternal mortality in 2009, before the launch of CARMMA, and the latest data on MMR available for member states that signed up for the CARMMA initiative. It also illustrates the gap for attaining the 2030 SDG target of 70 maternal deaths/100,000 live births. Figure 4 shows that countries such as Benin, Burkina Faso, the DRC, Cote d'Ivoire, Eswatini, Equatorial Guinea, Guinea Bissau, Liberia, Mali, Nigeria, Sierra Leone improved their MMR by between 1 and 71 per cent, between 2009 and 2017. The majority of member states also made tremendous progress on MMR, with most reducing levels by over the last decade. Nevertheless, examination of current rates

and SDG targets shows that nearly all countries – except Mauritius, with an MMR of (53/100,000), Seychelles (14.7/100,000) and Tunisia (62/100,000) – must improve their performance on MMR by 50 per cent to reach the SDG target by 2030. It should be noted, however, that the three member states mentioned already had good MMR indicators prior to the launch of CAR-MMA.

Figure 4: Comparison of maternal mortality across AUC countries



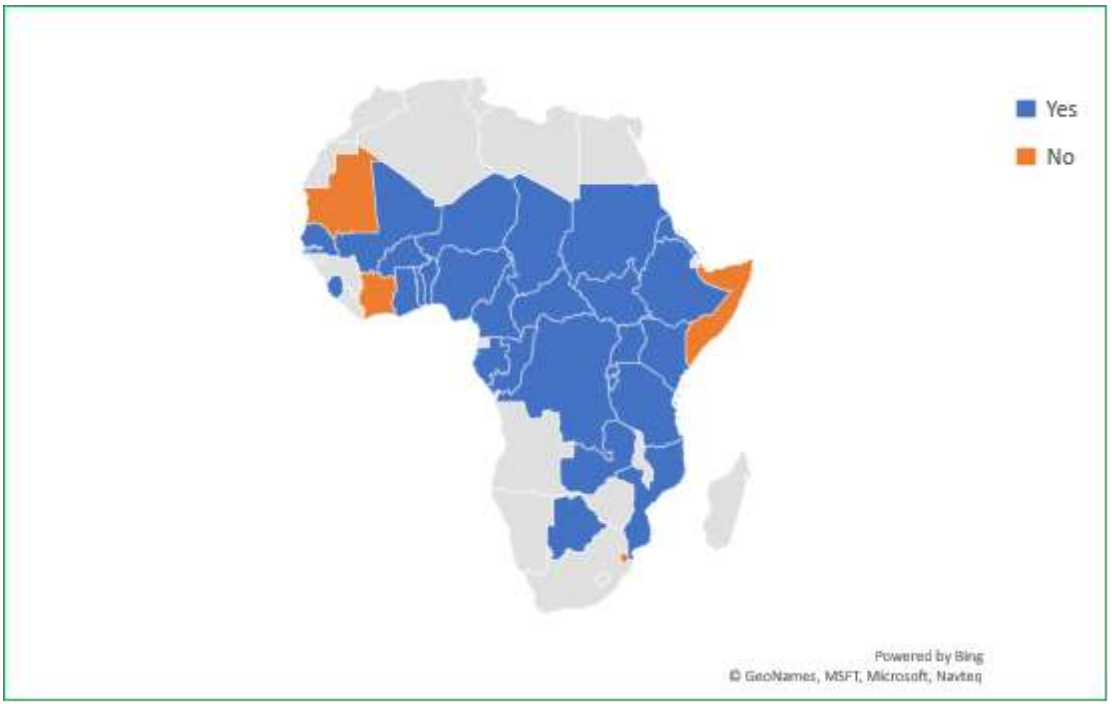
97 Evidence available indicates that the AU campaign, in addition to the interventions that member states put in place, may have played a role in the changes observed: *"The benefits I have seen is that, although we have a lot of challenges, there was focus being put on the reduction of maternal deaths, because we know, we have one of the highest rates of maternal deaths. This year they said that the maternal deaths reduced to 239, so people were committed to reducing it, although the quality of service continued to be a major challenge. But the minister of health focused on it and*

all the donors were asked to support maternal health. It was put in the main agenda". (Key informant 5)

98 The attention on reducing maternal death rates indicates to the seriousness with which member states demanded accountability for women who die during childbirth. Angola, for example, established a national commission, appointed by the president, to report directly to him on all maternal deaths. The commission followed up to see where women are dying and why. The reason for maternal deaths is a discussion not only among high-level government officials, but also among partners, leading one informant to note: "I *can say that now there is attention to maternal health. Although we need to improve but the focus is maternal health now*". (Key informant 6)

99 To illustrate the zeal with which member states approached accountability for maternal deaths, figure 5 shows member states where a policy of reviewing all maternal deaths is in place. Thirty of the 35 member states where data was available had a policy. The year of adoption varied; one member state established a policy in 2000, 2004 and 2005, two in 2007, one in 2008, one in 2009, five in 2010, two in 2011, four in 2013, three in 2014 and two in 2015. Two member states did not have data on the date of adopting the accountability policy.

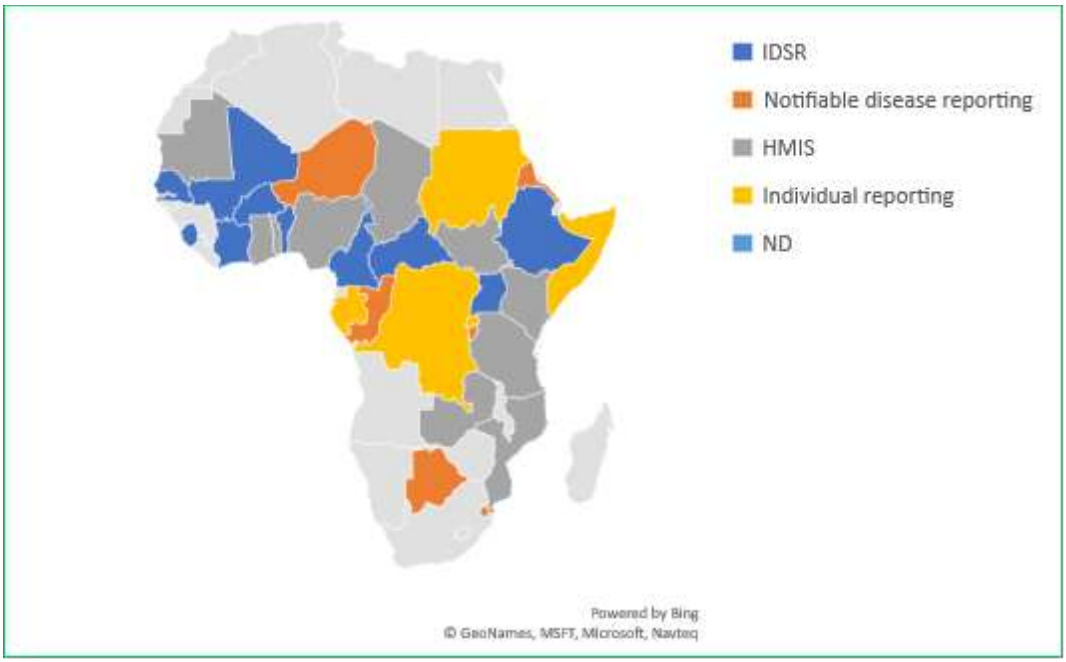
Figure 5. Countries with a policy to review maternal deaths



Source: WHO MDSR surveillance database.

86 A review of systems used to report maternal deaths, 10 member states use surveillance systems such as integrated disease surveillance and response, seven use notifiable diseases reporting systems, while 10 use health management information systems and five use individual reporting. One country did not have any data reported on the type of health management systems in place. (Figure 6).

Figure 6: Mechanism for reporting maternal deaths



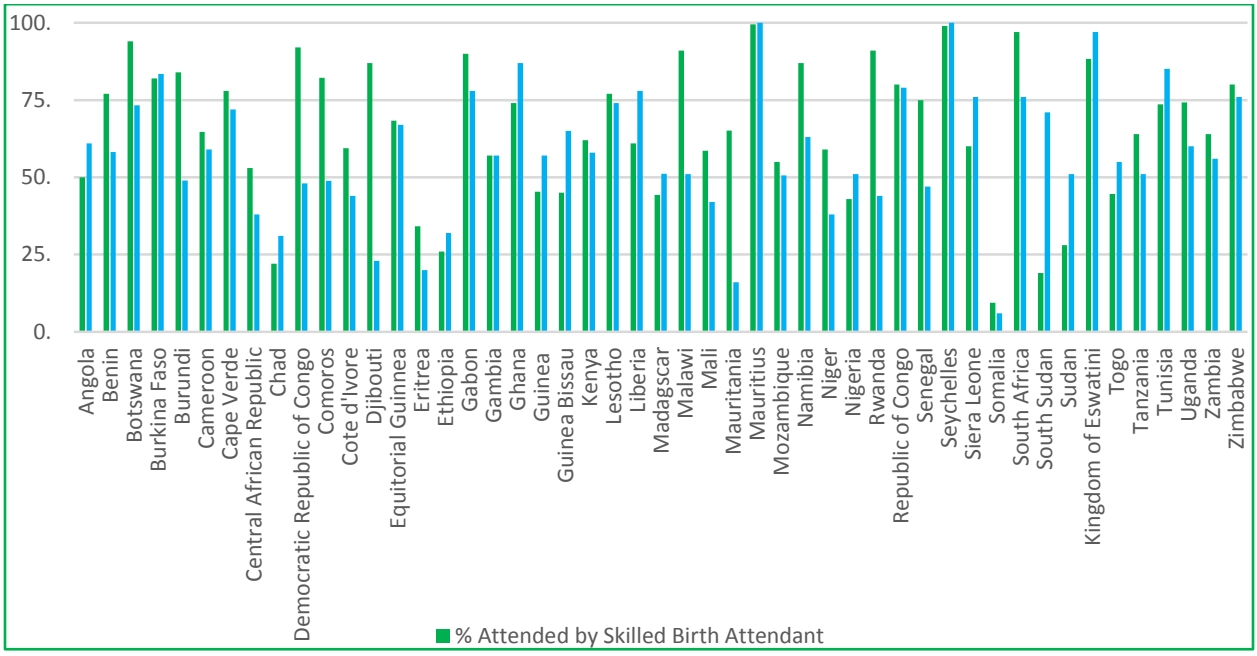
Progress on skilled birth delivery and antenatal care attendance

87 Analysis of data on skilled delivery at birth indicates that nearly 30 member states reported a percentage of skilled birth deliveries of over 60 per cent. Those that reported a higher rate were Botswana, the Kingdom of Eswatini Gabon, Malawi, Mauritius, Rwanda and South Africa, with over 90 percent. It is noteworthy that member states like Seychelles and South Africa had already made good progress on these indicators. Burundi, Comoros, DR-Congo, the Kingdom of Eswatini Namibia, and Zimbabwe had skilled birth attendance rates of above 80 per cent. The lowest-performing member states were Chad, Ethiopia, South Sudan and Somalia, which had skilled delivery rates of between 9 and 28 per cent.

88 The continent seems to be doing relatively well in terms of the first ANC visit, but very poorly with regard to the fourth visit. Figure 7 shows that the Kingdom of Eswatini has high coverage for the fourth visit (97 per cent) and Tunisia reported an average of 85.1 per cent attending the fourth ANC visit,

which reflects high rate of skilled deliveries. Averages for Botswana, Lesotho, South Africa and Zimbabwe were above 70 per cent. Disparities between skilled delivery rates and fourth ANC visit coverage were apparent in Benin, Burundi, Comoros, DR-Congo, Gabon, Mauritania, Namibia Rwanda, Senegal and Uganda. These member states reported high rates of skilled deliveries but lower coverage for four ANC visits. This could be an issue of prioritizing skilled deliveries over ANC visits.

Figure 7: Status of skilled birth delivery and ANC coverage in African countries



Coverage of contraceptives and unmet need for family planning

86 To reposition family planning as a key development strategy, CARMMA emphasized its inclusion as a component of the MNCH service package. Contraceptive prevalence rates are an important measure of the level of women's use of contraceptives and an indicator of health, population, development and women's empowerment. They can also serve as a proxy measure of access to reproductive health services related to child mortality, maternal health, HIV/AIDS and gender equality. In addition, contraceptive prevalence rates are a measure of outcomes of family planning programmes across the population.

87 Figure 8 shows that contraception coverage is generally low. Member states with the highest contraceptive prevalence rates are Zimbabwe (67 per cent), Kingdom of Eswatini (66 per cent), Mauritius (64 per cent), Tunisia (63 per cent), Cape Verde (61.3 per cent) and Lesotho (60.2 per cent). Other member states with rates above 50 per cent include: Malawi (59.2 per cent), South Africa (57.9 per cent), Namibia (56 per cent), Rwanda (53 per cent) and Botswana (52.8 per cent). But some 23 member states have rates below 20 per cent. The lowest coverage is in South Sudan (4 per cent), Chad (5.7 per cent) and the Gambia (9 per cent). Low coverage of contraceptives is an area on which the AUC may need to focus during the next phase of advocacy, to ensure that countries put more efforts and resources into providing women with effective methods of birth planning and control to better manage their families.

88 Unmet need for family planning measures the capacity of a member status's health system and social conditions to support women's ability to decide on the timing and number of births. It also measures how well women succeed in achieving their desired family size and birth spacing, thus indicating the success of reproductive health programmes in addressing the demand for family planning services. Unmet need for these services implies a gap between demand and supply for which programmes are needed to fill the gap. Around the world, about 222 million women have an unmet need for family planning services, while the needs of 645 million women are met through the use of a modern contraceptive method, such as IUD, pill, injections or sterilization.

89 Figure 9 shows that the African Union member states with the lowest levels of unmet needs for family planning are Tunisia (7 per cent), Zimbabwe (10.4 per cent), Namibia (12 per cent), Kingdom of Eswatini (15.2 per cent), Mali (15.8 per cent) and Republic of Congo (17.9 per cent). Nigeria and South Africa both have rates of between 7-18 per cent. Unmet need in others, such as Cameroon, Kenya, Lesotho, Malawi and Rwanda, average about 18 per cent. Countries with the highest unmet needs are: Angola (38 per

cent), Equatorial Guinea (33.8 per cent), Mauritania (33.6 per cent), Togo (33.1 per cent), Benin (32.6 per cent), Comoros (32.3 per cent), Ghana (32.3 per cent), Liberia (31.1 per cent) and Djibouti (30.4 per cent). No data was available for Seychelles.

