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DEVELOPMENT OF AN *ACCOUNTABILITY PARTNERSHIP FRAMEWORK* FOR THE CARMMA CAMPAIGN

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Abbreviations and Acronyms

APRM	African Peer Review Mechanism
AU	African Union
AUC	African Union Commission
CARMMA	Campaign for the Accelerated Reduction of Maternal Mortality in Africa
CoIA	United Nations Commission on Information and Accountability for Women's and Children's Health
DSA	Department of Social Affairs
IAP	Every Woman Every Child's Independent Accountability Panel
CT	Information Communication Technology
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MoH	Ministry of Health
MMRs	Maternal mortality ratios
MNCAH	Maternal, newborn, child and adolescent health
NMR	Neonatal mortality rate
RECs	Regional Economic Communities
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goals
SRHR	Sexual Reproductive Health and Rights
STC-HPDC	Specialised Technical Committee on Health, Population and Drug Control
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations Childrens Fund
WHO	World Health Organisation

Introduction

Overview of document

This document contains the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Accountability Partnership Framework [hereafter called the Framework].

Following a chapter providing context and background to the Framework, the document describes the components of the Accountability Partnership Framework and provides further detail through outlining its:

- Objectives,
- Guiding principles,
- Scope and purpose,
- Potential partners,
- Accountability mechanism, and
- Implementation plan.

Several tables and figures provide further depth throughout the document and in the annexures.

Background

Within the African Union's Agenda 2063, the inspiring and visionary strategic framework which provides a blueprint for inclusive and sustainable development on the continent, Aspiration 1 states that "African people [should] have a high standard of living, and quality of life, sound health and well-being" (AUC, 2015, p. 2) and Aspiration 6 states further that the continent's development should be "people-driven, relying on the potential of African people, especially its women and youth, and caring for children" (AUC, 2015, p. 8). For the optimal health and well-being of African women, children and adolescents to be realised, it is recognised that maternal, infant and child mortality needs to be addressed on the continent.

Maternal health has profound and long-term effects on the future health of the infant, and therefore, future African generations. In African countries, maternal morbidity and mortality has complex and far-reaching consequences, affecting both individual and household levels, and with the potential to create a financial burden for the wider family. Women need to be healthy and safe to sustain and nourish their children's lives post-birth (Knight, Yamin, 2015). As Former President of Malawi, Ms. Joyce Banda states "Women are the backbone of African communities – they are farmers, they are business people, they are caregivers".

While steady progress has been made in reducing maternal mortality globally, maternal mortality ratios (MMRs) on the African continent remain high but are declining (WHO, 2018). According to United Nations (UN) inter-agency estimates, the global MMR declined by 44% from 385 to 216 deaths per 100,000 live births, during the period 1990 to 2015 (AUC, ECA, African Development Bank Group, UNDP, 2016), with an annual continuous rate of reduction of 2.3% (Alkema et al., 2016). Currently Africa's MMR stands at 444 per 100,000 live births (ADBG, 2018). Of the 20 countries with the highest maternal mortality ratios, nineteen are situated in Central, East, West and Southern African regions. It remains clear that improvements need to be made to achieve the Sustainable Development Goal (SDG) of achieving the global target of less than 70 (UN, 2015b) and no country higher than 140 maternal deaths per 100,000 live births by 2030 (Agyepong et al., 2017). If the pace of decline during the SDG period does not increase, it may not be until 2084 that Africa, as a continent, will achieve the 70 maternal deaths per 100 000 live births target (WHO, 2018). The gradual progress made in maternal survival has helped progress newborn, and therefore, child survival (Starrs et al., 2018).

The health of the mother and her newborn are closely linked. Progress in maternal survival has helped progress newborn, and therefore, child survival (Starrs et al., 2018). While survival rates for children have improved dramatically in Africa - the continent has more than halved its under-five mortality rate since 1990 (UNICEF, 2017) – mortality rates remain high with one in every 11 African child born still dies before their fifth birthday, a rate 14 times greater than the average in high-income countries (UNICEF, 2017). The continent currently accounts for more than half of the world's child deaths. This share will continue to rise to around 70% by the middle of the century, given the continent's current mortality, fertility and demographic levels and trends, and assumptions of, continued rates of progress elsewhere (UNICEF, 2017).

The fact that one in four babies worldwide are born without skilled care (United Nations, 2015) makes them vulnerable to preventable causes, most of which remain uncounted by national health information systems (Bryce et al., 2005). This shows in the neonatal mortality rate (NMR) trend. During the Millennium Development Goal (MDG) period (2000 to 2015), the NMR was moving towards a substantial decline in deaths but the current pace is insufficient to meet the SDG target of reducing NMR to at least as low as 12 per 1000 live births and under-five mortality to at least as low as 25 per 1000 live births (WHO, 2018).

When investments are made in adolescent health, a triple benefit can be reaped - their health now, their health in the future, and the health of the next generation. While adolescents are often thought of as a healthy group, this is not the case in Africa (WHO, 2018), which is exceptionally worrying seeing that the African adolescent population total is on the rise. Given that adolescent pregnancy is a major contributor to African maternal and child mortality rates and increased risk of birth injuries, there is an urgent need to improve the provision of services and effective monitoring of adolescent health (WHO, 2018).

Several key international continental decisions and documents exist to guide African policy-makers to operationalise the gains necessary to achieve reduced maternal, newborn, child and adolescent mortality rates. At least 18 high-profile initiatives striving to mobilize greater funding or enhance the provision of reproductive, maternal and new-born health care in low- and middle-income countries have been published, including The Sustainable Development Goals (SDGs), The Global Strategy for Women's, Children's and Adolescent's Health (2016 – 2030), "Every Woman, Every Child"; Women Deliver; and Family Planning 2020.

Continentally, African policy-makers have continued to take decisions, produce policy and support documents that provide a pathway to operationalising the gains necessary to achieve reduced maternal, newborn, child and adolescent mortality rates.

Derived from key priority areas enshrined in the 2005 African Union Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa (AUC, 2006) and the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010 (AUC, 2006a), the African Union Commission launched the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in May 2009 (AUC, 2012). The Campaign seeks to promote and advocate for renewed and intensified implementation of the Maputo Plan of Action for reduction of maternal, newborn, child and adolescent mortality in the Africa region. Through the sharing of best practices, the generation and sharing of data on maternal, newborn, child and adolescent health, the advocacy for increased political commitment and mobilisation of domestic resources in support of maternal, newborn, child and adolescent health as well as the communication with the wider African public, the campaign's vision is to build on existing efforts to improve maternal, newborn, child and adolescent health across Africa. CARMMA believes in ensuring accountability: every single loss of a mother's or child's life should be reported.

In each of the Member States, key stakeholders and influential personalities were involved in the national launches of CARMMA as an effort to obtain very high political commitment. Key actors of the campaign included the AUC; national governments (presidents, first ladies, ministers, parliamentarians); birth attendants; community health workers, doctors, nurses and midwives. The Campaign has a history of partnership with other stakeholders including several UN agencies, such as the World Health Organisation (WHO), the United Nations Childrens Fund (UNICEF), the Food and Agriculture Organisation of the United Nations (FAO), the United Nations Population Fund (UNFPA), the joint United Nations Programme on HIV and AIDS (UNAIDS), United Nations Development Fund for Women and the World Bank, as well as bilateral partners the 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.