Figure 8: Contraceptive prevalence rates

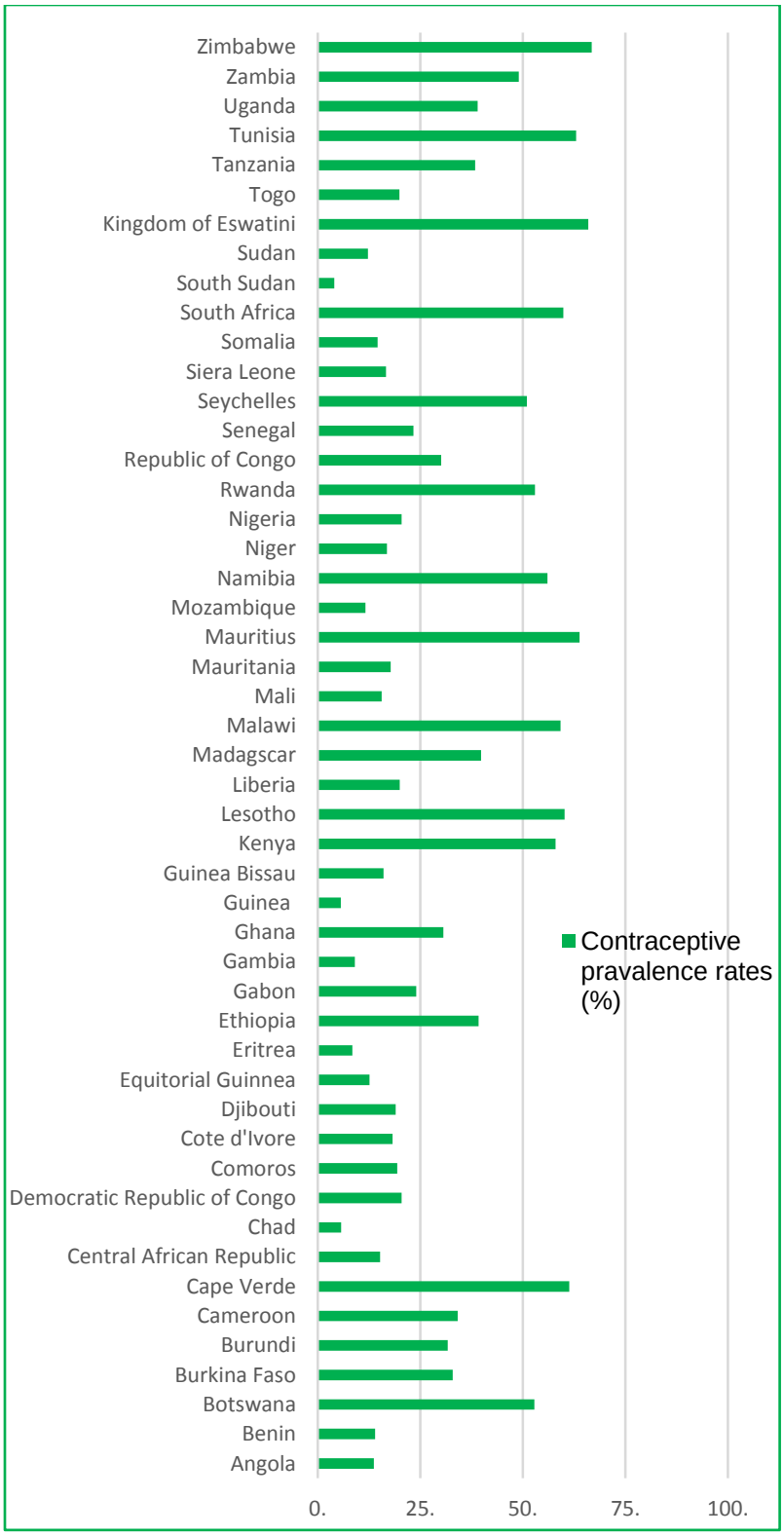
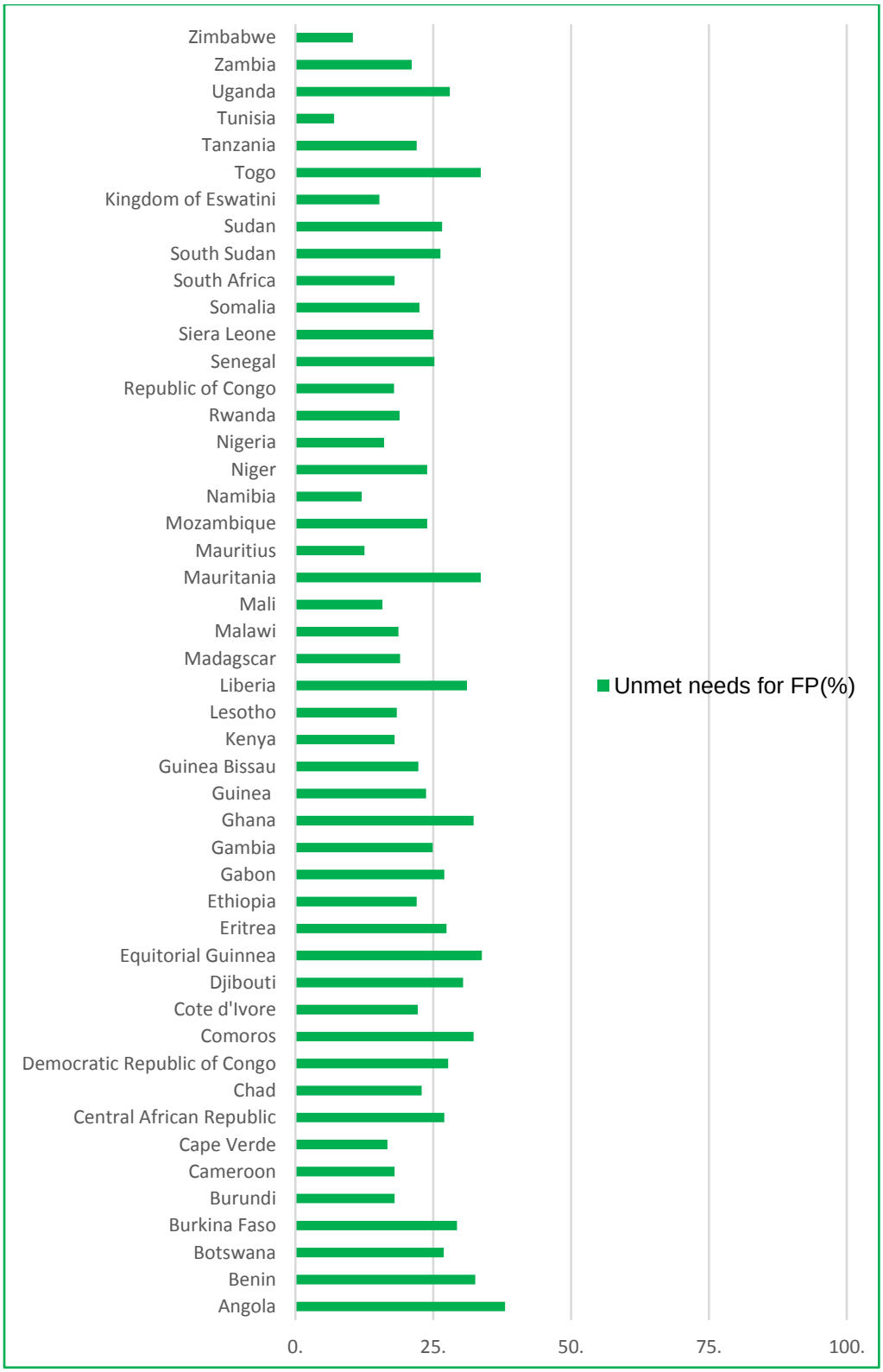

Zimbabwe
Zambia
Uganda
Tunisia
Tanzania
Togo
Kingdom of Eswatini
Sudan
South Sudan
South Africa
Somalia
Siera Leone
Seychelles
Senegal
Republic of Congo
Rwanda
Nigeria
Niger
Namibia
Mozambique
Mauritius
Mauritania
Mali
Malawi
Madagscar
Liberia
Lesotho
Kenya
Guinea Bissau
Guinea
Ghana
Gambia
Gabon
Ethiopia
Eritrea
Equitorial Guinnea
Djibouti
Cote d'Ivore
Comoros
Democratic Republic of Congo
Chad
Central African Republic
Cape Verde
Cameroon
Burundi
Burkina Faso
Botswana
Benin
Angola
0.
25.
50.
75.
100.
Contraceptive pravalence rates (%)

Figure 9: Unmet needs for family planning across African countries

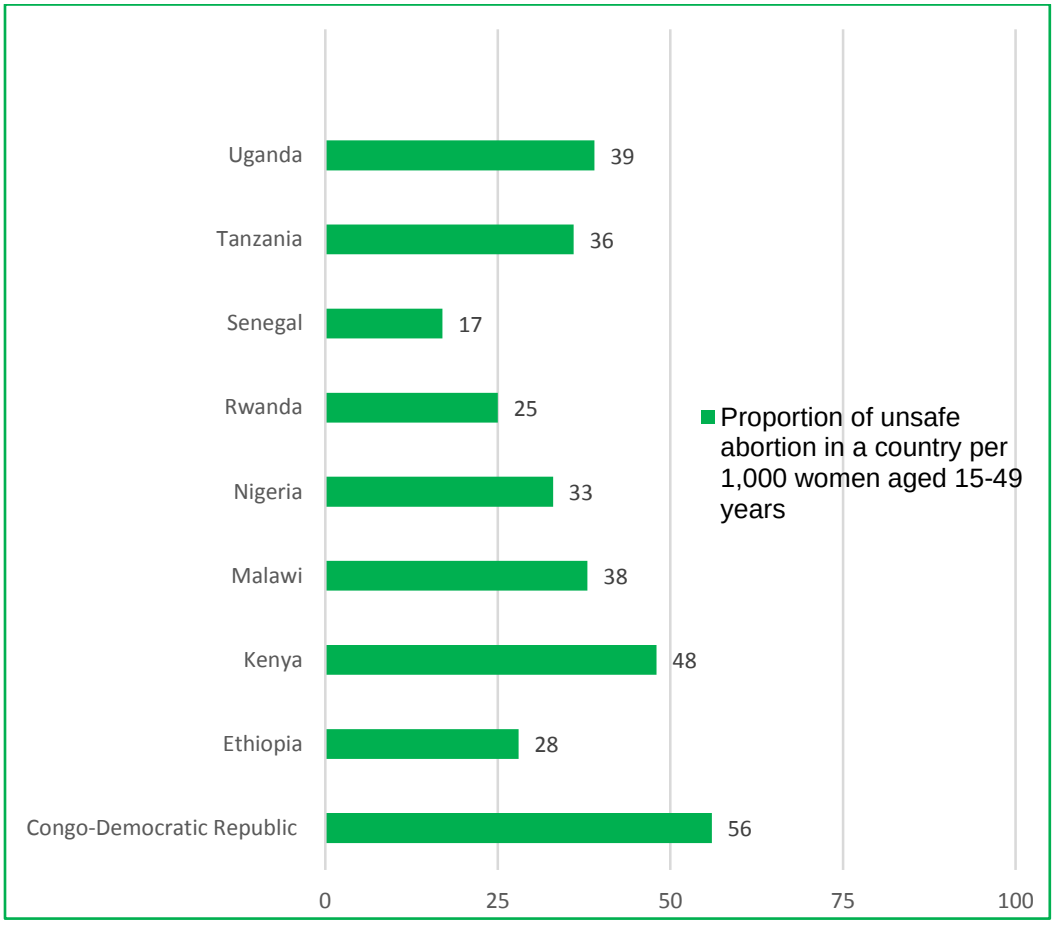


Evaluation of the Campaign for Accelerated Reduction of Maternal Maternity in Africa (CARMMA) 2009-2017

Estimates of unsafe abortion

86 Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards, or both[11]. Although the true global burden of unsafe, abortion-related mortality remains unknown, WHO estimates that in 2008 approximately 13 per cent of maternal mortality worldwide, or 47,000 deaths, were due to unsafe abortion[12]. Globally, between 2010–2014 an estimated 56 million induced abortions occurred each year worldwide, representing an increase from 50 million annually during 1990–1994, mainly due to population growth.[13] The global annual rate of abortion, estimated at 35 abortions per 1,000 women of childbearing age (those 15–44 years old) in 2010–2014, has declined slightly (from 40 per 1,000 in 1990–1994). The overall abortion rate in Africa was 34 per 1,000 women in 2010–2014. Sub-regional rates ranged from 31 in West Africa to 38 in North Africa[13]. For purposes of this report, data was sought on the proportion of unsafe abortions in a country per 1,000 women aged 15-49 years, but were rarely available. In those member states where estimates were available, figure 10 shows that the member states with the lowest estimates was Senegal (17/1,000 women) and those with the highest estimated rates were the DRC (56/1,000) and Kenya (48/1,000).

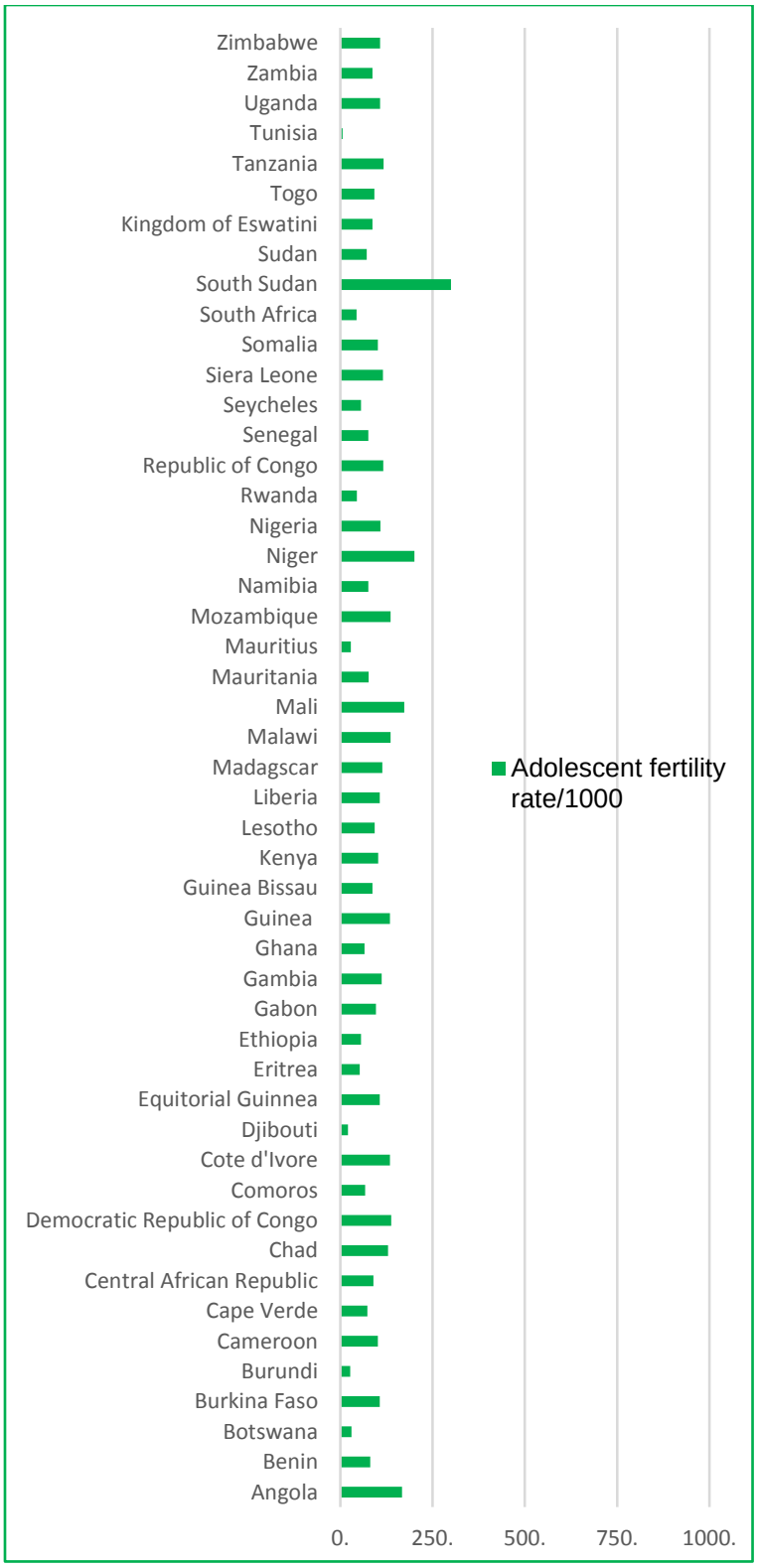
Figure 10: Estimates of unsafe abortion



Adolescent fertility rates

87 The adolescent fertility rate is defined as the annual number of births to women 15-to-19 years of age per 1,000 women in that age group. Data shows that countries with the highest rates per 1,000 are South Sudan (300) and Niger (201). Others that recorded rates of between 120-200/1,000 women include: Mali (173/1,000), Angola (167/1,000), Burkina Faso, Chad (129/1,000), DR-Congo (138/1,000), Malawi (136/1,000), Mozambique (136/1,000), Cote d'Ivoire (135/1,000) and Guinea (135/1,000). The rest had fertility rates below 120/1,000 women; the lowest rate was in Tunisia at 6/1,000 women (figure 11).

Figure 11. Adolescent fertility rates


Zimbabwe
Zambia
Uganda
Tunisia
Tanzania
Togo
Kingdom of Eswatini
Sudan
South Sudan
South Africa
Somalia
Siera Leone
Seycheles
Senegal
Republic of Congo
Rwanda
Nigeria
Niger
Namibia
Mozambique
Mauritius
Mauritania
Mali
Malawi
Madagscar
Liberia
Lesotho
Kenya
Guinea Bissau
Guinea
Ghana
Gambia
Gabon
Ethiopia
Eritrea
Equitorial Guinnea
Djibouti
Cote d'Ivore
Comoros
Democratic Republic of Congo
Chad
Central African Republic
Cape Verde
Cameroon
Burundi
Burkina Faso
Botswana
Benin
Angola
Adolescent fertility rate/1000
0.
250.
500.
750.
1000.

Progress and status of child health

88 This section describes the progress and status of child health, presenting four main indicators: neonatal mortality/1,000 live births, under-five mortality rates/1,000 live births, proportion of stunting among children under five years and proportion of infants 12–23 months immunized against DPT3.