In order to address the need for sustainable maternal and child health and well-being in Africa, following the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), a reappraisal of CARMMA's practices, programmes and policies was required (AUC, 2018). An evaluation of the CARMMA Initiative, analysing the period from May 2009 to December 2017, was therefore commissioned by the AUC's 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 achievement of the AUC's 'Transformational Agenda 2063', as well as global sustainable Agenda 2030 and other global commitments (AUC, 2018).

Several learnings and themes arose from the evaluation report, including, but not limited to:

- ***Strong political leadership*** *and* ***commitment*** *is necessary for tremendous improvements in maternal and child health indicators.*
- ***National champions*** *were critical role in maintaining the national focus on maternal and child health.*
- *A* ***monitoring mechanism*** *for the Campaign was lacking, while the* ***Mama Afrika award****, and the* ***Maternal, Newborn and Child Health (MNCH) Task Force****, remain relevant to the campaign and efforts should be made to operationalize them.*
- *Involvement of* ***Regional Economic Communities (RECs)*** *and the* ***private sector*** *need to be encouraged.*
- ***Improved use*** *of* ***statutory meetings*** *and events, i.e the International Conference on Maternal, Newborn and Child Health (ICMNCH), are needed.*
- ***Policy*** *and* ***service delivery environment*** *was substantially and positively influenced.*
- ***Accountability structures*** *need to be strengthened continent-wide through the existing peer review mechanisms established by the AU.*
- ***Human*** *and* ***financial resources*** *are needed to maintain the momentum of the campaign in countries.*
- ***Harmonisation*** *of the* ***goals*** *of the AUC and partners, at both the regional or national level, are important.*
- ***Partnerships*** *with* ***academic institutions*** *and other* ***development actors*** *should be expanded.*
- *The CARMMA Secretariat should be established with* ***adequate human resources****.*
- *The advocacy campaign of the CARMMA initiative should focus on:*
    - *The health of* ***adolescents****,*

- *The link between **family planning,** the **demographic dividend** and **development,***
- *The need for **economic development** for women.*

Overarchingly, the evaluation's major recommendation stated that the Commission should act to put in place an ***accountability mechanism*** that monitors campaign implementation progress with a view to identifying the levels at which key quantitative and qualitative indicators or parameters are measured against the ideal levels, best practices or international standards.

Accountability is essential to accelerating progress for women's, children's and adolescents' health. It enables the tracking of resources, results and rights and provides information on what works, what needs improvement, and what requires increased attention. Accountability ensures that decision-makers, and fellow partners with mutual goals, have the information required to meet the health needs and realize the rights of all women, children and adolescents and to place them at the heart of related efforts. (EWEC, 2015). With an accountability partnership framework in place, systems can be operationalised to gather evidence to monitor progress on the regional and in-country CARMMA commitments, independent review mechanisms can be enforced and make relevant recommendations for regions and countries, and mechanisms for enforcement and rewarding performance can be actioned.

It is with this in mind that an Accountability Partnership Framework for the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), hereafter referred to as the Framework, needs to be developed, with the purpose of strengthening the current objectives of the Campaign and to continue to strive to ensure that "no woman should die while giving life".

Guiding Principles of the CARMMA Accountability Partnership Framework

In order to achieve CARMMA's mission of accelerating actions across Africa to reduce maternal, newborn, child and adolescent mortality, the CARMMA Accountability Partnership Framework will be guided by 13 guiding principles. These principles will ground the Framework and provide a foundation for its implementation and were drawn from the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), the AUC's visionary Agenda 2063, the Maputo Plan of Action (2016 -2030), the African Health Accountability Framework and CARMMA's own values.

Accountability *and* ***transparency:*** The CARMMA Accountability Partnership Framework needs to be founded on evidence provided through periodic data collected at national, sub-national, regional and continental level. This data must be used to inform the progress being made towards the performance monitoring, review and implementation of reducing maternal, newborn, child and adolescent mortality.

Advocacy: The CARMMA Accountability Partnership Framework must advocate for increased political commitment, and mobilise domestic resources in support of maternal, newborn, child and adolescent health. Through increasing awareness around CARMMA, it's goals and achievements related to maternal, newborn, child and adolescent mortality, accountability can be sought and efforts can be enhanced and assist in increasing resources and political will towards further implementation.

Alignment: The African Union, it's Member States and their partners must speak with one voice and advocate around a common agenda for maternal and child health. In order for accountability to occur, all parties involved in putting an end to preventable maternal and child deaths need to understand and agree on the strategic direction and priorities for this cause.

Communication: Available, reliable and timely information about indicators, actions and resources should be shared routinely in an accessible, visible and understandable way,

unless the information is deemed confidential. The CARMMA Accountability Partnership Framework needs to communicate with the wider African public and inspire action.

Dialogue: In order for meaningful progress to be made towards ending preventable maternal and child deaths, effective and transparent dialogue should occur. As a unified community of partners, feedback will need to be provided. It is through continuous review, sharing successes and challenges of programmes and the achievement of results that lessons are learned.

Equity: Accountability should be informed by disaggregated data that considers equity concerns. It is through identifying where the need is the greatest, that resources and efforts can be channelled to make improvements.

Harmonisation: The CARMMA Accountability Partnership Framework will seek to harmonise and streamline the current actions around accountability and partnership in order to achieve the goal of reducing preventable maternal, newborn, child and adolescent mortality.

Inclusivity: In order to be effective, the CARMMA Accountability Partnership Framework should be transparent and inclusive, ensuring the meaningful participation of all key stakeholders, particularly civil society.

Partnership: The CARMMA Accountability Partnership Framework should build on existing efforts to improve maternal, newborn, child and adolescent health across Africa by embracing common linkages, and generating and sharing data and best practice with a view to achieve the goals as set out in relevant continental and global targets for maternal, newborn, child and adolescent mortality.

Ownership: The CARMMA Accountability Partnership Framework must be built on the principle of ownership by the various partners who seek to reduce maternal, newborn, child and adolescent mortality. Through stakeholders owning the current situation, accountability can exist. This ownership will ensure that that prescribed roles and responsibilities within the Framework are implemented.

Leadership: Through able stewardship, institutional will and support, AUC country Member States and non-governmental partners are urged to take the lead in implementing all facets of the CARMMA Accountability Partnership Framework in order for true accountability and a reduction in maternal, newborn, child and adolescent mortality in Africa to occur.

Unification: The CARMMA Accountability Framework must promote the unification of African Governments, civil society, the private sector and all multi-sector development partners. Through these partners joining forces, work to end the preventable deaths of African mothers, newborns and children can be strengthened.

Scope and purpose of the CARMMA Accountability Partnership Framework

Through the development of the CARMMA Accountability Partnership Framework, an accountability mechanism for monitoring campaign implementation progress and providing a platform, at a continental level, to share mutual experiences and endorse decisions regarding the reduction of maternal mortality in Africa, will be established.

As is the case with the CARMMA campaign itself, the Framework will seek to build on existing structures, partnerships and events to provide this platform and motivate the reduction of maternal, newborn, child and adolescent mortality in Africa. The focus of the Accountability Partnership Framework will not be to develop new strategies and plans, but to ensure the effective coordination and implementation of existing ones.

While the responsibility and accountability for implementation and results belonging at the country level, with the active engagement of governments, communities and civil society, the Framework seeks to provide a roadmap for how a mechanism can effectively hold all parties involved to account.

The Framework will be facilitative in nature and it aims to be applicable to all Country Member States that have launched the CARMMA campaign, following the ratification of the Framework.

Objectives of the CARMMA Accountability Partnership Framework

Based on the confirmed outcomes of the CARMMA Accountability Partnership Framework and in order to achieve the purpose of the Framework, the following objectives have been set for the Framework to accomplish:

Objective 1:

- Develop an Accountability Partnership Framework that set targets for and details the following aspects of the Framework:

- The strengthening and coordination of potential **partnerships,**
- The enhanced **monitoring**, **continuous assessment** and **data analysis** of MNCAH indicators,
- A **reporting system** that **communicates** the Framework's actions and progress, keeping in mind **modern technology** and includes report formats and key report recipients;
- The **cost-effectiveness** of the Framework, as it relates to the monitoring of and reporting on progress, human resources and maintenance of proposed activities,
- The **inclusivity** of all relevant partners related to MNCAH in the realisation of the Framework,
- The **ability** for responsible stakeholders and partners to **access** information needed to inform continental, regional and national action,
- The **transparency** of responsible stakeholders and partners regarding information informing continental, regional and national action.

- The Framework will propose a **budget** and personnel **components** that would operationalize and sustain the envisaged accountability partnership framework, all year round, bearing in mind the aspects of the Framework listed above.

Objective 2:

- Validate and harmonise **identified parameters** or **indicators** with CARMMA campaign and fellow partners goals for advancing the reduction of preventable maternal, newborn, child and adolescent mortality.
- **Identify** and **select** key **indicators** of success in implementation of the campaign.
- Provide baseline data on CARMMA indicators; and their current and ideal levels.

Objective 3:

- Provide an assessment of the existing **readiness** and capacity of Member States and the Commission for **monitoring and evaluation** through establishing:
  - National requirements with regard to accountability.
  - Participatory nature of the accountability process.

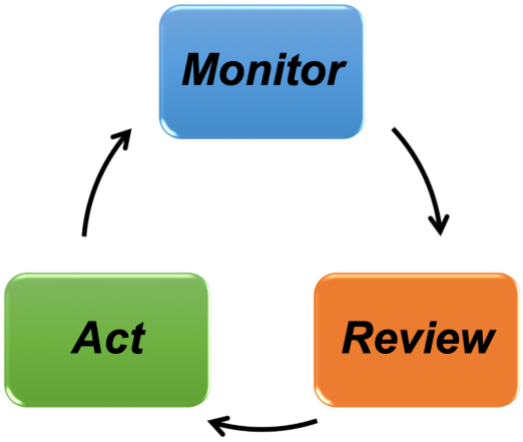
The CARMMA Accountability Partnership Framework

Introduction

With several continental policy instruments agreed upon, African policy-makers continue to take decisions, produce policy and support documents that provide a pathway to operationalising the gains necessary to achieve reduced maternal, newborn, child and adolescent mortality rates.

The CARMMA initiative, borne from a need to build on existing efforts to improve maternal, newborn, child and adolescent health across Africa, believes in ensuring accountability: every single loss of a mother's or child's life should be reported. Accountability begins with national sovereignty and the responsibility of a government to its people and to the global community. However, all partners are accountable for the commitments and promises they make and for the health policies and programmes they design and implement (CoIA, 2011). National accountability mechanisms are more likely to be effective if they are selected by countries, rather than directed from outside, and fit their specific circumstances (CoIA, 2011). The Framework assumes that mechanisms will be nationally or locally adapted, supported by high-level political leadership, and be effective, transparent and inclusive of policy, technical, academic, professional and civil society constituencies.

In order to ensure accountability, at a continental, regional and country level, a cyclical process that ensures learning, continuous improvement and harmonisation of goals is necessary. This ongoing, cyclical process comprises of **three** interconnected processes – monitor, review and act.



Monitor means providing essential and relevant information on what is happening, where and who is affected (results). Resources also need to be monitored in order to track progress and thus, monitor should also ask how much is spent, where, on what and on whom.

Review means scrutinising data to determine whether preventable maternal, newborn, child and adolescent mortality has been reduced, and whether pledges, promises and commitments have been kept by countries and their fellow partners. The review process also requires that stakeholders recognise and learn from successes, drawing attention to good practice, identifying challenges and, as required, making recommending as how to move forward towards progress.

Act means using the information and evidence that emerge from the review process and implementing the recommendations made to accelerate progress towards the reduction of preventable maternal, newborn, child and adolescent deaths, meeting commitments, and reallocating resources for maximum health benefit. It may include increasing the support for and wider adoption of policies and programmes that are having a positive impact, and taking action to address what is not working, remedying problems with data, weak practices and any mismatch between actual resources and promises. It also includes learning from best practices and experience to enhance the effectiveness of efforts to improve women's and children's health.

In embarking on the development of the Framework, these three key processes will be described in further detail in the context of CARMMA's mission, goals and priorities.

While a continental framework provides guidance and facilitates support regarding accountability, action at the country level is where accountability for improved outcomes needs to occur (PMNCH, 2012). The nature of accountability mechanisms for CARMMA may vary from member state to member state but they should abide by the same guiding principles and be transparent and inclusive of all key stakeholders. The "Monitor, Review and Act" sub-sections below will address what activities country Member States can implement to assist in the implementation of the CARMMA Accountability Partnership Framework.

Potential partners

In order to achieve the ambitious but achievable goals set out within international and continental policy documents, the Framework calls upon all potential partners to renew and re-energise their efforts with regards to accelerating the reduction of preventable maternal, new-born and child mortality.

The suggested potential partner institutions are listed below and elaborated on further in Annexure 1:

- National governments
- Health practitioners and their corresponding professional associations
- Bilateral organisations
- Multi-lateral health and development organisations
- Civil society organizations
- Academia
- Community and religious leaders
- The private sector.

Building on existing efforts and partnerships will be essential in implementing the Framework, and ultimately, improving the maternal, new-born and child health across Africa. Accountability should be a constructive and balanced process. However, it can at times be seen as a threatening exercise, particularly if there is a history of punitive rather than supportive measures if progress is poor (PMNCH, 2012). Trust is needed between stakeholders and this is developed through visibility, open dialogue and a continued presence at every stage of the cyclical Accountability Framework process. Potential partners are encouraged to identify their roles and responsibilities within the CARMMA campaign and the Framework, as well as the outcomes they jointly seek to deliver. True partnerships also involve tracking and evaluating progress to achieve these shared objectives and outcomes and mutual accountability is encouraged. This includes partners holding themselves and each other to account for progress (UNAIDS, 2011).

Key partners as the Framework is advanced, include (but are not limited to):

- **The Regional Economic Communities (RECs):**
    - The comparative advantage of the AUC's **RECs** should also be leveraged to advance campaign goals and address specific issues. Redefining and strengthening 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.
- **The Every Woman Every Child's Independent Accountability Panel (IAP):**

- In September 2015, the United Nations Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health to help further the Sustainable Development Goals (SDGs) and the 2030 Agenda for Sustainable Development. In order to ensure strong implementation of the SDGs, the United Nations Secretary-General appointed the Every Woman Every Child's Independent Accountability Panel (IAP). The Panel provides an independent assessment of progress and challenges to help strengthen the response from the international health community and countries (IAP, 2017). The Every Woman Every Child Global Strategy's unified accountability framework (UAF) [see Annexure 2] serves as the foundation for the IAP's review process and will be leveraged throughout the Framework's "Monitor, Review, Act" cycle.