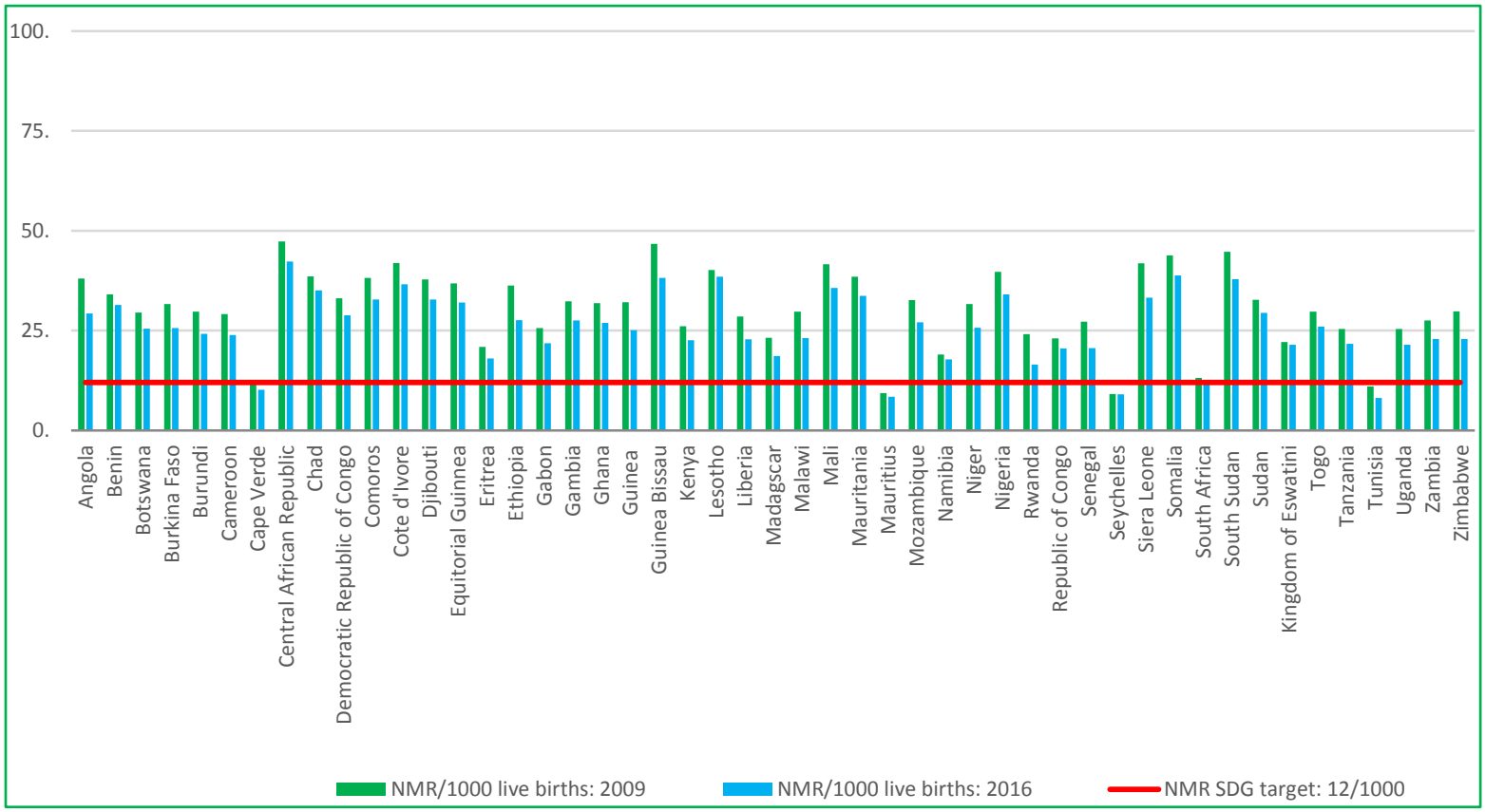
Progress and status of neonatal mortality

89 Progress toward reducing neonatal mortality since 2009 is presented in figure 12. As of 2016, 11 member states had neonatal mortality levels above 30/1,000 live births. Listed from the highest to lowest rates, the member states were: Central African Republic with rates of 42.3/1000 live births, followed by Somalia (38.8/1,000), Lesotho (385/1,000), Guinea Bissau (38.2/1,000), South Sudan (37.9/1,000), Cote d'Ivoire (36.6/1,000), Mali (35.7/1,000), Chad (35.1/1,000), Nigeria (34.1/1,000), Mauritania (33.7/1,000), and Sierra Leone (33.2/1,000). The member states with the lowest levels of neonatal mortality were Mauritius at 8.4/1000 live births, Seychelles (9/1,000) and Cape Verde (10.2/1,000).

90 Since 2009 all member states have taken positive steps to reduce neonatal mortality. Member states achieving the greatest reductions were: Angola and Ethiopia, with a 22.9 per cent difference between 2009 and 2016, followed by Guinea Bissau (22.4 per cent), Rwanda (20 per cent) and Sierra Leone (22.6 per cent). Member states where the least change took place are: Seychelles at 0.3 per cent; South Africa and Eswatini (1.8 per cent), Mauritius (2.4 per cent), Namibia (3.2 per cent), Lesotho (4.5 per cent), Cape Verde (6.1 per cent), Eritrea and Tunisia at (7.6 per cent), Benin (7.1 per cent) and Chad (9.2 per cent).

91 To reach the SDG target of 12/1,00o live births, most member states have gaps of between 20-90 per cent. Those with the highest gaps are: Somalia (91.5 per cent), Lesotho (90.4 per cent), Guinea Bissau (89.4 per cent), South Sudan (88.1 per cent), Cote d'Ivoire (84 per cent), Mali (80.9 per cent), Chad (78.8 per cent), Nigeria (75.4 per cent), Mauritania (74.1 per cent), Sierra Leone (72.4 per cent), Comoros and Djibouti(71.0 per cent), and Equatorial Guinea (68.3 per cent). Member states with the lowest gaps are South Africa (1.4 per cent) and Namibia (19.5 per cent), while those that have already reached the SDG target are Cape Verde (10.2/1,000), Mauritius (8.4/1,000), Seychelles (9/1,000) and Tunisia (8.1/1,000).

Figure 12: Progress and status of neonatal mortality



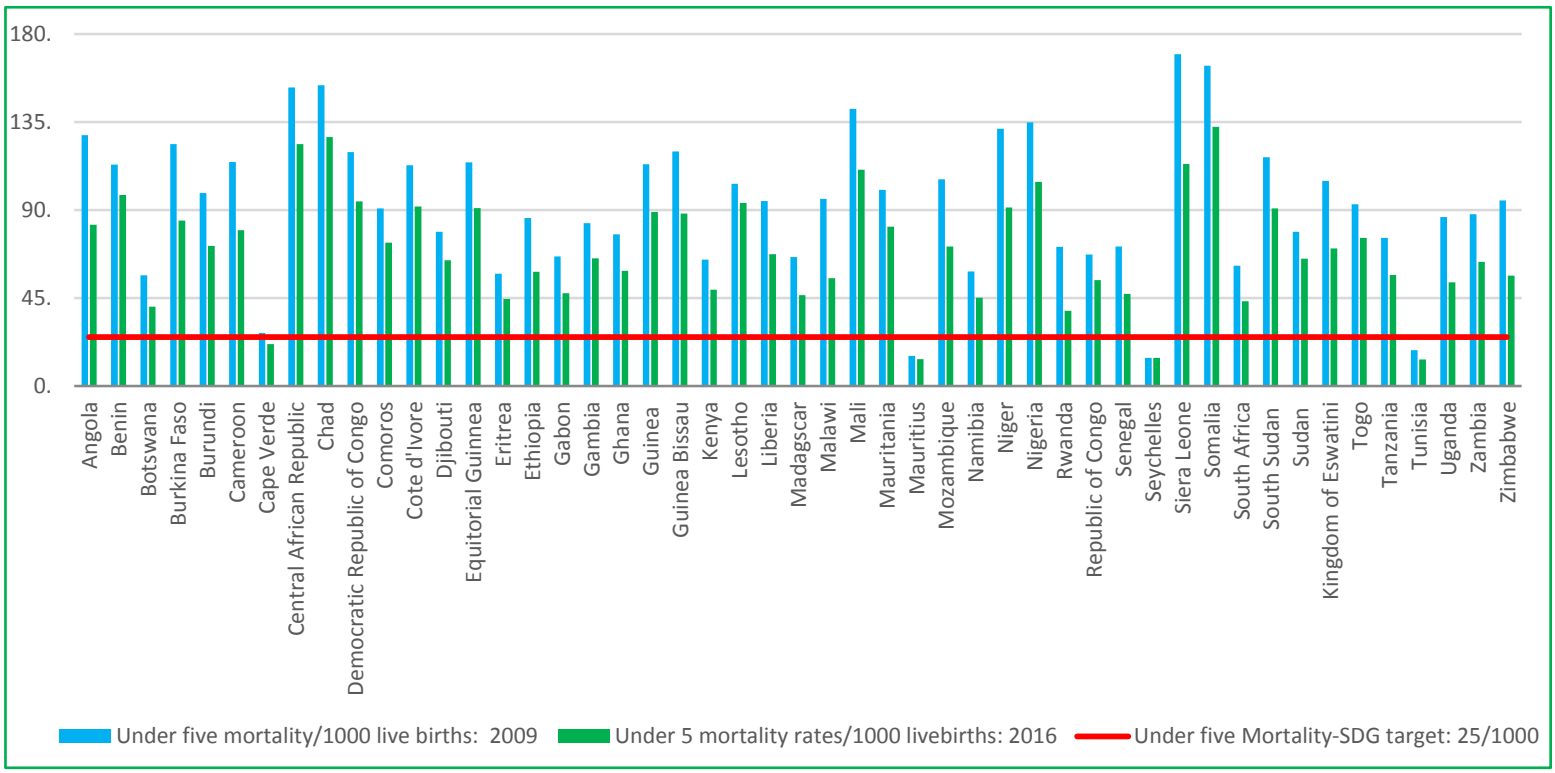
Status of under-five mortality

86 Figure 13 illustrates mortality among children under five years in member states participating in CARMMA. As of 2016 member states with the highest levels of under-five mortality were: Somalia (132.5/1,000 live births), Chad (127.3/1,000), Central African Republic (123.6/1,000), Sierra Leone (113.5/1,000), Mali (110.6/1,000); Nigeria (104.3/1,000), Benin (97.6/1,000), DRC (94.3/1,000), Lesotho (93.5/1,000); Cote d'Ivoire (91.8/1,000), Niger (91.3/1,000), Equatorial Guinea (90.9/1,000), South Sudan (90.7/1,000) and Burkina Faso (84.6/1,000).

87 It is important to note that all Africa Union member states made progress toward reducing under-five mortality during the period under review. The highest percentage point reduction was realized in Angola (35.2 per cent), followed by Niger (31.4 per cent), Burkina Faso (30.4 per cent) and Zimbabwe (30.0 per cent).

88 By 2016 only four countries had reached the 2030 SDG target for under-five mortality (25/1,000 live births): Cape Verde (21.4, Seychelles (14.3), Mauritius (13.7) and Tunisia (13/6). Member states with the steepest climb to reach the SDG target are: Somalia (81.1 per cent), Chad (80.4 per cent) and Central African Republic (79.8 per cent).

Figure 13: Progress and status of under Five mortality



Status of nutrition among children

86 An important indicator of child health is the proportion of stunting among children under five years of age. Stunting in early life – particularly from the first 1,000 days after conception through the age of two – has lifelong consequences. Among these consequences are: poor cognitive and educational performance, low adult wages, lost productivity and, when accompanied by excessive weight gain later in childhood, an increased risk of nutrition-related chronic diseases in adult life. Thus, linear growth in early childhood is a strong marker of healthy growth, given its association with morbidity and mortality risk, non-communicable diseases in later life, learning capacity and productivity.

87 Figure 14 shows that the nine member states with the highest percentage of stunted children under five were: Burundi (56 per cent), Eritrea (50 per cent), Madagascar (49.2 per cent), Mozambique (42.9), DRC (42.7 per cent), Niger (42.2 per cent), Zambia (40 per cent) and Central African Republic (41 per cent). The lowest percentages were reported by Mauritius (13.2 per cent), Tunisia (10.1 per cent) and Seychelles (7.9 per cent). Stunting levels in other member states ranged between 20 and 40 per cent.

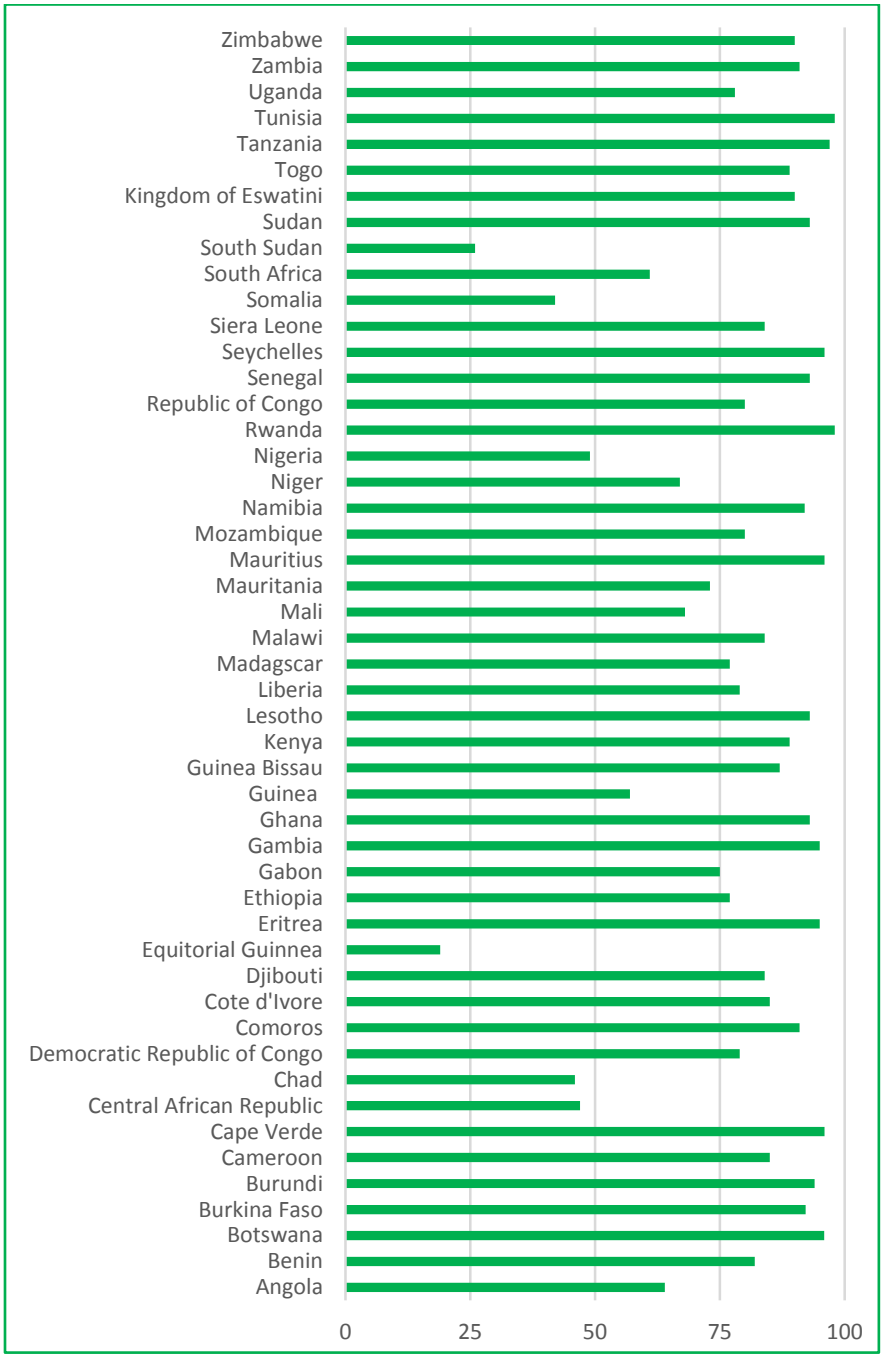
Figure 14: Childhood stunting in African countries

Evaluation of the Campaign for Accelerated Reduction of Maternal Maternity in Africa (CARMMA) 2009-2017

Immunization coverage

86 Overall coverage of immunization, as measured by the proportion of infants fully immunized with DPT3, was good across member states, as shown in figure 15. Member states with the highest coverage were: Tunisia (98 per cent), Tanzania (97 per cent), Seychelles (96 per cent), Mauritius (96 per cent), Cape Verde (96 per cent), Botswana (95.6 per cent), Eritrea (95 per cent), and Gambia (95 per cent). Other member states with high coverage included Burundi (94 per cent), Ghana (93 per cent), Lesotho (93 per cent), Senegal (93 per cent), Sudan (93 per cent), Burkina Faso (92.2 per cent), Namibia (92 per cent), Comoros (91 per cent), Zambia (91 per cent), Zimbabwe (90 per cent) and Kingdom of Eswatini (90 per cent). Member states with the lowest coverage were South Sudan (26 per cent) and Equatorial Guinea (19 per cent).

Figure 15: Coverage of DPT3 among 12-23 month-olds



Effectiveness of the campaign focus, structure, ownership and coordination arrangements

87 This section assesses the appropriateness of campaign management tools, and the challenges and opportunities experienced.

Campaign focus and structure

88 The campaign was timely, as it was launched at a time when it was clear that MDG targets were unlikely to be achieved. The target audience was appropriate, and took into account the political structures of the member states, was essential for buy-in and accelerated implementation of MNCH interventions. Analysis showed that the initiative is still relevant in Africa, but will need to be re-designed to advocate for the delivery of better health options for African mothers, children and adolescents, in the context, of the Agenda 2063 and SDG periods. One participant expressed this as: "*CARMMA is still relevant for Africa". Across Key informant_4*

89 The campaign sufficiently leveraged and utilized African Union structures to advocate for the prioritization of maternal and child health on the continent. By focusing on maternal health and later child health, the campaign was successful in increasing the visibility of the two issues, and drawing the attention of African leaders to the high maternal and child mortality across the continent. Going forward, the campaign should continue to focus on unfinished MDG business, carried forward to the period of the SDG's and in the context of achieving Agenda 2063. The campaign should also maintain the strong focus on maternal, child as well as adolescent health.

90 The MNCH Taskforce established in 2013 was to play a pivotal role in guiding the campaign's MNCH activities. However, the evaluation could not document any meetings of the Taskforce after the inaugural meeting in 2013. The Taskforce was not fully operational at either the technical or political level, largely due to lack of financial resources. In addition, the Mama Afrika Award – another significant element of the campaign – was not launched due to lack of financial resources. These two structures remain relevant to the campaign and efforts should be made to operationalize them.

91 The Department of Social Affairs was the most suitable department to situate the campaign. Campaign activities crossed the two divisions of health as well as other divisions, and units of the Commission. This Campaign was also managed at a level that allowed for a fair degree of autonomy that resulted in interaction with other divisions of the Department of Social Affairs as well as other relevant departments. The campaign was grossly understaffed, and the two staff members who run the campaign overwhelmed. These staff members also had other task to undertake while at the same

time providing support to other divisional/departmental activities. A campaign secretariat with sufficient number of staff and technical capacity was initially envisioned, but not implemented. The evaluation could not determine the circumstances that hindered the establishment of the secretariat. However, moving forward efforts to staff the department for optimal support for the next phase of the campaign will be required.

Ownership and coordination arrangements

86 Key informants noted that the campaign was largely country-driven, and did not require extra implementation structures. Rather it called for the implementation of advocacy strategies designed the member states to be driven by innovation as part of day-to-day activities. One informant noted: "I *like this word because innovation should be what we can do every day". (*Key informant 3*)* National-level ownership of the campaign is one of the key direct outcomes of CARMMA, was achieved as a result of sustained high-level advocacy.

87 A recurring concern across all interviews was the AUC's failure to provide adequate follow-up of member state- commitments. Despite having set up accountability mechanisms such as biennial reporting and data platforms, participants felt that the AUC lacked structures for enforcing accountability processes. This was coupled with changes in government and political regimes, made it difficult for member states to commit to agreed too initiatives, as reported by another informant: "*Where we failed is follow up of commitment. Yeah, follow up of commitment to make sure that commitments are fulfilled. This is very important, was very important but you know, we didn't put in structures for follow up". (*Key informant 2)

88 Discussants voiced the need for effective follow-up on implementation of CARMMA commitments by the AUC as a coordinating body, which need to be strengthened. Efforts to strengthen the coordinating body might include: building the capacity of the AU monitoring and evaluation unit to improve data collection and complication and data from member states. Also critical is the promotion of the, proactive use of the data platform as well as regular updates of the indicators to encourage use of website for advocacy. "*Somehow AU should find a way to reach out to more country legislators….Get the message across and link them up to use the website. I don't know if the site is monitored. How many people visit etc." (*Key informant 1)

89 Follow-up accountability structures need to be strengthened continent-wide; first, for example, through the existing peer review mechanisms established by the AU. Additionally, the launch of 'CARMMA Week' provides a platform

for member states to review progress toward various indicators. The need for structures at the continental level to enforce accountability and push governments to commit themselves was considered an element for future success. Many informants agreed that the mechanism could be hosted at the AUC; e.g.: "*There is a department for social affairs. I think that is where the mechanisms should be*". (Key informant 3)

90 Discussants reported that the process of enforcing accountability should incorporate adequate communication with every member status's health ministry to ensure that it is technical people, not politicians, who provide information for accountability. Although discussants noted that launches served as catalytic events to provide encouragement to member states to prioritize the issues of maternal health, no strategic roadmap was put in place to ensure that momentum was maintained.

91 The lack of a well-resourced (financial and human) secretariat at the level of the Commission made it difficult to coordinate national-level activities including CARMMA launches and post-launch activities. As documented elsewhere in this report; this gap explains why the opportunity for the Commission to drive the campaign and establish national-level accountability mechanisms was missed.

Strengths, Opportunities, and Challenges

92 This section outlines the Strengths, Challenges, Opportunities and lessons learned for the future of the campaign.

Strengths of the CARMMA campaign

93 Overall, CARMMA's successes appear to be based on four key strengths (Box 7). The use of existing structures enabled member states to minimize duplication, maximize resource efficiency and enhance MNCH on national political agendas. The different focus of member states indicates that CARMMA was domesticated to the local context, ensuring that actions were tailored to maximize impact on the most pressing needs.

94 Second, community engagement and the use of innovations such as technology to implement low-cost interventions appears to have yielded results.

95 Third, using influential personalities, increased awareness and enhanced political commitment and leadership for improving MNCH in countries. This

approach also provided visibility for the campaign, ensuring that MNCH agenda remained high on the political agenda.

96 Fourth, the campaign increased partnerships, commitment and involvement by a variety of stakeholders in support of CARMMA activities and helped to prioritize MNCH. It was apparent that the initiative was perceived as home-grown and owned by African Union as noted by one participant: "*Yeah. Strong partnerships which came under the umbrella of CARMMA you know? And CARMMA being an initiative of African Union which is owned by Africa. So it's home-grown… that gives you a sense of strong partnerships". (*Key informant 1) These partnerships at the country and regional levels helped to domesticate the MNCH agenda.

Box 7: Strengths of CARMMA

- ✓ Integrating CARMMA into existing structures that maximized efficiency and enhanced MNCH issues on political agendas
- ✓ Use of innovations and community engagement sustained efforts to improve MNCH services
- ✓ High-level launches of the initiative in countries increased political commitment to MCNH issues
- ✓ CARMMA increased MNCH partnerships at the regional and country levels

Challenges

i. Perception of campaign as lacking adequate linkages with changing times

97 There was a perception that the campaign has not adapted overtime in light of new efforts that have arisen after the initial launch and advent of new global strategies and initiatives some informants noted that it was imperative to re-design CARMMA in a way that incorporates new ideas. The campaign should also remain a platform for advocacy and accountability for member states in order to enable them to rank themselves over time. If the campaign is re-designed as a tool for accountability, then a better way of presenting the data (such as the use of info graphics, with fewer indicators) might help reach different audiences.

ii. Inadequacies of follow-up

98 As noted above, informants observed that the campaign lacked adequate structures and follow-up mechanisms to enforce commitments made. The established data platforms could be used to provide requisite data and information to support the accountability mechanism. A long-term solution could be linking the platform with national health information systems.

iii. Maintaining the launch momentum over time

99 Given several activities and changes in leadership and priorities in member states, the campaign vision was lost in some member states leaving only a few individuals holding the vision. This may have contributed to the slow momentum and lack of better structures and innovative systems to articulate the vision with the new office bearers. The next phase could be designed to ensure continuity of the ideas behind the campaign.

Operational challenges

100 Beyond challenges associated with health systems, other challenges were linked to operationalization of the campaign Africa-wide and within member states. Although the campaign was designed to be embedded into existing structures, some countries reported lack of national coordinating mechanisms to influence change after the launch, while others reported resource constraints to follow through on commitments and maintain the momentum. Additionally, it was apparent that due to the diverse character of African political regimes, maintaining harmony required continuous engagement with the changing political leadership. Ensuring ownership by new governments is always critical

i. ***Inadequate human and financial resources to maintain the momentum of the campaign in countries***.

101 Across Africa, CARMMA did not enlist sufficient human and financial resources to run a successful campaign. AUC financial resources were not adequate to establish a functional campaign secretariat. Of greater concern, however, was the lack of a budget to support the implementation of CARMMA activities. These problem areas help to explain why some countries felt that the AU was not at the centre of the campaign.

102 Member states were expected to provide resources for the national initiatives planned, and this was in competition with other national priorities, political will and available funding in each context. Although the design was meant to build on existing structures for sustainability, there were changes in priorities and loss of momentum for various reasons at the national level. In many context across the continent where resources are scarce, prioritizing budgets for the sustainability of MNCH programs and activities, in each country, over time often proved difficult, as demonstrated in the several quotes of informants: highlighted below:

103 "There are challenges especially in terms of both human and financial resources. Availability of resources and translating the commitments into action may be difficult as there are challenges in terms of nurturing capacity to implement these commitments". (Key informant 1)

104 *"The major challenge we are facing is financial support, government due to lack of money and with reducing donor support because of political challenges… although this year we started new projects focusing on reproductive health and maternal health, a five-year project. World Bank is financing another project and European Union is supporting two other projects, so these are the funds available for maternal health being provided by donors".* (Key informant 6)

105 *"In the government policy, there are some departments that are not supposed to have funds. The funds in the ministry of health they tend to use as they want. So, they say that they just paid salaries. As for budget for activities, they only buy medicines. And considering that in 2010 we started doing the recent renovation of health services, most of the provinces received their budget through the provincial government. The problem is that the provincial governor is a political guy; he is not a technical person, so he can use the money as he wants. Health department received 5 million, I don't know how much of this is in dollars, but although sometimes for the health budget, the provincial governor is the one who decides if they give all to health or if it can be used to by the housing sector. This is one challenge we are still facing. So, the planning and commitment and good use of resource, accountability is the problem".* (Key informant 5)

106 A number of member states suffer from human resource constraints that hinder effective service delivery. The number of health providers and their distribution affects effective implementation of high-impact interventions.

107 To alleviate the resource challenge, it was generally reported that member states need to increase domestic resource mobilization to reduce their dependency on external funding. Domestic resources could be sourced from ministry line budgets, philanthropy or other sustainable sources to drive advocacy within each member state. . The role of partners such as the UN Health focused agencies and other development agencies should be to continue to support leadership for MNCH and ensure that maternal health remains visible on regional and global agendas.

ii. Competing priorities with local partner and development agencies

108 In some context, discussants reported that member states had partners with a different programmatic focus, which was not necessarily aligned with indicators linked to CARMMA. Although the activities may have been instrumental in one way or another to progress on MNCH, inadequate linkages with local priorities driven by different partners made it hard to coordinate the campaign. Harmonization and coordination of multiple maternal health initiatives made it difficult to accelerate the campaign mandate within some member states.

iii. Inadequate Reproductive Health Commodities and Supplies

109 Poor supply chain systems and commodity stock-outs may have limited service delivery for MNCH, slowing down progress. In addition, human resource challenges that affected the quality of service was reported: "*And the other challenge is quality of service and availability of midwives. We conducted a midwife survey and we were able develop a policy for human resources, but all this is on paper since to operationalize was constrained by resources. Another constraint is the skills for the midwife. This is another challenge too. We revised I think at the beginning when we launched the CARMMA then, essential packages for reproductive health that saved lives, but the challenge is the availability of human resources".* (Key informant 6)

iv. Complexity of implementation in fragile states and during humanitarian crises

110 In situations of protracted humanitarian crisis and in fragile states, health systems become increasingly weak, as was the case in the DRC, Somalia and South Sudan. Complex emergencies with high insecurity provide an additional challenge to universal health coverage and thus negatively impact on MNCH indicators. The negative impact of slow onset humanitarian crises – for example drought and food insecurity in the Horn of Africa, where El Niño (2015-2016) resulted in over 22 million affected persons – on maternal and new-born morbidity and mortality cannot be underestimated. Slow onset disasters highlight the need to strengthen health systems to withstand shocks and short-term and protracted crises. In certain countries where peace and security were challenges, CARMMA implementation stagnated: *"To some extent also there are many countries in our region who are under crisis affected by humanitarian situations. And there's no strong system that you can use to implement your commitments. Sometimes you go back and forth whenever there is a disaster*". (Key informant 1)

Opportunities for CARMMA

Existing Opportunities to improve the CARMMA Initiative:

1. ***Political Will and Engagement*** *–*

a) ***Changes in political regimes***

111 It was noted that since changes in political power can affect support for campaigns such as CARMMA, utilizing these changes to reignite the MNCH agenda could yield fruit. For example, in Angola it was noted: "*I think there are a lot of opportunities, for example now we have a new government and a new president was appointed on Thursday three days ago, and we have a new minister of health. The speech of the new president was maternal health. We hope that the new minister will be supportive and since this year we have a new public health director who is very supportive and committed. This year it was possible for them because in the past the national department of health, the department of reproductive health and maternal*

*health; they used to have one or three technicians now there is almost five new staff. That means that they have started growing……and I believe this will be a great opportunity as the new appointed minister who is leading this commission is new and before she used to be a secretary of state and she was very interested in all these CARMMA campaigns, so she was very committed and I believe that with our support we will improve". (*Key informant 5)

i. While changes in political leadership may positively or negatively affect support for such campaigns, utilizing such changes to reignite the MNCH agenda may yield results.
ii. The political will at the level of AU recognized Regional Economic Communities (RECS) need to be strengthen in order that the AU recognized RECs engage with the CARMMA campaign
iii. Member states should also be encouraged to develop High impact and low cost roadmaps that leverage on multi-sectorial platforms.

1. Partnerships-

112 Many member states have partners , including those within the private sector whose focus is health, reproductive health or maternal health and can provide advocacy support and or resources that can be tapped to reinvigorate the CARMMA campaign at the national level. . Their presence could be utilized in the next phase of the campaign, as suggested by an informant: "*I think this is one point that we can use to reinforce the need to support for CARMMA. Because all of them, their main objective is to improve women's health, reduce maternal deaths. So, this is a good entry point for us to continue advocating them. And there are some private companies who have money…but if we can advocate and use them, I believe we can get support for CARMMA". (*Key informant 6) and identify resources that can be tapped for reinvigorating the campaign. Since i the campaign did not come with a budget for implementation at national level, there is need to advocate for a budget line within government budgeting cycles. Funding should also be used to invest in systems such as primary health care and not stand alone programs. It is recommended that a CARMMA partnership framework (that involves the Regional Economic Communities) to support member states developed, to focus on high impact interventions.

113 For effective implementation, for partners should better harmonize the goals of the CARMMA campaign with those of the partners, at both

the regional or national level. The approach should ensure that partners' work plans align with those of government. Perhaps inclusion of several partners would contribute to better synergy for MNCH. Harmonization will reduce duplication that often arises when there are many new, un-coordinated MNCH initiatives. Avoiding duplication is the responsibility of both governments and development partners.

2. *Strengthening accountability –*

i. Although the campaign is designed with reporting structures and process, weak national mechanism for accountability and the monitoring of commitments, needs to be strengthened. A robust Accountability Framework needs to be developed, as well as improved data collection and knowledge management systems.

ii. The need for robust accountability mechanisms should be founded on strong evidence- Such a mechanism would maintain the momentum of CARMMA, ensuring that member states sustain focus on MNCH issues. In addition member states and partners should support ongoing processes at the AU Commission to develop an accountability mechanism for health commitments.

ii. Iii. There is a need to improve on the effectiveness of the coordination of stakeholders engaged in the implementation of the CARMMA campaign, , of all stakeholders engaged in the campaign at all levels should be improved aThis will also improve opportunities for mobilizing technical and financial resources for effective delivery of the MNCH agenda.

3. Linkages with academic institutions and other partners including communities

114 The campaign could benefit from strategically expanding its relationships with academic institutions and other development actors to attract expertise for its activities. Universities, private sector and local communities can help generate innovative technologies for accelerating the reduction of maternal mortality, while the private sector can also provide resources for advocacy.

115 This assessment has also illustrated the need to forge new partnerships within and across Africa and beyond to sustain the momentum on MNCH over time. Creating networks with grassroots communities and their leaders, via member states, will help tap into the role of women and custodians of culture to stimulate demand for services and reduce barriers to care.

i. ***5. Linkages with other AU reporting Frameworks and Initiatives***:

i. The CARMMA Campaign platform can be used to address other maternal, child and adolescent health issues such as Skill birth delivery, Access to modern Contraception and Reproductive Health Commodities, Unsafe Abortion, Neonatal and Child mortality, Nutrition (Stunting and Malnutrition, Immunization to name a few

ii. The CARMMA Initiative should take advantage of relevant and existing reporting Frameworks and Initiatives including the NEPAD peer review mechanisms, the Conference of Finance Ministers and the Committee of the Africa Rights and Welfare of the Child, to strength member state reporting on MNCAH.

iii. Linkages need also to be made with the changing times and interest. Linkages of Maternal, Newborn and Child Mortality need to be made with emerging areas such as Population Growth, Human Resources for Health, Climate change, Urbanization and Emergency/Humanitarian Health.