The CARMMA Accountability Partnership Framework Mechanism: Monitor, Review and Act

Monitor

The CARMMA Evaluation Report asserted that through the weak linkages between the AUC and Member States in driving the campaign at the national level and the absence of a mechanism to monitor implementation, there was a loss of a critical opportunity for the AUC to hold leaders accountable for their CARMMA commitments.

It is through the action of monitoring that essential and relevant information can be tracked according to location, amount and who it affects, yet, certain conditions are required for adequate and effective monitoring to occur.

The **strengthening of collection of vital statistics** is essential as accountability cannot occur without timely, reliable and accessible health information and data (CoIA, 2011). Solid information at the country level is essential to measure and monitor results. A strong capacity in countries to collect data on the health of women, children and adolescents is essential to determine where investments should be focused and whether progress is being made. Through countries integrating their health surveillance information from multiple population-based sources, such as surveys, with facility and administrative data, and embarking on moving toward modern

information and communication technology, major gains can be made with regards to effective monitoring.

When **collected indicators are disaggregated** and maternal, new-born, child and adolescent mortality can be reported according to quintile, gender, age, urban/rural residence, geographic location and ethnicity; and, where feasible and appropriate, for education, marital status, number of children and HIV status, stakeholders will have a better idea of where and how to act, and who is affected.

The use of **modern information and communication technology** will enable countries to submit and access relevant data related to their CARMMA achievements and goals. Information Communication Technologies (ICTs) can assist in disseminating and sharing information on results and resources, providing new possibilities to capture and process data, linking information systems, increasing the timeliness of information produced, and storing data for institutional memory (CoIA, 2011). The African Health Stats Africa Health Stats platform (www.africanhealthstats.org), CARMMA website (www.carmma.org) and CARMMA scorecards are critical communication and advocacy tools that provide data and information for African Union Member States and should be used as such. Social media platforms related to CARMMA, while available, need improvement in order to be effective (AUC, 2018). Efforts should be made in renewing the CARMMA social media platforms as social networking offers fresh opportunities for strengthening accountability mechanisms, provides relevant information to many people, while broadband technologies can accelerate connectivity between community, national and continental levels and progress towards generating, synthesizing and sharing comprehensive health information for improving women's and children's health (CoIA, 2011).

Improved **tracking of resources** for women's and children's health is essential to the accountability process. Tracking resources is critical for transparency, credibility and ensuring that much needed funds are used for their intended purposes and reach those who need them the most (CoIA, 2011). Tracking expenditure on maternal, child and adolescent health stretches the capacities of many countries, and this is where potential partners can assist (CoIA, 2011). To enable countries to achieve this target, their capacity to track resources for health, organize data into established accounting frameworks, and analyse and use information in national policy and accountability processes needs to be strengthened. Public expenditure studies and budget

tracking by civil society can also complement government efforts (PMNCH, 2012). In order to improve transparency around resource allocation and link it to results, the CARMMA Accountability Partnership Framework will expand the CARMMA scorecard to assess expenditure on MNCH issues. Tracking this information will help with priority-setting and enhance the focus on the areas within MNCH that require attention. It is also encouraged that development partners should be also be required to report their development assistance to ascertain if they are aligned with continental priorities, strategies and planning cycles.

Two recommendations relevant to monitoring were made within the CARMMA Evaluation Report. Firstly, that the **streamlining and harmonisation of current reporting requirements** was encouraged. Stakeholders are encouraged to reduce the reporting burden by aligning the systems that are used to monitor and evaluate their national approach to accelerating the reduction of preventable maternal, newborn, child and adolescent mortality. Additionally, stakeholders are encouraged to strengthen and harmonise the existing international mechanisms to revise the and track progress on post-2015 continental and global post-2015 commitments on MNCH and adolescent health. During the 2nd International Conference on Maternal, Newborn, Child Health (ICMNCH) 2018, it was recommended that the CARMMA initiative be strengthened by relating maternal deaths to social economic development to re-invigorate political commitment. In order for countries to survive, thrive and transform, it is important to address the social determinants of health and development too.

Cognisant of these recommendations, as per Objective 2, the Framework aims to identify, validate, select and harmonise parameters or indicators with relevance to the CARMMA campaign. Taking into account the various targets and aspirations described within the Sustainable Development Goals (SDGs), Agenda 2063, African Health Strategy (2016 – 2030), as recommended within the CARMMA Evaluation Report (AUC, 2018), Annexure 3 details the indicators outlined for the current CARMMA initiative, Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (2016 – 2030), the Maternal, Newborn and Child Health Scorecard, the African Health Stats website, the “Countdown to 2030” and proposed, updated CARMMA indicators. Annexure 4 further elaborates on the indicators available on the African Health Stats website and compares them to the currently available CARMMA scorecard.

Taking into account these sources, Table 1 proposes the updated CARMMA indicators to be monitored on the updated CARMMA scorecard. The indicators marked in grey are proposed to be added to the current indicators:

Table 1: Updated CARMMA indicators

Area	Indicators
Health financing	Government health expenditure as % general government expenditure
	Percentage of national health budget allocated for reproductive health
Health systems and policies	Proportion of districts that have an established and functional MDSR systems
	Maternal deaths reviewed
	Reproductive health packages in place (MH, FP, PAC and STI prevention, HIV)
	Proportion of health facilities offering Basic EmOC services
	Health facilities providing integrated SRH services
Maternal, Newborn, Child and Adolescent Health	Maternal mortality ratio
	Neonatal mortality rate
	Under-five mortality rate
	Percentage of pregnant women who attended at least four ANC visits
	Percentage of pregnant women who attended at least eight ANC visits
	Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy
	Proportion of unsafe abortions, per 1,000 women aged 15-49 years
	Proportion of births attended by skilled health personnel
	Percentage of women who received post-partum care from a skilled birth attendant within two days after delivery
	Percentage of new-borns who received post-partum care from a skilled birth attendant within two days after birth
	Coverage of first dose of measles vaccination
	Percentage of children fully immunized
	Percentage of children with diarrhoea receiving oral rehydration salts (ORS)
	Proportion of children with suspected pneumonia taken to an appropriate health provider
	Use of insecticide-treated nets (ITNs) in children under 5 (% of children)

	Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery
	Percentage of infants <6 months who are fed exclusively with breast milk
	Proportion of infants who were breastfed within the first hour of birth
	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age
	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)
	New HIV infections
	Antiretroviral medicine coverage HIV positive pregnant women
	New TB infections
	New malaria infections
	New HIV infections
Sexual and Reproductive Health	Very early child bearing under age 16
	Adolescent birth rate ages 15 to 19
	Child marriage before age 18
	Contraceptive prevalence rate
	Demand satisfied for modern contraception
	Adolescent fertility rate
	Adolescent mortality rate, by sex
	HPV vaccine coverage
	Proportion of population below the international poverty line, by sex, age, employment status and geographical location
Economic and research development	Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex
	Research and development expenditure as a proportion of GDP, disaggregated by health/RMNCAH
	Proportion of youth (aged 15-24 years) not in education, employment or training

Proposed activities:

- Collaboratively, representatives of the AUC DSA, country Member State representatives and potential partners should **agree upon the updated and validated indicators** required to track sustainable reduction of maternal, newborn, child and adolescent mortality.