Lessons learnt and best practices for future advocacy strategies

i.Effective coordination of advocacy strategies in national setting

116 Member states with effective coordination mechanisms embedded within national structures tended to implement campaign strategies effectively. It was observed that political commitment and financial investment in health contributes to better MNCH results; and is thus an essential ingredient of an effective advocacy campaign. More generic issues, such as investment in family planning programmes, tend to yield dividends for women and children; hence in some member states a focus on family planning was an important driver for improving women's health and became an entry point for the campaign. In other member states, strong partnerships and having a system for coordinating key MCNH players helped to facilitate campaign strategies.

117 In addition, multi-sectorial strategies were found to be a key driver of success. The focus should not be only on the health sector, but also on health-related sectors that influence care seeking. For example, one respondent noted that:

> "*The other lesson is that of multi- sectorial linkages. Some people think that if a woman is dead, this is a health problem, and not my problem. So, water energy, road transport has a role to play in assisting health problems. We need to have this conscious effort that this is a problem of all and maternal death is not the problem of health sector alone because the woman died, so health is the one responsible for that death. We need have an open mind and ways to integrate the responses to solve the problem". (*Key informant 6)

ii. Re-investing in high- impact interventions and increasing resources for specific strategies

118 The benefits of investing in high-impact interventions was identified as a best practice. Member states like Ethiopia invested in community health programs and increased the number of midwives to increase coverage of services that contributed to improved access. Kenya, meanwhile, continued to invest in its community health programme, with varied outcomes. Rwanda has invested in improving the supply chain management system, which has helped to track the commodities to the service level. In Madagascar, an electronic commodity system helped the country ensure the availability of reproductive health commodities. Thus commitment to implementing high-impact interventions, along with the ability to measure their impact, is a critical driver of success.

iii. Use of existing structures – critical for ownership and domestication

119 Where the campaign was effectively embedded within local, national or regional structures its implementation was easily contextualized – meaning that the chosen intervention was likely to make a difference in that setting. This underlines the importance of understanding interventions being implemented at the national level, as well as ensuring that they are anchored in the existing policy frameworks

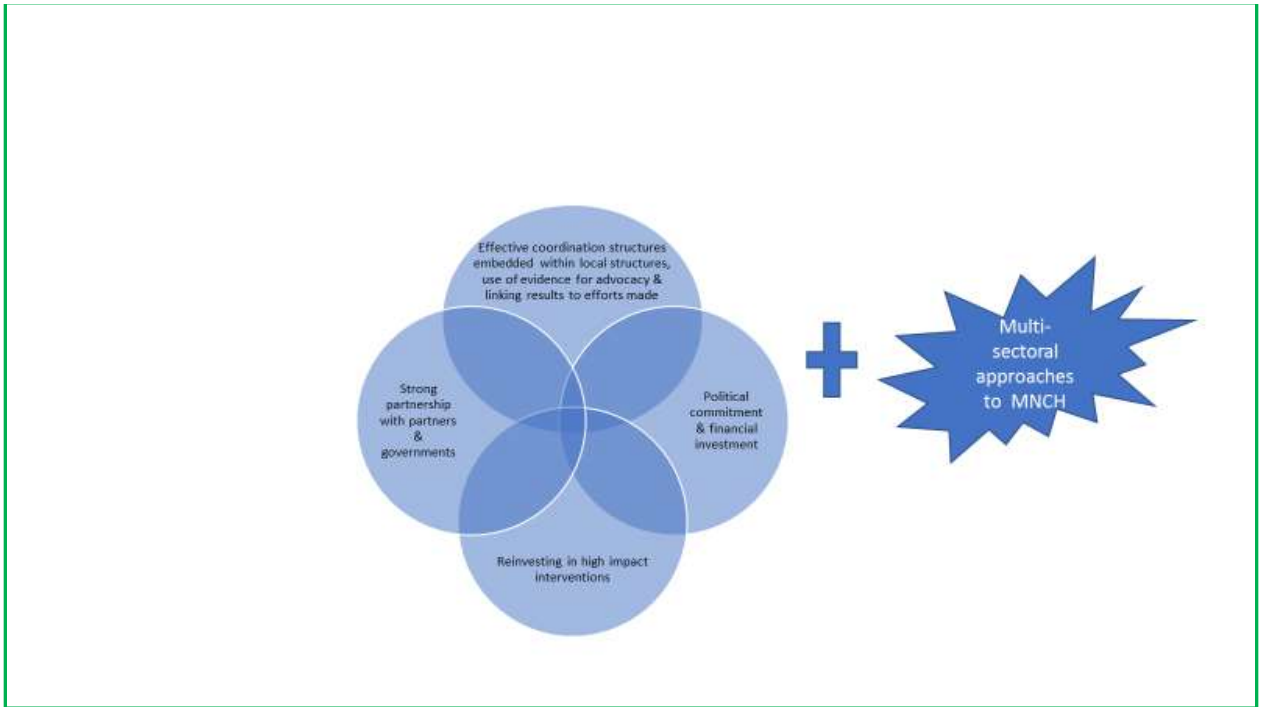
iv. Evidence-based advocacy

120 Use of data for decision-making is becoming widespread and could be developed further. It was, however, noted that the results should be made simpler to make it easier for policy makers and politicians to understand and use. In settings where the campaign linked efforts with results via use of data, there appeared to be identifiable progress on key indices. Through the campaign initiatives, the issue of maternal mortality in member states was made visible and became a tool for action. The inclusion of evidence enabled countries to identify gaps for future focus. These lessons are summarized in Figure 16.

v. Domestic Financing

121 The CARMMA campaign did not relie on in-built budgetsfor activities at the national level action. , tAdvocacy for budgetlines dvocate within government funding cycles will be i an advantage to national CARMMA campaigns. Limited funding has also limited the activities that could be carried out at the national level..

Figure 16: Effective ingredients for successful CARMMA advocacy strategies



Policy and practical implications of the campaign

122 This section examines the key policy and practice implications resulting from CARMMA implementation. It seeks to illustrate whether new ground was broken in terms of policy, practice or influencing member states and key partners relevant to the campaign, and whether campaign structures could influence MNCH policy and practice on the continent.

123 Overall analysis of the campaign indicates that CARMMA was able to create a continent-wide advocacy movement in Africa for addressing MNCH. The branding strategy was appropriate and built on the poignant issue of caring for Africa's women, illustrated by the slogan "*Africa Cares: No woman should die while giving life".* The campaign succeeded in influencing national policies; for example, member states revised their national policies to, *inter alia*, provide free maternal and child health services and institute maternal death audit systems.

124 The campaign elevated the maternal and child health agenda high on political agendas, prompting African leaders to ask, *"What should then be done?"* The campaign focus on low-cost, high-impact interventions resonated very well in the African context and reality. African leaders bought into this idea and across the continent, high-impact maternal and child health interventions were launched, thanks to the campaign.

125 CARMMA also had a tremendous influence on the global agenda for maternal, child and adolescent health. The campaign influenced the African Common Position on the Post-2015 Development Agenda, which in turn influenced the Global Sustainable Development Agenda. Furthermore, the current discourse on ending preventable maternal, new-born, child and adolescent deaths began at the International Conference on MNCH in Africa.

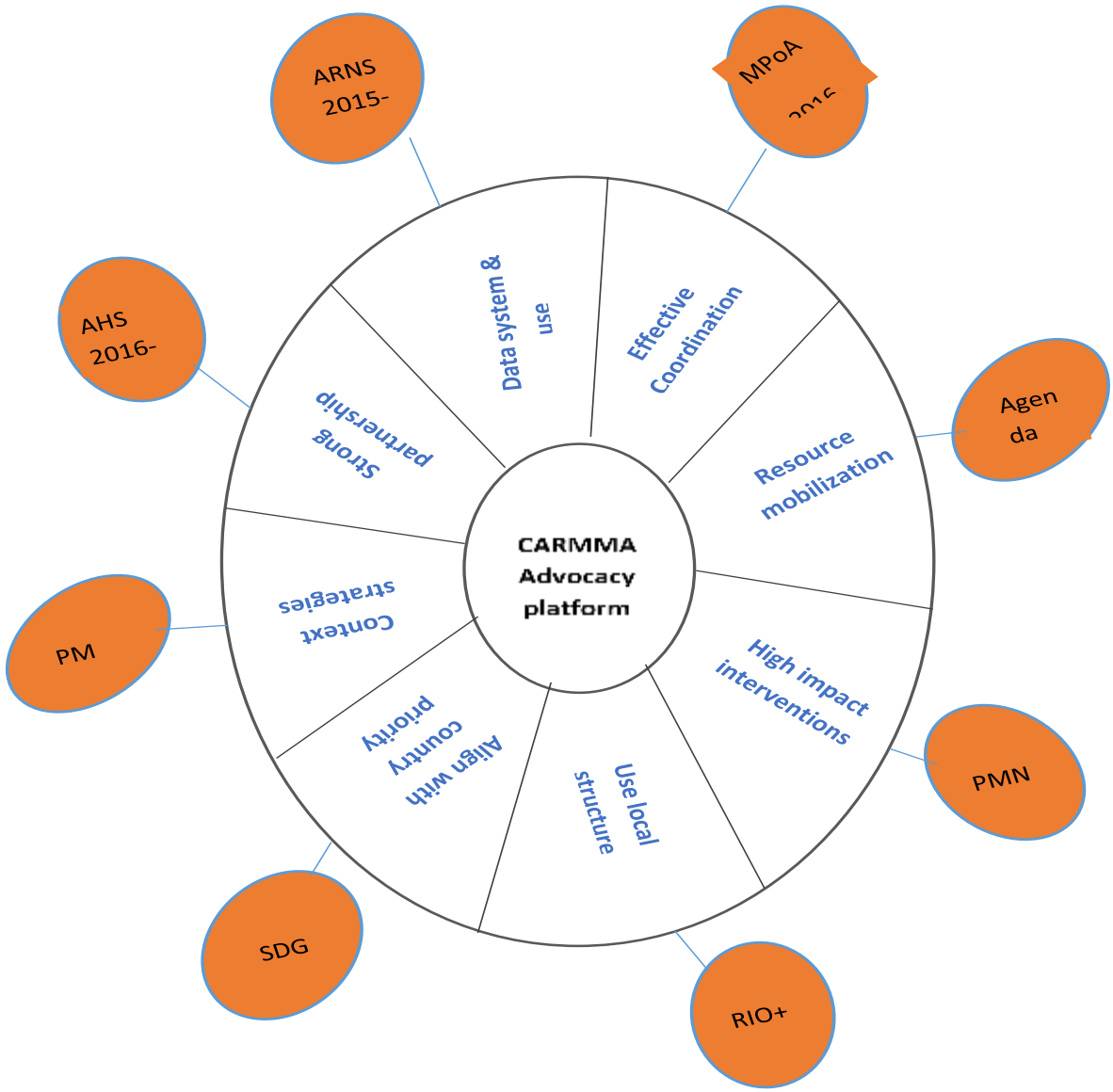
CHAPTER FOUR: CONCLUSION

122 The evaluation has illustrated the importance of the CARMMA campaign in championing the health maternal and sexual and reproductive rights of women, children, inclusive of and with an emphasis on adolescences. The CARMMA platform also enabled the African Union to spearhead and prioritize maternal and child health issues on the political agenda of most countries. The campaign further influenced the global agenda on women and children's health. The advocacy campaign had several successes that can be used to further propel this agenda, considering the changing global landscape and new initiatives to galvanize past efforts to improve women's and children's health. A focus on the health of women, children and adolescents has the potential to improve health systems delivery and to retain a central place in the social and economic development of member states.

123 Three main conclusions can be drawn from this evaluation:

i. The CARMMA campaign generated interest and contributed to sustaining the agenda for women's and children's health. The campaign also, provided a vehicle for many other initiatives with a similar focus. However, to drive change in Africa the new initiatives will also need to support the campaign's advocacy agenda, as illustrated in figure 17. CARMMA's advocacy agenda should be at the center of all strategies related to women's, children's and adolescent health and all future initiatives, that seek to improve not only health indicators, but also health systems in general. The CARMMA campaign should build on the lessons learnt and best practices identified by the assessment. This includes, but is not limited to the continued use of local structures for implementation of the campaign at national level. Aligning the campaign with local priorities and leadership, is critical to ensuring that entry points are identified that are context specific and relevant

Figure 17: Conceptual framework for re-organizing a future CARMMA campaign



Key:

MPoA- Maputo Plan of Action: SDGs-Sustainable Development Goals; PMNCH- Partnership for Maternal, New-born & Child Health; PMPA-Pharmaceutical Manufacturing Plan for Africa; AHS- African Health Strategy; ARNS- Africa Regional Nutrition Strategy

ii. The advocacy strategy implemented under the CARMMA icampaign is still relevant for Africa, as it will continue to provide a self-assessment platform for AU member states on matters of health, particularly of women, children and adolescents. Women, children and adolescents are core to the political agenda of member states. The next phase of implementation should endeavor to incorporate reflections and suggestions provided in this report as a way to improve the campaign's efficiency and effectiveness. Involving other stakeholders that were not engaged during the last decade could also be instrumental for resource mobilization, as well as for supporting accelerated implementation of the campaign.

In conclusion the CARMMA campaign generated several successes that have resulted in continued placement of women's, children's and adolescents health high on political agendas of the continent. It's therefore an initiative that provides a solid platform for future initiatives. The CARMMA campaign will require some restructuring and the mobilization of additional resources to effectively deliver results in coming years. The focus of the campaign should also be on ensuring that countries implement high-impact interventions at scale.

The future of Africa depends on how well it treats women, children and adolescents and in the ending of all *preventable maternal neonatal, child and adolescent deaths.* **"Africa Cares: No Woman Should Die while Giving Life-and all preventable maternal, neonatal, child and adolescent deaths should end by 2030"** should continue be the CARMMA goal.

CHAPTER FIVE: RECOMMENDATIONS

124 One of the aims of this evaluation was to propose changes that need to be made on campaign design and implementation, to ensure that CARMMA meets the commitments set out in the AUs transformative Agenda 2063, the revised AU health policy instruments, , and other global commitments. The campaign's post-2015 focus should be guided by the revised African Health strategy (2016-2030) and the revised MPoA (2016-2030). The campaign's vision, mission, objectives and strategic focus should be reviewed to reflect this reality, as initially everything was tailored to achieving the MDGs. This section synthesizes some of key ideas that emerged from the literature review, observation and key informant interviews.

a) Mobilization of adequate resources to support campaign activities

125 The campaign relied on high-visibility actors in each member states to reinforce its messages on MNCH. The next phase requires the mobilization of adequate financial resources (including domestic resources) to support clear strategic activities across the continent and specific activities at the national level. Key approaches to sustainable financing for advocacy could be developed as follows:

- Member states should place emphasis on activities that ensure the integration and institutionalization of CARMMA objectives within national frameworks.
- The mobilization and generation of sustainable domestic financial resources drawn from domestic budgets at all levels of governance.
- The use of technology such as social media to publicize information on the campaign on focus areas and for targeted audiences.
- Mobilize funds at the AUC level to enable the CARMMA Secretariat to improve accountability of CARMMA Initiative, improve accountability of the CARMMA Initiative on follow-up and ensure that continent-wide strategies are implemented effectively.

b. Strengthen the CARMMA Secretariat with adequate human resources and a fair degree of autonomy

126 The African Union Commission should consider strengthening CARMMA's human resources to ensure adequate capacity to implement campaign activities and achieve the expected outputs and desired outcomes. The Secretariat should be situated within the Department of Social Affairs and facilitate functional linkages with all the other relevant divisions and departments. Linkages with other advocacy activities on the continent might help sustain the AUC's efforts.

c. Broaden campaign partnerships with specific attention to bringing the private sector and regional economic communities on board

127 Partnering with the private sector presents a great opportunity for the campaign in terms of financial, (including mobilizing domestic resources) health services provision and technology and innovation for health. Moving forward, the campaign should reach out to the private sector for buy-in and support.

128 The Mama Afrika Award is one of the initiatives that could be supported by an engaged private sector. The campaign should also leverage the comparative advantage of RECs, both to advance campaign goals and address specific issues, such as sustainable domestic financing of CARMMA activities and regional accountability mechanisms that feed into the continent-wide accountability mechanism. Redefining the coordination mechanisms between RECs and the AUC could lead to including joint monitoring, joint evaluation (whenever possible) and regular information exchange, all of which could help strengthen working relations.

c. Strengthen the accountability mechanism

129 The need to strengthen the accountability mechanism was mentioned by almost all key informants. The Commission should be nerve centre of the mechanism, which should take advantage of existing REC and country accountability structures. The Commission should seek support from partners – especially those supporting national and regional accountability systems – to strengthen REC and national accountability mechanisms

130 It is also recommended that the indicators of the CARMMA scorecard are fully in line with the indicators of the revised Maputo Plan of Action (2016-2030).

e. Review the frequency of the MNCH status reports and meetings

131 This evaluation noted that tremendous effort was required to generate MNCH status reports and follow up on recommendations and decisions. Lack of resources. The following should be considered:

- Review the timing between reports and meetings to reduce the administrative burden and allow reasonable time for implementation of recommendations and decisions. Three to five years intervals between reports and meetings should be considered.

b. Revise the campaign strategy in line with continental and global post-2015 commitments on MNCH and adolescent health

132 Looking ahead, the campaign should continue to focus on the unfinished MDG health agenda for women, newborns and children, and take into account the sustainable and transformative agendas of the global SDG's and Agenda 2063 for women and children with a specific focus on adolescent health.

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3. ENDNOTES

1. World Health Organization, *Trends in maternal mortality: 1990 to 2013 – Estimates by WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division*, WHO, Geneva, 2014.

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8. L. Liu et al., 'Global, regional, and national causes of under-5 mortality in 2000-15: An updated systematic analysis with implications for the Sustainable Development Goals*', The Lancet*, **388**(10063), pp. 3027-3035, 2016.

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11. World Health Organization, 'The prevention and management of unsafe abortion,' Technical Working Group report, WHO, Geneva, 1992 *(WHO/MSM/92.5).*

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13. G. Sedgh et al., 'Abortion incidence between 1990 and 2014: Global, regional, and subregional levels and trends'*, The Lancet*, 388(10041), pp. 258-67, 2016.

Annex 1: List of core CARMMA indicators

No.	INDICATOR
1	Existence of a national health policy that integrates SRHR, HIV/AIDS/STI and malaria services
2	Existence of laws addressing sexual and gender-based violence
3	Proportion of stunting under five years
4	Contraceptive prevalence rate
5	Unmet need for family planning
6	Adolescent fertility rate
7	Proportion of unsafe abortion in a country per 1,000 women aged 15-49 years
8	Costed national implementation plan(s) for maternal, new-born and child health available
9	Proportion of births attended by skilled health personnel
10	Maternal mortality ratio (MMR)
11	Neonatal mortality rate
12	Proportion of infants 12 – 23 months immunized against DPT3
13	Infant Mortality Rate (IMR)
14	Under-5 mortality rate
15	Percentage of pregnant women who attended at least 4 ANC visits

16	Number of facilities per 500,000 providing basic and comprehensive emergency obstetric care
17	Percent of women receiving postpartum care by a skilled health personnel within two days of childbirth
18	Percentage of new-born who receive post-partum care from a skilled birth attendant two days after delivery
19	Reproductive health packages in place (MH, FP, PAC and STI prevention, HIV)
20	Proportion of districts that have an established and functional MDSR system
21	Percentage of the allocation on budget line for RMNH expended

Annex 2: Assessment Tools

Annex 2a: Key informant interview guide for African Union staff

Date of discussion: [___|___ /___|___/__2_|_0___|__1_|_7__]	Interviewer:
Note-taker:	
Start time: [___|___:___|___]	End time: [___|___: ___|___]
Venue of interview:	Country/setting:
Position of participant:	Gender:

Introduction:

Thank you for your willingness to take part in the interview. Your responses will be most helpful for understanding the relevance/appropriateness, effectiveness, efficiency, impact and sustainability of the CARMMA campaign. We will be asking you questions based on your knowledge of and experience in getting involved in activities that have implications on CARMMA initiative.

Focus areas/questions:

- To what extent has the CARMMA campaign objectives, outcomes and impact been achieved;
- What are the key elements of effectiveness of the campaign focus- structure, ownership and coordination arrangements within countries/regions
- What are the opportunities, challenges and lessons learnt in implementing the campaign at continental, regional and country level?
- How can the policy initiatives under CARMMA be utilized for future agenda-technical requirements, structural adjustments needed to effectively contribute

to the attainment of Agenda 2063, Agenda 2030, UN Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health as well as any other global commitments.

Ice breaker	**Probes and follow on questions**
Q1: Tell us is about a short history of the CARMMA initiative.	-What are the key activities that have been implemented by AU to effectively ensure the campaign is implemented at country level? -what structures did you put in place to effectively ensure ownership of the campaign at country level? -What is your opinion about these activities? **[Probe for their views on the political commitment of the countries, governance, approaches being implemented in country]** ***Key focus: whether they think the campaign has been useful -relevance with changing context and their view on whether they think it is a good vehicle for coordinating and accelerating MNH activities in countries.***
Topic I: Implementation experience of CARMMA campaigns	

Q2: Let us now specifically talk about the implementation experiences of the CARMMA campaign at country level. How has the countries implemented/domesticated the campaign locally?	-Type and range of activities implemented- activities done at country level to ensure • Political commitment-has these been achieved why and how? • Sharing best practices-forums that have been used and has that been effective? • Data sharing and generation- how has that been useful at country level/regional. What are the existing efforts for data use? Has that been useful in accelerating initiatives for MNCH • Domestic Resource mobilization for MNHCH- any progress on that, challenges and success -How best has the campaign been accepted locally- what are the coordinating structures in country/regional level -do you think the initiatives has been adequately domesticated- if no why if yes how- acceptance levels, tendency to ownership What were the various organization's roles and performance as implementation agencies? Were there new ground broken in terms of policy, practice or in influencing member states and key partners relevant to the campaign? Tell us do you think the campaign has adequate structures to influence maternal, new-born and child health policy and practice in the continent?

Q3. What are the opportunities do you think CARMMA campaign has in accelerating reductions on key maternal and new-born outcomes?	- What avenues can be used to strengthen the initiative towards achieving its objectives? [**Probe for how they have used that or planning to do so, frequency, existing mechanism for ensuring targets are reached]** -How can the strategies be strengthened to reach the targets set? **[Probe for what alternative approaches they think would be made better, how it will operate and why]** What changes have you made in the past to ensure adherence to that target set? **[Probe for changes and reasons for changes)** **How appropriate are approaches used to ensuring the targets are achieved**
Topic II: Challenges and barriers experienced in the past	

Q4. What are the greatest barriers to ensuring the CARMMA campaign gain roots in your countries/regions?	**What were the challenges of implementing the campaign?** **What country /regional level barriers exist**? **[probe for the following issues and any other]** - political commitment -coordination challenges with other initiatives - governance structures - resource to domesticate process - Attitude of leadership due to various strategies being employed -competing interests -What other context barriers exist? -Are there any structural barriers that may exist In your opinions, what should be done to address the challenges and why? How appropriate were the campaign management tools and the challenges which exist? How appropriate were the coordination and governance structures of the campaign in meeting the objectives? What can be improved? What were the opportunities?
Topic III: Benefits lessons & Sustainability	

Q5 What are your views regarding the future of CARMMA in the region?	What is the greatest achievement can you cite that has resulted from the CARMMA initiative? What are the key outputs, outcomes and impacts that can be attributed to the campaign? In your opinions, what positive influences do you foresee if the Campaign is implemented adequately What about negative influences you foresee if implemented inadequately? -How can the campaign be sustained over time to ensure it delivers on its mandate? What measures have been taken to ensure long term sustainability of the campaign? What are the lessons that emerge from the implementation of the initiative? What are some of the best practices that you can cite because of the campaign? What are some of the new information/evidence that has been gathered/generated by the campaign? How the campaign strengthened African Union work in maternal, new-born and child health? How appropriate were the implemented activities in addressing the campaign purpose, objective and outputs? d) The lessons learnt and best practices
Topic IV: Recommendations	

Q6 What suggestions do you have for improving the CARMMA in the African region?	What are the ways in which the campaign can be improved [**Probe for structures needed-coordination, ownership, future strategies that can be used etc)** Who should be involved in improving it & why? Is there any other general issue you would like raise? -What would you recommend should be done differently regarding the campaign? What changes that need to be made on the campaign design and implementation to be in tandem with Agenda 2063, AU health policy documents and other global commitments? Is there any recommendation you can make for future continental campaigns?
Q7. Do you feel that there is anything we have left out? Is there something you would like to mention regarding the CARMMA initiative for the region?	

We have now come to the end of our discussion.

THANK YOU VERY MUCH FOR YOUR TIME

Annex 2b: Key informant interview guide for regional UNFPA/country teams

Date of discussion: [___|___ /___|___/__2_|_0__|__1_|_7__]	Interviewer:
Note-taker:	
Start time: [___|___:___|___]	End time: [___|___: ___|___]
Venue of interview:	Country/setting:
Position of participant:	Gender:

Introduction:

Thank you for your willingness to take part in the interview. Your responses will be most helpful for understanding the relevance/appropriateness, effectiveness, efficiency, impact and sustainability of the CARMMA campaign. We will be asking you questions based on your knowledge of and experience in getting involved in activities that have implications on CARMMA initiative.

Focus areas/questions:

- To what extent has the CARMMA campaign objectives, outcomes and impact been achieved;
- What are the key elements of effectiveness of the campaign focus- structure, ownership and coordination arrangements within countries/regions
- What are the opportunities, challenges and lessons learnt in implementing the campaign at continental, regional and country level?
- How can the policy initiatives under CARMMA be utilized for future agenda-technical requirements, structural adjustments needed to effectively contribute

to the attainment of Agenda 2063, Agenda 2030, UN Secretary-General's Global Strategy on Women's, Children's and Adolescents' Health as well as any other global commitments.

Ice breaker	**Probes and follow on questions**
Q1: your country/region has been involved in the CARMMA initiative. In general, what specific task has your organization/country been involved in?	-What are the key activities has your organisation/country been involved under the CARMMA campaign? -How long has the organisation/country been involved in CARMMA? -What is your opinion about the activities that your organisation/country has been involved? **[Probe for their views on the political commitment of the organisation/country, governance, approach being implemented in country, ask what they know about the CARMMA campaign - focus areas covered)** ***Key focus: whether they are aware of campaign and their view on whether they think it is a good vehicle for coordinating and accelerating MNCH activities in their country.***
Topic I: Implementation experience of CARMMA campaigns	

Q2: Let us now specifically talk about the implementation experiences of the CARMMA campaign at country level. How has the country implemented/domesticated the campaign locally?	-Type and range of activities implemented- activities done at country level to ensure • Political commitment-has these been achieved why and how? • Sharing best practices-forums that have been used and has that been effective? • Data sharing and generation- how has that been useful at country level/regional. What are the existing efforts for data use? Has that been useful in accelerating initiatives for MNCH • Domestic Resource mobilization for MNCH- any progress on that, challenges and success -How best has the campaign been accepted locally- what are the coordinating structures in country/regional level -do you think the initiatives has been adequately domesticated- if no why if yes how- acceptance levels, tendency to ownership How appropriate were the campaign management tools and the challenges which exist? How appropriate were the coordination and governance structures of the campaign in meeting the objectives? What can be improved? The various organizations' roles and performance as implementation agencies?

Q3. What are the opportunities do you think CARMMA has in accelerating reductions on key maternal, newborn and child health outcomes?	- What avenues can be used to strengthen the initiative towards achieving its objectives? [**Probe for how they have used that or planning to do so, frequency, existing mechanism for ensuring targets are reached]** -How can the strategies be strengthened to reach the targets set? **[Probe for what alternative approaches they think would be made better, how it will operate and why]** What changes have you made in the past to ensure adherence to set targets? **[Probe for changes and reasons for changes)** **How appropriate are approaches used to ensuring the targets are achieved?** What were the opportunities? What lessons learnt and best practices out of the campaign?
Topic II: Challenges and barriers experienced in the past	
Q4. What are the greatest barriers to ensuring the CARMMA gain root in your countries/regions?	What are the greatest challenges of implementing the campaign? **What country level barriers exist**? **[probe for the following issues and any other]** - political commitment -coordination challenges with other initiatives - governance structures - resource to domesticate process -competing interests -What other context barriers exist?

	-Are there any structural barriers that may exist In your opinions, what should be done to address the challenges and why?
Topic III: Benefits lessons & Sustainability	

Q5 What are your views regarding the future of CARMMA in the country?	What are the main outputs, outcomes and impacts that can be attributed to the campaign? What is the greatest achievement can you cite that has resulted from the CARMMA initiative? In your opinions, what positive influences do you foresee if the Campaign is implemented adequately What about negative influences you foresee if implemented inadequately? -How can the campaign be sustained over time to ensure it delivers on its mandate? What measures have been taken to ensure long term sustainability of the campaign? What are the lessons that emerge from the implementation of the initiative? What are some of the best practices that you can cite because of the campaign? Was there any new information/evidence gathered/generated by the campaign? If yes what was it How the campaign strengthened African Union work in maternal, new-born and child health? In your opinion how appropriate were the implemented activities in addressing the campaign purpose, objective and outputs? Is there new ground broken in terms of policy, practice or in influencing member states and key partners relevant to the campaign? What is the adequacy of the campaign structures to influence maternal, new-born and child health policy and practice in the continent?
Topic IV: Recommendations	

Q6 What suggestions do you have for improving the CARMMA in the African region?	What are the ways in which the campaign can be improved [**Probe for structures needed-coordination, ownership, future strategies that can be used etc)** Who should be involved in improving it & why? Is there any other general issue you would like raise? -What would you recommend should be done differently regarding the campaign? What changes need to be made on the campaign design and implementation to be in tandem with Agenda 2063, AU health policy documents and other global commitments? Do you have any recommendations for future continental campaigns?
Q7. Do you feel that there is anything we have left out? Is there something you would like to mention regarding the CARMMA initiative for the region?	

We have now come to the end of our discussion.

THANK YOU VERY MUCH FOR YOUR TIME

Country	Activities
Angola	The Government of Angola launched CARMMA in August 2010. It was launched by the vice president of Angola, Fernando da Piedade Dias dos Santos, with the participation of ministers and vice ministers from key sectors (health, family and women's promotion, and the interior), provincial vice-governors and representatives of the African Union. The WHO Regional Director for Africa, Dr. Luis Sambo, and representatives of key UN Agencies (UNFPA, UNICEF and WHO) were also in attendance. At the launch the Government of Angola created an inter-sectorial committee for the accelerated reduction of maternal and infant mortality, under the chairmanship of the Minister for the Promotion of Family and Women. UNFPA, UNICEF and WHO worked in partnership to support the Government in the launch and committed to provide support in terms of follow-up actions. The vice president has regularly made reference to CARMMA, including at the Second Inter-Ministerial Conference on Health and Environment in Africa held in Luanda in November 2010, during which he called for multi-sectorial support for maternal mortality reduction.
Burkina Faso	The CARMMA launch ceremony in Burkina Faso was chaired by Mrs. Traoré Clémence from the Ministry of the Promotion of the Woman, and attended by UNFPA Representative Mr. Mamadou Kanté, Mr. Traoré Adama of the Ministry of Health, Mr. Jean-Christophe Ilboudo, assistant to the Mayor of the city of Ouagadougou and Mrs. Djamila Cabral, representing WHO. The end of the ceremony was marked by the distribution of sanitary equipment and contraceptive products.
Benin	CARMMA was launched in Benin on 27 October 2010, and a national road map was developed and implemented for the duration of that year's campaign. During CARMMA Week in 2011, the roadmap was revised. Different strategies have been adopted for social mobilization, including: the free offer of contraceptives and voluntary HIV testing, interactions with young people, spotlight on reducing maternal mortality, dissemination of messages through community radio stations, use of billboards across the country to display messages and development of a short film on the fight against maternal mortality. Most of these activities were extended during CARMMA Week in 2011. CARMMA has had a very positive impact in the country and several activities enjoyed support from partners, government institutions, traditional leaders, religious organizations, civil society and communities. While preparing to launch the campaign in 2010, resources were mobilized from technical and financial partners (UNFPA, WHO, UNAIDS, European Union, USAID, Care International, and Population Services International. Similarly, with the support of UNFPA and other partners, a national strategy to integrate HIV/RH was developed and validated by the Ministry of Health.
Burundi	To accelerate the reduction of maternal mortality, CARMMA was officially launched in July 2011 by the wife of the first vice-president of the Republic of Burundi during the National Week of Reproductive Health, under the theme: "No woman should die giving birth: Family Planning for the well-being of families." CARMMA helped to reposition family planning and a review of policy documents and programmes on reproductive health (e.g., introducing maternal death audits, increasing government budget for securing reproductive health products).