- Through their monitoring activities, all stakeholders are called upon to focus on the health of adolescents, their sexual and reproductive rights and health and the need for economic development for women.

- The AUC DSA will **harmonise, validate and disseminate** (via relevant communication channels) the **updated CARMMA indicators**, as per Table 1, for the inclusion with the monitoring and review of in-country CARMMA goals and achievements.
    - Potential partners and country Member States are encouraged to improve the tracking of resources for women's and children's health through expanding the CARMMA scorecard indicators related to MNCH expenditure.
- Country Member States will be encouraged to **establish reliable sources** of data, strengthen their collection of vital statistics, household and other population-based surveys, facility reports and facility surveys and population censuses, and subsequently map these updated and validated indicators against data sources.
    - While in-country monitoring activities of this sort may be timeous, country Member States should ensure that maternal mortality audits are undertaken regularly.
- The AUC DSA will help to **facilitate collaborations** between country Member States and **potential partners** (as listed in Annexure 1) that could assist in improved monitoring of validated indicators through the facilitation of meetings between country Member States and potential partner representatives.
    - In order to leverage partner reporting and data sources to monitor the issues of MNCAH on the continent, the Framework will invite relevant inputs from the following reports and data sources developed by United Nations agencies:
        - **UNFPA:** Reports and information, including the State of the World Report
        - **WHO:** Reports and information, including Global Health Observatory (GHO) data
        - **UNAIDS:** Reports and information, including the Prevention GAP Report
        - **UNICEF:** Reports and information, including the Knowledge for children in Africa
        - **Partnerships for Maternal, Newborn and Child Health:** Reports and information, including their annual Accountability Report.
        - **Every Woman Every Child Every Adolescent Independent Accountability Panel (IAP):** Reports and information, including the annual Accountability Report.

- The AUC DSA will ensure that the **African Health Stats website, CARMMA website, CARMMA Scorecards and social media platforms** are updated timeously in order to instill the importance of social accountability and access to information.
- Regional Economic Communities (RECs) and Country Member States are encouraged to **adopt** the **updated** and **validated CARMMA indicators** (as per Table 1).
    - Country Member States are encouraged to **disaggregate** these indicators by **equity** concerns and consider all sources of information.
- As development partners may work outside the country Member States' national plan and budget and not in parallel with national systems, Member States are encouraged to **partner** with **RECs** and **international development partner representatives** in their countries to harmonise and streamline their strategic plans that address issues related to maternal, newborn, child and adolescent mortality. Utilising the same validated, updated CARMMA indicators could assist in this regard.
- Regional Economic Communities (RECs) and Country Member States are encouraged to implement and monitor disaggregated **CARMMA scorecards** for their own region and sub-national districts.
    - These resources should be made available to their constituents in an **accessible** manner, either at health facilities, community centres or online as this will assist in encouraging social accountability and public awareness around CARMMA and its goals.
- Country Member States and **research institution partners** are specifically asked to promote investment in research for better measurement and monitoring.

Review

As the accountability process can be seen to be threatening and perhaps punitive (PMNCH, 2012), the CARMMA Accountability Partnership Framework will seek to build trust, instil inclusivity and encourage dialogue between all partners during the review process. Certain conditions are required for a just, fair and productive review process to occur.

In order to ensure the legitimacy of the review process, the **meaningful inclusion of all potential RMNCAH-related partners** should occur, including other government departments whose activities impact on health, parliamentarians, health-care professional organizations, civil society

organizations (particularly women's groups), the private sector and academia (Partnership for Maternal, Newborn and Child Health, 2012). The involvement of higher political levels, such as a president, prime minister or a first lady's office, generates better progress on reproductive, maternal, new-born, child and adolescent health, and helps strengthen crucial political will. The Framework will seek to promote the renewal of energy related to the CARMMA initiative through inviting meaningful implementing partners and those political stakeholders, who were once involved in the launch of their campaigns, to join the statutory meetings where stories related to RMNCAH are shared, success stories celebrated and forward action is committed to. Focus will also be placed on strengthening the inclusion and involvement of the RECs, and their relevant representatives, as per the CARMMA Evaluation Report.

The **Maternal Newborn and Child Health (MNCH) Task Force** meeting prioritises MNCH concerns and should be used as the platform to review the results of CARMMA monitoring activities and implementation actions. In order to hold AUC country Member States to account on CARMMA goals, as per the CARMMA Evaluation Report (AUC, 2018), it is suggested that this statutory meeting occurs at intervals of three or five years, to capture meaningful change and ensure actionable strategies. To improve inclusivity and broader engagement, the Framework recommends that the MNCH Task Force meeting be made available in a **digital webinar format**. Electronically available contributions need to be able to be made by the members attending remotely.

Activities:

- The AUC DSA will convene the **MNCH Task Force meeting** to be held every 3 to 5 years. Activities will include reviewing the CARMMA commitments and progress will be an agenda point. The inclusion of remote stakeholders, hosted digitally, to the MNCH Task Force meeting is proposed.
    - Invitations to all stakeholders deemed meaningful to the achievement of CARMMA goals will be invited to the MNCH Task Force timeously.
- Country reporting should be focused on informing national review processes. Country Member States are encouraged to use **health sector review** to inform their progress of implementation of the national health plan and enable a consistent link between reviews and resource allocation through medium-term expenditure frameworks and annual planning cycles and subnational processes of review and action.

- Country Member States are encouraged to strengthen and advocate for the continuation of the **Maternal Death Surveillance and Response** (MDSR) system. Consistent information about the nature and cause of death is needed for country's to plan their health systems and distribute resources, as well as for improving the quality of care at the point of service delivery (WHO, 2016).
- Two proposals for the CARMMA Accountability Partnership Framework could be contemplated for future actioning.
    - The establishment of a **CARMMA Community of Practice (CoP)**:
        - A CARMMA CoP will enable members to share up-to-date evidence amongst themselves ensuring that best practices are implemented across the continent. A select committee of contributors from various potential partners could facilitate what is shared amongst members, and the wider community of country Member States through the CARMMA website and the social media platforms.
    - Incorporation of CARMMA monitoring tools within existing African Peer Review Mechanism (APRM):
        - When reviewing RMNCAH issues, it is proposed that the APRM uses CARMMA scorecards to establish a more holistic understanding of the country's transformative agenda and their ability to sustain MNCH and development gains.

Act

Following the information and evidence that emerges from the Framework's review process, actions can be taken to identify what is necessary to remediate and accelerate progress towards reducing the number of the preventable maternal, newborn, child and adolescent deaths. Actions, such as acknowledging successes and overcoming challenges, will need to be taken to firmly continue on the path towards CARMMA's vision for Africa.

The **Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC)** will be the **preferred platform** to present the evidence for action. At the highest level, reviewed evidence will be presented, and action requested from the Executive Council and the Assembly. Other established high-level forums of the African Union such as the International Conference on Maternal, Newborn, Child Health in Africa, the Girl Summit – African Chapter, Annual meeting of Director-Generals of Statistics, Day of the African Child and African Peer Review Mechanism will

also be used to present the evidence and encourage action. National, regional and international forums such as *INTERNATIONAL CONFERENCE* on AIDS and Sexually Transmitted Infections in Africa (ICASA), Family Planning Conference, Women Deliver, Africa Health Agenda International Conferences will also be used as fora for the presentation of evidence related to the CARMMA initiative.