Botswana	Following the launch of CARMMA in 2011 the Ministry of Health, working through the Safe Motherhood Initiative Programme and its Public Relations Section, collaborated actively with the media to enhance the public profile of the campaign. One of Botswana's most successful maternal mortality reduction efforts has been the very active and public work of its CARMMA champions. Botswana has started special training programmes that involve doctors, midwives and nurses in a variety of subjects and skills.
Central African Republic	CARMMA was launched in the CAR in April 2010 by President François Bozizé, who thereby demonstrated his Government's commitment at the highest level to improve maternal health. The launch took place with the participation of high-level Government officials and policy makers, parliamentarians, diplomats, professional associations (journalists, medical associations), civil society (including White Ribbon Alliance) and community members. UN Secretary-General Special Representative to CAR, Mrs. Sahle Work Zewde, spoke on behalf of the UN System. The aim of CARMMA in CAR is to ensure that every pregnant woman delivers in a health facility.
Chad	The launch of CARMMA in Chad was organized under the auspices of the First Lady, Mrs. Hinda Deby Itno. She expressed a desire to see CARMMA yielding a new Chad, where fewer women die while giving birth. In order to ensure a rigorous follow-up of the commitments and the Action Plan, which covers a period of three years, Mrs. Itno nominated the first Chadian midwife, the late Mrs. Achta Toné Gossingar, as CARMMA Goodwill Ambassador. Speaking at the ceremony, the then UNFPA's Deputy Executive Director for Programmes, Mrs. Purnima Mane, reaffirmed UNFPA's commitment to support Chad's efforts to reduce maternal mortality.
Democratic Republic of Congo	The Democratic Republic of Congo is one of three African countries and six countries worldwide that contributes to 50 per cent of the world's maternal mortality rate. Thus it was expected that the DRC would be among the early adopters of the CARMMA programme. Following the visit of Mrs. Thoraya Obaid, former Executive Director of UNFPA and Mr. Michel Sidibé (ED of UNAIDS) to the DRC in May 2010, the Head of state, Mr. Joseph Kabila Kabangue, committed to launching an initiative on an AIDS-free generation and combating maternal mortality. With the assistance of the minister of health, the high-profile CARMMA launch event was held in April 2011, presided over by the First Lady, Mrs. Marie Olive Lemba Kabila. In her supportive address, the First Lady appealed to spouses to assist their partners before, during and after pregnancy and called on Government to increase the budget for the health sector; Parliament to enact laws to promote family planning; and local/ provincial governments to mobilize resources for maternal and child health and launch CARMMA in their provinces.

Cameroon	Following the launch of CARMMA in 2010 the Government developed the 2011-2013 national strategic plan on CARMMA, based on the Maputo Plan of Action. To support the Ministry of Public Health in implementing the MPoA, UNFPA led the development of the H4+ Joint Programme to implement CARMMA in Cameroon – the first of its kind in the country. A first concrete result of CARMMA and its supporting programme frameworks was the Government decision to open eight midwifery training schools across the country – the last midwife in Cameroon previously having graduated in 1987. The second wave of 200 students is currently being trained as midwives. Among other recent developments is a project in the North region to make obstetric kits (for deliveries and Caesarians) available to pregnant women at a fixed price. This increased the number of monthly deliveries at participating health facilities by about 70 per cent during a six-month period. UNFPA Cameroon also benefited from the first debt-for-health sector-wide approach for the Government of Cameroon, with debt relief funding from France. The programme provides for an innovative and large-scale training scheme for health personnel on delivery of emergency obstetric and neo-natal care, including prevention of mother-to-child transmission of HIV in Cameroon's three northern regions.
Equatorial Guinea	The Government and the First Lady of Equatorial Guinea, Mrs. Constancia Mangue de Obiang, organized the launch of CARMMA at a luncheon event before a meeting of the executive committee of the Association of First Ladies Against HIV and AIDS in June 2011. UNFPA's Executive Director, Dr. Babatunde Osotomehin, was one of three keynote speakers, along with Minister of Health Antonio Martin Ndong Ntutumu and the First Lady. The event attracted more than 500 people representing Government, civil society organizations, the private sector and international NGOs. It was a wake-up call and a reminder to all that although there is a road map for improving maternal and child health and Government budgetary commitment funds have yet to be made available to carry out activities.
Eritrea	At the launch of CARMMA in Eritrea, in September 2010, Minister of Health Amina Nurhussien, pledged the commitment of her Ministry to the accelerated reduction of maternal and perinatal mortality in Eritrea. The Ministry' focus is on such effective strategies as awareness of clients, families and communities to make preparations for delivery by skilled birth attendants in health facilities; expanding maternity waiting homes; improving access to fully functional basic and comprehensive emergency obstetric care facilities; ensuring availability of equipment, supplies, drugs and human resources; introducing life-saving drugs such as Magnesium sulphate and Misoprostol; expanding postpartum home visits within 24 hours and three days of delivery; and strengthening the programme on fistula prevention, treatment and reintegration. The programme is strengthening the health system by empowering young doctors to provide emergency obstetric and neonatal care, including Caesarean deliveries. Also, strategic health centres are being upgraded to

	community hospitals, enabling them to offer comprehensive emergency obstetric and neonatal care services, while in-service training is being given to midwives and other health care providers, as well as young doctors, in the provision of these services
Ethiopia	During the launch of CARMMA on 23 February 2010, Minister of Health Tedros Adhanom pointed out the importance of having facility-based interventions in addition to community-based ones. CARMMA has led to special services on maternal mortality reduction becoming an integral part of the health sector development programme and the maternal and new-born health road map. Among the most significant developments is that the month of December is now recognized and dedicated nationally to advocacy for the reduction of maternal mortality.
Gambia	Development of the national road map for CARMMA implementation in The Gambia is being undertaken by the National Assembly select committee on health. The launch of the campaign on 24 July 2010 by Vice President Dr. Isatou Njie Saidy was followed in four regions by social mobilization, behavior change communication/information education counselling, publicity, awareness-raising and community sensitization activities. These activities involved regional governors, women's groups and Ministry of Health staff. Some of the activities in the regions involved resource mobilization and partnership with the private sector, civil society and other agencies, cofounded by UNFPA and regional authorities. The government has pledged to continue to support activities on maternal mortality, and the country has Global Fund support for strengthening health systems through capacity building. Since 2010, hospitals have been carrying out maternal death audits funded by UNFPA; audits were expanded to all regional hospitals and the main referral hospital. With the support of UNFPA, WHO and the Global Fund, efforts are underway to improve the capacity of health care workers, particularly midwives, and those rendering emergency obstetric services. Among notable local efforts, some communities have developed a funding mechanism through which women preparing for hospital deliveries can obtain interest-free loans for transportation.

Guinea Bissau	The campaign was launched in Bissau under the theme, “Giving Life without Dying.” The ceremony was chaired by the Minister of the Presidency of the Council of Ministers, representing the Prime Minister. Present were parliamentarians, the Director-General of the West African Health Organization, members of Government, a representative of the First Lady, members of the diplomatic corps and international organizations, including UNFPA, WHO, and UNICEF. “Maternal mortality is one of the highest priorities of the Government,” said the Minister, “and the launch of CARMMA shows once more the urgent need to mobilize the resources required to overcome the challenge and sensitize communities for their greater involvement.” She pledged that the Government would do its best to improve working conditions for professionals in order to ensure the reduction of maternal and neonatal mortality.
Ghana	Under the guidance of the then-First Lady, Mrs. Ernestina Naadu Mills, CARMMA made tremendous strides in Ghana after the national launch in 2009. Naadu Mills also formed a technical team comprised of staff from the Ghana Health Service, UNFPA and her office, which was tasked with formulating a concept paper that enabled her to take the message to the nation’s 10 administrative regions. She ensured that traditional authorities were included because they wield a lot of power and have a critical role to play in reducing maternal deaths. At the launches, municipal and district assemblies made a variety of maternal health commitments, including the development of basic infrastructure, transportation, provision of equipment, personnel training, free ambulance services, CHPS compounds and antenatal clinics. Each region and district of Ghana has pledged to make commitments and contributions to reduce maternal mortality by ensuring the provision of services and infrastructure (including transport) with a direct bearing on reducing maternal deaths within their respective districts and municipalities. These commitments are reviewed yearly as part of the MDG Acceleration Framework (MAF) – Ghana Action Plan.
Gabon	The official launch of CARMMA in 2011 by the First Lady, Mrs. Sylvia Bongo Ondimba, has catapulted maternal and child health to the front and centre of the Gabonese national health agenda. As a renowned national champion for maternal and child health, Mrs. Bongo Ondimba has, through her programme Tous Unis pour la Santé maternelle (United for maternal and child health), embarked on the capacity building of hundreds of health workers from both the public and private sectors on sexual and reproductive health, including family planning. Thousands of delivery kits and mosquito nets were distributed to expectant mothers. The high profile 2012 The New York Forum hosted by Gabon devoted an entire day’s session on action for improving health systems and maternal health, with the active participation of high-level speakers such as Ms. Edna Adan Ismail and Mrs. Nahid Toubia of White Ribbon Alliance Sudan. Gabon has since been positioning family planning through development of a national family planning strategy. Other key ini-

	tiatives include the revision of the road map for maternal mortality reduction, a national survey on family planning and mass family planning sensitization campaigns.
Kenya	The launch of CARMMA in Kenya in November 2010, led to increased publicity and donor engagement on maternal and new-born health. Prior to the launch, in August 2010, the Government launched a maternal and new-born health (MNH) roadmap, the objective of which was to achieve the Millennium Development Goals. At the primary and referral levels, hospital reforms are continuing. Monitoring and evaluation systems have also been strengthened. An annual national maternal mortality audit has not been carried out yet, but MDSR is being implemented. Reorientation of some health facility staff was undertaken during the first half of 2012 to ensure that regular reviews are conducted, and reports submitted.
Lesotho	In May 2010, the Lesotho Parliamentary Session was devoted to the launch of CARMMA by the Minister of Health and Social Welfare, Dr. Mphu Ramatlapeng, and parliamentarians pledged their support to the campaign. Dr. Ramatlapeng, who highlighted the need for interventions to reduce maternal and new-born morbidity and mortality, appealed to members of parliament to sensitize communities on this topic and advocate with community councils for the revival of village health committees. The Minister pleaded with parliamentarians to advocate for sexual and reproductive health and rights with men and women, as well as mothers-in-law. “We should talk to mothers-in-law, pregnant mothers and others to encourage attendance at prenatal clinic and advocate for deliveries at health facilities.” Parliamentarians should also mobilize the business community to provide support for timely transportation of pregnant mothers to health facilities during emergencies. He urged legislators to promote HIV testing in their constituencies and advocate for male involvement in the prevention of maternal deaths. “CARMMA hopes to bring on board communities and decision makers to ensure that no woman should die giving life,” he said. As one of many parliamentarians who were passionate in their support for CARMMA at the launch, the speaker of the National Assembly, Ms. Nthloi Motsamai, asked, “Why should women die when giving birth? It is time we vow that no woman dies when giving birth. The situation is totally unacceptable. We have a special responsibility as Parliament to allocate funds that will go towards sexual and reproductive health programmes.” Another Member of Parliament, Mr. Lekhetho Rakuoane, added, “This is the holiest issue to be discussed in Parliament.”

Liberia	The Campaign on Accelerated Reduction of Maternal Mortality in Liberia (CARMML) was launched by the Superintendent of Grand Bassa County, Mrs Duncan Cassel, on behalf of Mrs. Ellen Johnson Sirleaf, President of the Republic of Liberia, during the Country's 4th National Health Fair held in Buchanan City, Grand Bassa County on 1 December 2010. The theme of the launch was "The nation thrives when mother survives - we must strive to keep them alive." The launch focused on promoting maternal health care, raising awareness and the need for concerted action by the Government, donors, communities and women to improve health outcomes for pregnant women.
Mauritania	Under the patronage of the President of the Republic, CARMMA was launched by Minister of Health Dr. Cheikh El Moctar Ould Horma Babana at a ceremony that marked the National Week of Reproductive Health. The minister announced that the Government had decided to increase investment in the health sector to at least 15 per cent of the national budget within the following three years. The launch was followed by a debate on the best ways of deploying CARMMA as an advocacy strategy for the promotion of maternal and new-born health, in order to achieve quick and significant results. Participants included parliamentarians, religious and community leaders, journalists, leaders of civil society organizations, policy makers and technical executives in health.
Malawi	Malawi was one of the first countries to launch CARMMA, on 7 August 2009. It was launched by President Joyce Banda (then Vice President). A number of CARMMA campaign activities with maternal and new-born health messages were disseminated by radio and television. UNFPA has been supporting the Presidential Initiative on Safe Motherhood to sensitize pregnant women to deliver under skilled attendance through implementation of community level by-laws on defaulters by chiefs. UNFPA, in collaboration with implementing partners, set up a media network on population and development (MENPOD), which continuously advocates and increases awareness on CARMMA-related issues. Malawi has a revised roadmap for accelerating the reduction of maternal and neonatal morbidity and mortality in the country, and the reproductive health strategy also includes a component on reducing maternal mortality through improved maternal health. CARMMA is having a significant impact in the country; it provides visibility to maternal health issues and has helped increase awareness on the importance of skilled attendance at delivery, as well as promoting access to SRH services. The training of more midwives is increasing the number of skilled attendants at birth, despite transfers and reassignment of medical workers.
Mozambique	The launch of CARMMA in Mozambique was led by the Ministry of Health, under the patronage of First Lady Maria da Luz Guebuza. The event was attended by the AU Commissioner for Social Affairs, members of the UN system present in

	Maputo and key national stakeholders such as ministries, NGOs, the private sector and parliamentarians. The event demonstrated the Government's commitment to improving maternal health and intensifying efforts needed in this regard.
Niger	The launch of CARMMA in Niger took place on December 20, 2011. CARMMA builds on the roadmap already in place for accelerating the reduction of maternal and neonatal mortality for the period 2006-2015. Since the launch resources with partners were mobilized from partners such as UNFPA, UNICEF, WHO and a variety of local organizations such as Animas SUTURA; Association Nigerienne pour le Bien Etre Familial (ANBEF); Societé Nigerienne des Produits Petroliers (SONIDEP); Loterie Nationale du Niger (LOLANI); and Rimbo Transport Passengers. Also involved are many associations and groups, including religious, men's and youth groups. In the area of health systems strengthening, Niger has undertaken massive recruitment and allocation of health care providers, including 536 doctors; ordered equipment and materials; purchased an ambulance for emergency cases, and enhanced communication within the system via SSB radios. Childbirth and Caesarean section kits were provided in health facilities. With reference to the development of monitoring & evaluation systems, there are efforts to strengthen supervision and monitoring of care providers. Currently, clinical audits of maternal deaths take place at health facilities, but clinical auditing is institutionalized in the new PDS 2011–2015, including training of trainers on clinical audit across the country. To implement the MPoA in the context of the African Health Strategy, Niger has so far seen a reduction of maternal mortality by 14 per cent between 2006 and 2010, and infant mortality declined by 34 per cent.
Namibia	Namibia was one of the first countries to launch CARMMA, in December 2009. Since the launch, the political commitment of First Lady Penehupifo Pohamba has been evident through her involvement as patron of the maternal health agenda has proven to be one of the most important strategies of the campaign. More partners have become aware of the need to address maternal health issues. There has also been inter-sectorial collaboration at the national level, marked by the involvement of various ministries and civil society in the national coordination mechanism, as well as the institutionalization of maternal, perinatal and neonatal death review. Maternal death review tools have been launched and reviews were institutionalized at all district hospitals. Resources have been made available to fund vacancies for nurses and midwives, but unavailability of manpower has hindered the process. The Government is negotiating with other countries to bring nurses and doctors into the country to fill vacant positions. CARMMA in Namibia is facing a number of challenges, including inadequate financial resources and health system strengthening at the primary level to deliver basic emergency obstetric care services.

Nigeria	Nigeria launched CARMMA in October 2009, with a focus on aligning and integrating CARMMA within its existing programmes, especially the integrated maternal, new-born and child strategy. CARMMA in Nigeria focuses on partnerships at the three tiers of Government – federal, state and local government – in collaboration with development partners. It aims to improve maternal health with the introduction of the midwives scheme and the rural posting of resident doctors or medical officers to improve skilled birth attendance, the provision of contraceptives and other life-saving commodities for MNCH and increase budgetary support. Nigeria has reduced its MMR from 1,100 per 100,000 live births in 1990 to the current figure of 545 per 100,000, according to the latest (2008) DHS. Since the launch of CARMMA, Nigeria has developed a national strategic health development plan and adopted a national roadmap for CARMMA. It has also seen increases in resources for reproductive health. For example, in addition to several investments in MNCH, the Nigerian Government provided about US$3 million for contraceptives in 2012. There is continued engagement of all stakeholders, especially policy makers, as well as collaboration among MNCH partners, including civil society organizations. Nigeria reported a pilot study on community-based access to injectable contraceptives; promotion of the use of Misoprostol and magnesium sulfate in the management of post-partum hemorrhage and eclampsia; and free distribution of contraceptive commodities at public health facilities. President Goodluck Ebele Jonathan, as a leading voice for health improvement in Africa and through his work as Co-Chair of the United Nations Commission on Life-Saving Commodities for Women and Children, as well as his Saving One Million Lives Initiative, has reaffirmed his commitment to intensifying maternal health and new-born interventions in Nigeria. He is also committed to mobilizing other African heads of state and government to provide fresh impetus to CARMMA and its follow-up implementation in terms of resource mobilization, strategic, collaborative partnership with donors, states and LGAs, private sector and other MNCH stakeholders. Continued advocacy and engagement of policy makers is required to ensure adequate funding of MNCH and accountability. Also in operation is of resource mobilization aimed at facilitating the timely release of annual Government funding.

Rwanda	Rwanda has made remarkable strides in maternal mortality reduction. The MMR in 2010 was 487 per 100,000 live births, which is high, but only five years earlier, it stood at 750 per 100,000. Similarly, in 2007/2008, the country's infant mortality ratio was 62 per 1,000 while in 2010 it was 50 per 1,000. CARMMA in Rwanda is coupled with the White Ribbon Alliance (WRA) Initiative, which was launched in 2009 with the objective of completing national efforts to reduce maternal mortality and morbidity. The WRA strategic plan (2010-2015) is being implemented and plays a key role in uniting the multiple programmes in support of safe motherhood around one framework of action. The role and commitment of First Lady Jeannette Kagame, who launched CARMMA in 2010 and brought together many stakeholders, is significant in the overall drive to reduce maternal and new-born deaths in the country. With Mrs. Kagame as patron, WRA's board of high-level decision makers and representatives from diverse areas can influence policies and laws in support of safe motherhood as a human right. As part of the national efforts, on 11 November 2011, WRA organized a one-day workshop to increase media awareness of safe motherhood and equip journalists on the subjects of maternal health and family planning. Coordination platforms are led by the Government through national working groups on MNCH and reproductive health, and a core maternal health technical committee exists at national and state level.
Republic of Congo	Under the leadership of the First Lady of the Republic of Congo, Mrs. Antoinette Sassou Nguesso, CARMMA was launched in October 2010 to accelerate the reduction of maternal death and disability. Minister of Health Georges Moyen reaffirmed the Government's commitment to tackle maternal mortality as a top priority. "The Government has initiated a series of measures to reverse this trend," he explained. We established a maternal health observatory and we are promoting public awareness about the importance of women and children's health. Caesarean sections are carried out free of charge in the public health system and we are committed to the campaign against obstetric fistula and the extension of the UNFPA programme on this issue." UNFPA Representative David Lawson affirmed UNFPA's support. "The extension of the fistula programme to two additional treatment centres in Pointe Noire and Owando is a key part of our contribution to CARMMA in the Congo." With as many as 140 cases already identified and potentially many more likely to be found in the near future, obstetric fistula is considered a serious public health issue in the country. The CARMMA launch focused on the eradication of obstetric fistula and the promotion of family planning.

Senegal	Senegal launched CARMMA in Dakar in July 2010. The event was chaired by Prime Minister Souleymane Ndéné Ndiaye, who was was accompanied by the minister of state in charge of family affairs, the minister of health and prevention, the director of the UNFPA sub-regional office in Dakar, and the WHO Resident Representative. The theme of the ceremony was "Bajenu Gox Programme: Community Response to Maternal, New-born and Child Mortality Reduction". Initiated by President Abdoulaye Wade, Bajenu Gox is a community programme to promote MNCH by women leaders in their neighbourhoods. Bajenu is a Wolof term which means father's godmother. They are a respected group which can therefore positively influence the community to encourage women to use health facilities during pregnancy, as well as during and after childbirth. The Bajenu Gox came from all 14 regions of Senegal to support the launch of CARMMA. The Prime Minister described reducing maternal and neonatal mortality as among the country's core priorities, and renewed the Government commitment not only to consolidate its achievements, but also to increase its support for programmes aimed at reducing maternal and neonatal mortality.
South Africa	The former African Union Commissioner for Social Affairs, Advocate Bience Gawanas, launched CARMMA in South Africa in conjunction with Health Minister Dr. Aaron Motsoaledi. The former First Lady of South Africa, Graca Machel, was the keynote speaker. The launch of the CARMMA strategy formed part of the implementation plan of the Strategic Plan for Maternal, New-born, Child and Women's Health and Nutrition in South Africa 2012-2016. Key elements of the CARMMA strategy for South Africa include: strengthening family planning services, elimination of mother-to-child transmission of HIV, improving access to maternity services (e.g., dedicated obstetric ambulances and maternity waiting homes), training doctors and nurses in maternity units to manage obstetric emergencies, training of additional midwives, supporting mothers to breastfeed exclusively and strengthening immunization coverage and neonatal services. The aim of the South African government is to accelerate efforts by all role-players to reduce maternal, neonatal, infant and under-five mortality. Key to achieving the goals of CARMMA is universal coverage – the national health insurance model was adopted to achieve this. To strengthen service delivery, the Ministry of Health is re-engineering primary health care. Interventions include the launch of provincial strategies, a national CARMMA strategy and compliance assessment tool, a national CARMMA dashboard tool to monitor progress and a revised contraceptive policy and complementary updated clinical guidelines.

Siera Leone	The launching of CARMMA in March 2010 was strongly supported by President Ernest Bai Koroma, who, the following month, launched a CARMMA-related free health service at health care facilities for pregnant and breastfeeding women and children under five years old. For the first time The Government pledged to provide contraceptives at an annual cost of US$165,000. Strengthening health systems was identified in the National Health Sector Strategic Plan 2010- 2015 as an important objective, and assessment of health systems was carried out and strategies were put in place to address areas that need to be strengthened. In the area of capacity building of health workers, a growing partnership consisting of the Government, UN agencies and NGOs is coordinating capacity building of health workers. Among other initiatives, the Canadian International Development Agency initiative is sponsoring 100 student midwives per annum for three consecutive years. The Maternal Health Thematic Fund and the Global Programme to Enhance Reproductive Health Commodity Security also supported the training of midwives and strengthening of the Midwifery Association. In February 2012, 55 state-registered nurses graduated from the National Midwifery School Freetown campus, while 75 state-enrolled community nurses graduated from the Makeni Midwifery school campus in April 2012.
Eswatini	In 2009, Eswatini made history by becoming one of Africa's first nations to launch CARMMA. An implementation framework is now in place, and CARMMA activities have been incorporated into the national SRH programme's annual work plan. A dialogue held for Members of Parliament on implementation of the MPoA resulted in Parliament pressuring the Ministry of Health to develop a national SRH policy, which is now at the finalization stage. Since 2011, several regional dialogues in support of CARMMA have been undertaken by the Ministry of Health's reproductive health programme. Political commitment in support of maternal health was initiated by the Ministry of Health, which among other things hosted a national symposium on sustainable financing for reproductive, maternal, new-born and child health in the country, procured for the six hospitals that provide maternity services. Equipment used to prevent mother-to-child transmission of HIV and testing reagents for CD4 cell machines were also procured. Eswatini also developed a quarterly review system, followed by an annual review. A triennial report (2008-2010) was published in 2011
Togo	Following the launch of CARMMA by the Republic of Togo on 14 September 2010, a framework for accelerating MDG goals 4 and 5 was developed. The nation then embarked on developing a new health development plan as the central axis for improved maternal health. The national launch of CARMMA was followed by the establishment of "committees of men to support the health of mothers and children." Togo is also developing a new coordination mechanism for financing the health sector, through its membership of the International Health Partnership (IHP), and is currently receiving funding from the French Government, through the G-8 MUSKOKA Initiative on Maternal, New-born and Child Health, to support maternal

	health. The campaign has had a very positive impact in Togo, with many activities receiving the support of partners, Government institutions, traditional and religious leaders and communities. CARMMA has become a gateway to many stakeholders in the field of promoting women's rights.
Tanzania	The introduction of CARMMA in Tanzania strengthened the nation's efforts and provided an opportunity for reflection on achievements made towards achieving MDG 5. CARMMA provided visibility for national planning and priority setting on issues related to maternal health. The health sector strategic plan is designed to focus on maternal health as a means of measuring health sector performance. The Government, under a sector-wide approach is currently formulating the national health sector financial strategy. In collaboration with UNFPA, the Ministry of Health and Social Welfare undertook an assessment of the midwifery situation in Tanzania. That report is guiding various interventions in the country, including development of the midwifery programme. The MPoA has been domesticated in different national plans, including the National Road Map for Accelerating Reduction of New-born and Maternal Deaths.
Tunisia	In November 2011, Tunisia became the first North African country to launch CARMMA, with the aim of sharing the country's experience in reducing maternal mortality with other countries in Africa. Tunisia is known for its progressive policies towards women's rights, capacity to promote the status of women and improve physical and financial access by the population to basic health services from the early 1970s until the present, in addition to its active role in South-South cooperation in population and development.
Uganda	CARMMA is having a positive impact on the visibility of maternal and neonatal health issues in Uganda, and enjoys parliamentary support. Religious and cultural institutions have been mobilized, and there are signed commitments with 12 of the 15 cultural institutions in the country. The UNFPA country office developed and implemented a resource mobilization plan that yielded over US$ 15 million for SRH. The Ministry of Health created an alternative distribution channel for reproductive health commodities, including contraceptives, through a public-private partnership with the Uganda Health Marketing Group, a social marketing organization. To obtain sustainable funding, Uganda is in the process of establishing a national health insurance scheme as a health financing mechanism. The Government acquired a World Bank loan of US$ 130 million for health. To strengthen the health system, a bursary scheme for training of midwives was introduced with support from development partners, including the Danish International Development Agency and UNFPA, as a strategy to improve staffing and retention of staff in

	hard-to reach and underserved districts. A community-based health information management system was also put in place. The Government made maternal death a notifiable condition, and maternal and pre-natal death reviews have been institutionalized; notification to the Ministry of Health is required within 24 hours.
Zambia	When President Rupiah Bwezani of Zambia launched CARMMA on 12 June 2010, he made history by being the first African Head of State to be personally and directly involved in such a launch. CARMMA has contributed to increased government commitment for MNCH and increased resources from the Government and donors. There have been increased referrals for SRH and local chiefs are now champions for maternal health. Most multilateral and bilateral donors that pledged support before the launch have increased resources for MNCH; USAID procures contraceptives; DfID initiated a maternal health programme (Mobilizing Access to Maternal Health Services in Zambia); UN H4+, in partnership and collaboration with the Ministry of Health, secured funding from the Canadian International Development Agency (CIDA) for maternal health; and the Ministry has increased its budget line for procuring contraceptives. The Ministry also introduced mentorships for MNCH to strengthen the skills of providers. With support from UNFPA and the EU, the Ministry of Health is promoting integrated HIV/AIDS and reproductive and family services, through implementation of a programme to strengthen SRH/HIV linkages.
Zimbabwe	CARMMA was implemented within the nation's maternal and neonatal roadmap (2007- 2015). The national task force, charged with advocating and monitoring the implementation of the campaign, mobilized resources for maternal and neonatal health. It also advocated for increased funding for health on the basis of the Abuja target of 15 per cent. The Ministry of Health and Child Welfare set up a Health Transition Fund (HTF). Some of the major areas of support by the HTF involve health system strengthening, as well as the removal or subsidization of user fees for maternal health, which has been a key barrier to accessing maternal health. The Ministry of Health, with support from development partners, scaled up support to 18 active midwifery schools through the procurement of midwifery teaching models and textbooks. More than 200 nurses have been trained in emergency obstetric and neonatal care by the Ministry of Health since the launch of CARMMA. Some strategies have been vital for CARMMA in Zimbabwe, including: the integration of CARMMA into existing MNH strategies, which is critical for sustainability

	and visibility of the campaign by ensuring Government ownership. Another important factor was the development and implementation of an integrated plan for MNH, nutrition, family planning, HIV and malaria prevention to ensure meaningful utilization of limited resources. Despite this limitation, CARMMA has had a positive impact, especially the increased Government commitment to maternal and neonatal health issues, evidence of which can be seen in Zimbabwe's implementation of the UN strategy on women's and children's health, which is aligned withCARMMA .

Annex 3: Summary of country activities under CARMMA

Table 1: Cluster of indicators used to track progress for MNCH

Thematic area	List of indicators
Maternal health	Mortality rate/ 100,000
	Per cent of births attended by skilled birth personnel
	Per cent of pregnant women who attended four ANC visits
	Per cent of women receiving postpartum care by a skilled health personnel within two days of childbirth
	Per cent of new-borns receiving postpartum care from skilled birth attendant within two days after delivery
	Contraceptive prevalence rates (per cent)
	Unmet needs for family planning (per cent)
	Proportion of unsafe abortion in a country per 1,000 women aged 15-49 years
	Adolescent fertility rate
Child and new-born health	Neonatal mortality /1,000 live births
	Under-5 mortality rate/1,000 livebirths
	Proportion of stunted children under five years of age
	Proportion of infants 12–23 months immunized against DPT3
Health system indicators	Existence of a national health policy that integrates SRHR, HIV/AIDS/STI and malaria services
	Existence of laws addressing sexual and gender-based violence

	Existence of costed national implementation plan(s) for MNCH
	Percentage of budget allocation for RMNCH expended
	Number of facilities per 500,000 providing basic and comprehensive emergency obstetric care
	Reproductive health packages in place (maternal health, family planning, post-abortion care and sexually transmitted illness prevention, HIV)
	Per cent of districts that have an established and functional MDSR system
	Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission.

Table 2: Type and number of interviews conducted by region

Region /Country	Category of key informant		Mode of inter-view
	Ministry of health	UNFPA country teams/regional office/AUC team	
Eastern and Southern Africa			
Angola		**1**	**Skype call**
Kenya		1	Skype call
DRC		2	Skype call
Eswatini	2	1	Skype call
Lesotho	1	2	Skype call
UNFPA regional office		2	
West and Central Africa			
UNFPA regional office		2	Face to face in-terviews
Burkina Faso		1	Skype call
North Africa			
Tunisia	1	2	Face to face

AUC team			
AU director of health department		1	Face to face
AU commissioner for social affairs		1	Face to face
AU chief of health and Nutrition		1	Face to face
Former commissioner of social affairs		1	Face to face
Former head of UN-FPA		1	Skype call
Former AUC head of health and nutrition		1	Skype call
Total	4	20	

Table 3 List of indicators used for tracking MNCH achievements

No.	INDICATOR	INDICATOR CATEGORY		
		MPoA	**CARMMA**	**MNCH Scorecard**
1	Existence of a national health policy that integrates SRHR, HIV/AIDS/STI and malaria services			
2	Existence of laws dealing with sexual and gender-based violence			
3	Proportion of stunted children under five years old			

4	Contraceptive prevalence rate			
5	Unmet need for family planning			
6	Adolescent fertility rate			
7	Proportion of unsafe abortions, per 1,000 women aged 15-49 years			
8	Presence of a costed roadmap for the reduction of maternal and new-born morbidity and mortality			
9	Proportion of births attended by skilled health personnel			
10	Maternal mortality ratio			
11	Neonatal mortality rate			
12	Proportion of infants aged 12–23 months immunized against DPT3			
13	Infant mortality rate			
14	Under-five mortality rate			
15	Percentage of the allocation for RMNCH expended			
16	Percentage of pregnant women who attended at least four ANC visits			
17	Proportion of health facilities offering Basic EmOC services			
18	Percentage of women who received postpartum care from a skilled birth attendant within two days after delivery			
19	Percentage of new-born who received post-partum care from a skilled birth attendant within two days after birth			
20	RH packages in place (MH, FP, PAC and STI prevention, HIV)			
21	Proportion of districts that have an established and functional MDSR system			

22	Percentage of HIV-positive pregnant women who received antiretroviral drugs			
23	HIV prevalence among population aged 15-24 years			
24	Percentage of pregnant women attending ANC who were tested for HIV and know their results			
25	Percentage of infants born to HIV-infected mothers who are infected			
26	Proportion of children under five years old who slept under an ITN the previous night			
27	Proportion of households with at least one ITN and/or sprayed by IRS in the last 12 months			
28	Per cent of children <5 years with fever in last two weeks who were screened for malaria			
29	Proportion of children under five years old with fever in last two weeks who received antimalarial treatment according to national policy within 24 hours of the onset of fever			
30	Proportion of pregnant women who received two doses of intermittent preventive treatment of malaria during their last pregnancy			
31	General government expenditure on health as a percentage of total government expenditure			
32	Per capita public funds for health			
33	Out-of-pocket expenditure on health as a per cent of total expenditure on health			

34	Percentage of population covered by a demand-side scheme; e.g., social health insurance, community- based insurance			