The Framework recognizes the need to **reward success** as a critical part of the framework. The **Mama Afrika award** recognises real-life heroes and heroines, including organizations from around the African continent, and commends those who exercise dedication, professionalism and compassion in the care of Africa's women and babies during and after childbirth. The Framework proposes that the Mama Afrika award be strengthened by awarding it bi-annually to a candidate following the CARMMA review that takes place at the MNCH Task Force meeting. By promoting the awarding of Mama Afrika on social media platforms, the award will be used to increase social accountability, advocacy and raise public awareness about the effects of preventable maternal, newborn, child and adolescent deaths and the need for support of the CARMMA campaign. Sponsorship and input from the private sector and development partners should also be sought in the granting of the Mama Afrika award.

Following on from the monitoring and review processes of the Framework, if it ascertained that Country Member States' CARMMA indicators are stagnating or deteriorating, it is strongly proposed that **follow-up visits to non-performing countries** are considered in order to support their implementation efforts. This may require facilitating partnerships between current political leadership, civil society organisations and international development partners to identify a way forward.

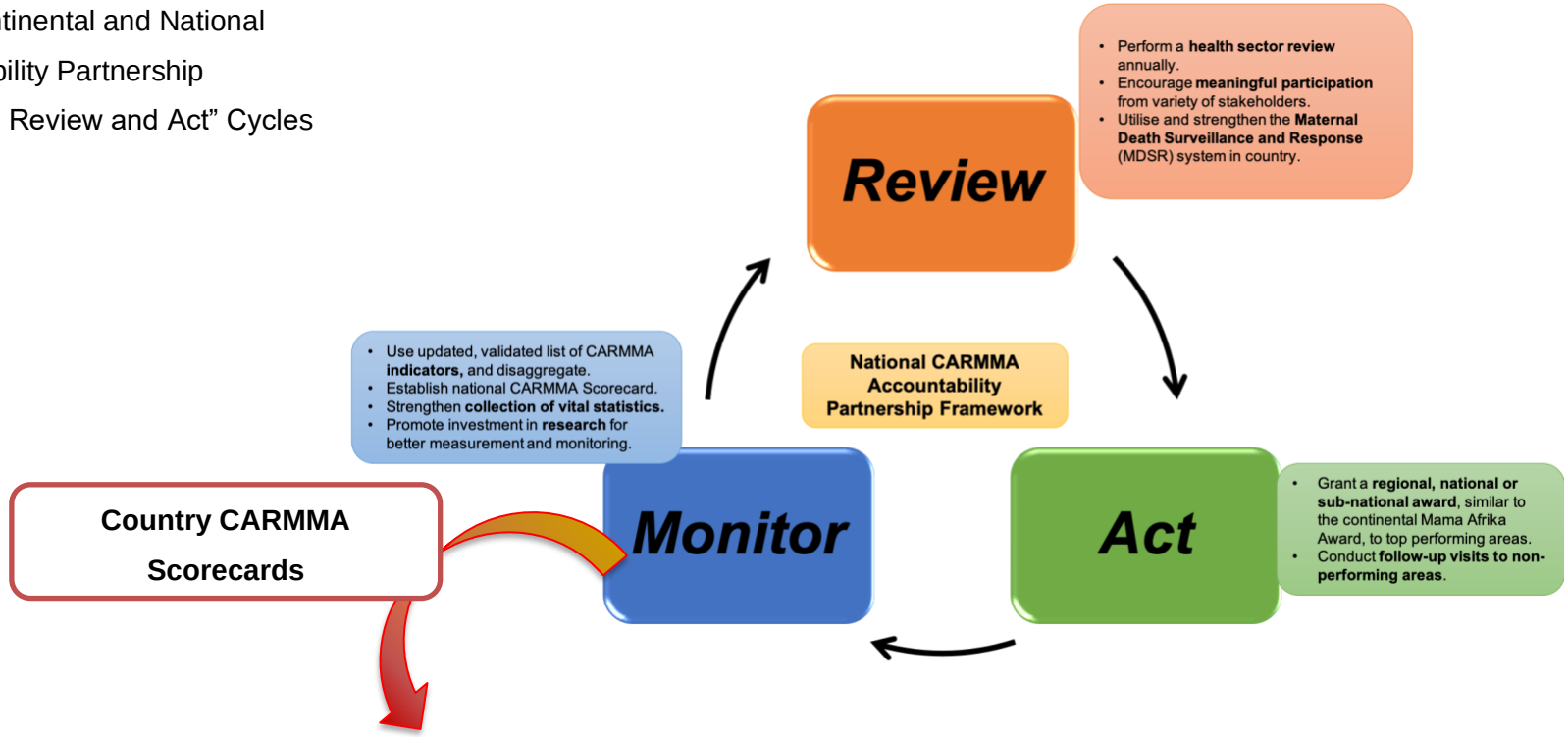
Activities

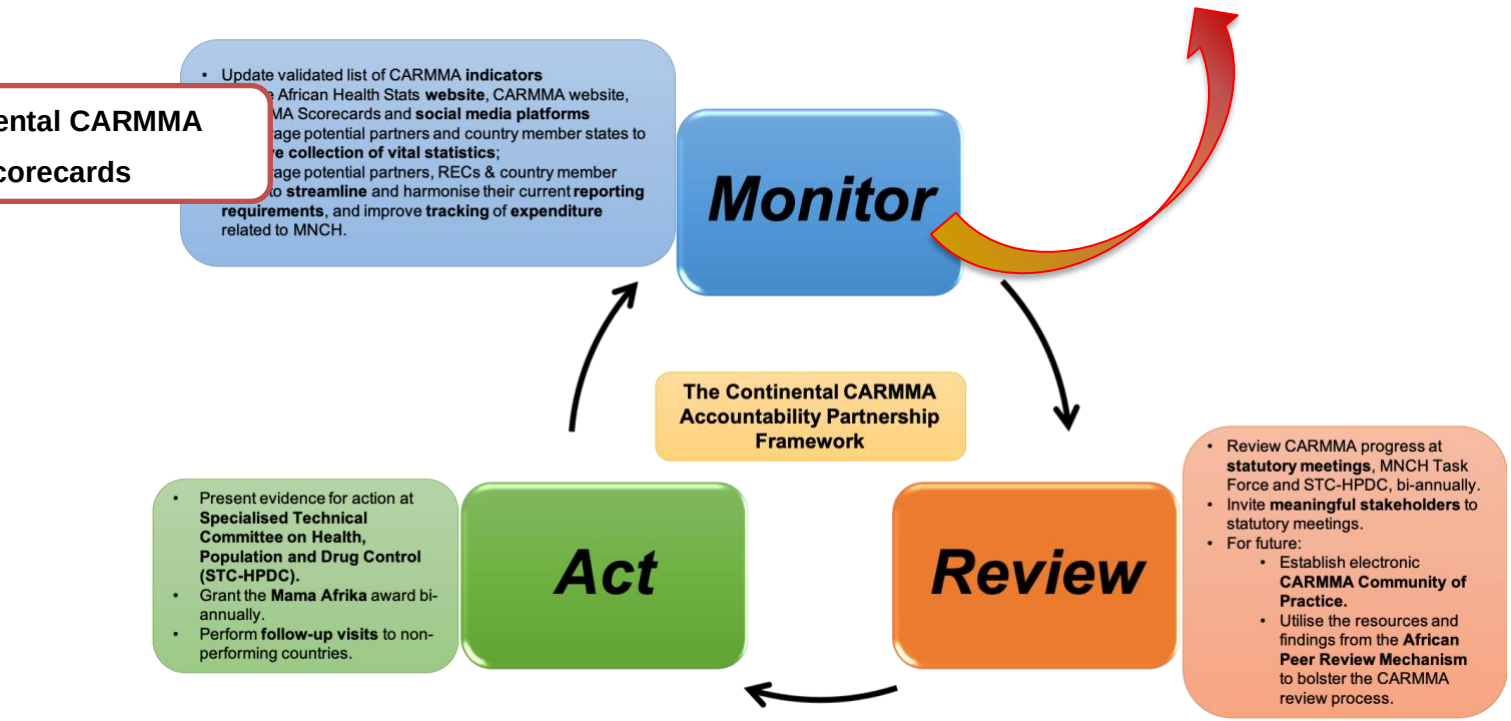
- The AUC DSA convenes the **Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC)** and iterates that this occasion will be the preferred platform to present the evidence for action and potential remediation within Country Member States.
- Country Member States' CARMMA achievements should be recognised through the granting of the **Mama Afrika award** bi-annually. The awarding process should be promoted on the CARMMA website and social media platforms.

    - Country Member States are encouraged to acknowledge where successes are occurring through granting a **national or sub-national award** related to their progress made in ending preventable maternal, newborn, child and adolescent deaths.
- **Follow-up visits** to non-performing countries are encouraged in order to support their implementation efforts to achieve CARMMA goals.

In diagram 1, pictured below, the continental and national actions to be undertaken in implementing the CARMMA Accountability Partnership Framework are detailed.

Diagram 1: The Continental and National CARMMA Accountability Partnership Framework "Monitor, Review and Act" Cycles




ental CARMMA
corecards
Update validated list of CARMMA indicators
African Health Stats website, CARMMA website,
MA Scorecards and social media platforms
age potential partners and country member states to
e collection of vital statistics;
age potential partners, RECs & country member
o streamline and harmonise their current reporting
requirements, and improve tracking of expenditure
related to MNCH.
Monitor
The Continental CARMMA Accountability Partnership Framework
Review
Review CARMMA progress at statutory meetings, MNCH Task Force and STC-HPDC, bi-annually.
Invite meaningful stakeholders to statutory meetings.
For future:
Establish electronic CARMMA Community of Practice.
Utilise the resources and findings from the African Peer Review Mechanism to bolster the CARMMA review process.
Act
Present evidence for action at Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC).
Grant the Mama Afrika award bi-annually.
Perform follow-up visits to non-performing countries.

CARMMA Accountability Partnership Framework Implementation Plan

In order for the CARMMA Accountability Partnership Framework to work effectively, an implementation plan is needed to outline specific activities, provide a clear timeline and assign roles and responsibilities to the relevant stakeholders. The continental CARMMA Accountability Partnership Framework implementation plan is detailed in Table 2, below:

Table 2: The CARMMA Accountability Partnership Framework Implementation Plan

	Activity	Whose responsibility is this?	How will it be communicated effectively?	Timeframe
MONITOR	Update validated list of CARMMA **indicators**	• AUC DSA • RECs • Country Member States • National CARMMA champions • Multilateral organisations • Development partners • Civil society organisations • Invited potential partners	• The MNCH Task Force meeting will propose that the CARMMA indicators are updated and validated, according to the CARMMA Accountability Partnership Framework. • The Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC) will ratify the updated CARMMA Accountability Partnership Framework and discussed indicators.	Next scheduled MNCH Task Force meeting. Next scheduled STC-HPDC.
	Update African Health Stats **website**, CARMMA website, **CARMMA Scorecards** and **social media platforms**	• AUC DSA	• The AUC DSA will announce an update of all ICT platforms relevant to the CARMMA initiative at the MNCH Task Force meeting. • The update will take 6 months to 1 year to complete.	From 2020 onwards.
	Ensure that indicators and issues related to CARMMA are included in the **MNCH Status Report**.	• AUC DSA • Author of MNCH Status Report	• The MNCH Status Report is presented at the Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC), and thus, the CARMMA initiatives achievements will be communicated on this occasion.	Bi-annually.
	Encourage potential partners and country Member States to **improve collection of vital statistics**;	• AUC DSA, • RECs, • Multilateral organisations	• The RECs will facilitate the provision of technical support to Member States to ensure a coherent and coordinated approach to the implementation of harmonisation. • Multilateral organisations will assist by providing technical support to Member States.	Ongoing.

	Encourage potential partners and country Member States to **streamline** and harmonise their current **reporting requirements**, and improve **tracking** of **expenditure** related to MNCH.	• AUC DSA, • RECs, • Multilateral organisations	• The RECs will facilitate the provision of technical support to Member States to ensure a coherent and coordinated approach to the implementation of harmonisation. • Bilateral, multilateral organisations will assist by providing technical support to Member States. • Potential partners are invited to identify their roles, responsibilities and outcomes within CARMMA initiative and Framework.	Ongoing from next scheduled STC-HPDC.
REVIEW	Review CARMMA progress at **statutory meetings**, MNCH Task Force and STC-HPDC, bi-annually.	• AUC DSA • RECs • Country Member States • National CARMMA champions • Multilateral organisations • Development partners • Civil society organisations • Invited potential partners	• The MCNH Task Force meeting will be the primary medium of communicating the reviewed achievements and challenges facing the CARMMA initiative.	As scheduled.

	Establish electronic **CARMMA Community of Practice.**	• A committee of contributors selected from the following partners:
		  ○ AUC DSA
		  ○ RECs
		  ○ Country Member States
		  ○ National CARMMA champions
		  ○ Multilateral organisations
		  ○ Development partners
		  ○ Civil society organisations
			• A select Established on the CARMMA website or the social media platforms.	Ongoing.

		○ Invited potential partners (		
	Invite **meaningful stakeholders** to statutory meetings.	• AUC DSA • RECs • Country Member States • National CARMMA champions	• In consultation with the RECs, Country Member States and national CARMMA champions, the AUC DSA will send out invitations to the relevant stakeholders timeously in order to ensure their availability.	Ongoing.
	Utilise the resources and findings from the **African Peer Review Mechanism** to bolster the CARMMA review process.	• AUC DSA • RECs • Country Member States	• The AUC DSA should pose the possibility of this partnership at the MNCH Task Force meeting. • Further discussions and decisions should follow this meeting.	To be determined.
ACT	Present evidence for action at **Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC).**	• AUC DSA • RECs • Country Member States • National CARMMA champions • Multilateral organisations • Development partners • Civil society organisations • Invited potential partners	• Following the presentation and review of the CARMMA initiative's achievements and challenges at the MNCH Task Force meeting, the evidence and recommendations for action will be presented and ratified at the Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC).	Bi-annually.
	Grant the **Mama Afrika** award bi-annually.	• AUC DSA • RECs • Country Member States • National CARMMA champions • Multilateral organisations • Development partners • Civil society organisations	• A decision about the Mama Afrika award will be taken at the MNCH Task Force meeting. • The presentation of the award will take place at the Specialised Technical Committee on Health, Population and Drug Control (STC-HPDC).	At next STC-HPDC, as scheduled.
	Perform **follow-up visits** to non-performing countries.	• AUC DSA • RECs • Country Member States	• Representatives from selected Country Member States, RECs and relevant various potential partner organisations may perform the follow-up visits.	Bi-annually.

		• National CARMMA champions • Multilateral organisations • Development partners • Civil society organisations	• Timeous and relevant communications must be made between relevant government officials and visiting team to • Press statements and communications via the CARMMA social media outlets can communicate the visit and the way forward.	

The CARMMA Evaluation Report found that several initially proposed activities, such as the establishment of a secretariat or an operational MNCH Task Force, were unable to be implemented due to lack of financial resources. As a part of the accountability process but also the sustainability of the CARMMA campaign, it is important to identify the budgetary and personnel components necessary for the realisation of the Framework, and in the long term, the realisation of the CARMMA vision and goals.

In the shorter term, in order to operationalise, coordinate and sustain the envisaged continental Framework, it is proposed that a personnel position within the AUC DSA secretariat is **jointly funded** by the AUC DSA, RECs, Country Member States, multilateral organisations, and identified development and private sector partners. This person would carry out the following functions:

- Conduct communication between the AUC DSA and Country Member States, and other identified partners.
- Ensure the circulation of updated reporting mechanisms, feedback, etc.
- Provide administrative functions for the CARMMA Community of Practice.
- Logistical functions leading up and in preparation for the statutory meetings related to CARMMA,
- Manage, create content and update the CARMMA online platforms, i.e website and social media outlets,
- Execute the administrative business of the MNCH Task Force, under the supervision of the AUC DSA.

It is still to be decided if this position will need to be full-time.

As part of a longer-term plan for the Framework, the establishment of a **CARMMA Secretariat**, perhaps within AUC DSA but with affiliations to APRM, can be explored.

Conclusion

For those involved in the realisation of CARMMA's vision and goals, the CARMMA Accountability Partnership Framework provides a roadmap for monitoring, reviewing and acting on promises and pledges made to end the preventable deaths of mother, newborns and children.

The Framework makes use of structures, such as the African Peer Review Mechanism, data platforms, the MNCH taskforce and the Mama Afrika Award among others, and updated tools, such as scorecards, to drive accountability.

The Framework recognises that this important work cannot be implemented without the essential support, technical and financial, of the AUC's potential partners and calls on them to renew their commitment to and re-energise their strategies towards the CARMMA initiative.

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Annexures

Annexure 1: Extended list of potential partners for CARMMA Accountability Partnership Framework

- National governments such as:
    - Presidents
    - First ladies
    - Ministers
    - Parliamentarians
- The following health practitioners and their corresponding professional associations:
    - Birth attendants
    - Community health workers
    - Doctors
    - Nurses
    - Midwives
- Bilateral partners such as:
    - United States Agency for International Development (USAID)
    - Department for International Development (DFID)
- Multilateral development organisations and initiatives such as:
    - World Health Organization (WHO)
    - The United Nations Population Fund (UNFPA)
    - The United Nations Children's Fund (UNICEF)
    - The Joint United Nations Programme on HIV/AIDS (UNAIDS)
    - The World Bank;
    - The Partnership for Maternal Newborn and Child Health,
    - Every Woman, Every Child
    - The United Nations Entity for Gender Equality and Women's Empowerment (UN Women);
- Civil society organizations such as:
    - International Planned Parenthood Federation
    - White Ribbon Alliance)
    - Women Deliver
    - MSD for Mothers

- Academia which would include, but are not limited to:
    - Universities within country Member States
    - Regional and national research units that focus on maternal, newborn, child and adolescent health issues,
- Community and religious leaders
- The private sector actors such as:
    - MERCK
    - Johnson & Johnson
    - Safaricom Limited

Annexure 2: The Every Woman Every Child Global Strategy United Accountability Framework

Annexure 3: The CARMMA Harmonised and Updated Indicator Table

Indicators	MPoA 2016 - 2030	CARMMA 2013	MNCH Scorecard	African Health Stats website	Countdown to 2030	Proposed CARMMA 2020
Governance						
Existence of a national health policy that integrates SRHR, HIV/AIDS/STI and malaria services						
Existence of laws dealing with sexual and gender-based violence						
Presence of a costed roadmap for the reduction of maternal and new-born morbidity and mortality						
Percentage of the allocation for RMNCH expended						
General government expenditure on health as a percentage of total government expenditure						
Per capita public funds for health						
Government health expenditure as % current health expenditure						
Government health expenditure as % GDP						
External health expenditure as % current health expenditure						
Out-of-pocket expenditure on health as a per cent of total expenditure on health						
Percentage of population covered by a demand-side scheme; e.g., social health insurance, community- based insurance						
Density of health workers – physicians						
Density of health workers – nurses and midwives						
Qualified obstetricians						
Birth registration						

Nutrition						
Proportion of stunted children under five years old						
Wasting – low weight for height under age 5						
Overweight – heavy for height under 5						
Early initiation of breastfeeding						
Exclusive breastfeeding						
Continued breastfeeding (year 1)						
Minimum dietary diversity						
Vitamin A supplementation, full coverage						
Reproductive Health						
Child marriage – before age 15						
Child marriage – before age 18						
Contraceptive prevalence rate						
Unmet need for family planning						
Unmet need for modern contraception						
Proportion of unsafe abortions, per 1,000 women aged 15-49 years						
RH packages in place (MH, FP, PAC and STI prevention, HIV)						
Sexual violence by age 18 – female						
Very early child bearing under age 16						
Female Genital Mutilation						
Maternal and Newborn Health						
Life Expectancy at Birth						
Maternal mortality ratio						
Proportion of births attended by skilled health personnel						
Postnatal care for mothers and babies						
Stillbirth rate						

Infant mortality rate						
Percentage of pregnant women who attended at least four ANC visits						
Percentage of pregnant women who attended at least eight ANC visits						
Proportion of health facilities offering Basic EmOC services						
Percentage of new-borns who received post-partum care from a skilled birth attendant within two days after birth						
Percentage of women who received post-partum care from a skilled birth attendant within two days after delivery						
Proportion of districts that have an established and functional MDSR system						
Percentage of HIV-positive pregnant women who received antiretroviral drugs						
HIV prevalence among population aged 15-24 years						
Percentage of pregnant women attending ANC who were tested for HIV and know their results						
Percentage of infants born to HIV-infected mothers who are infected						
Proportion of pregnant women who received two doses of intermittent preventive treatment of malaria during their last pregnancy						
Child Health						
Neonatal mortality rate						
Proportion of infants aged 12–23 months immunized against DPT3						
Coverage of first dose of measles vaccine						
Full immunization of children under-5						

Under-five mortality rate						
Appropriate care-seeking for diarrhoea, suspected pneumonia, or fever						
Appropriate treatment for malaria						
Proportion of children under five years old who slept under an ITN the previous night						
Proportion of households with at least one ITN and/or sprayed by IRS in the last 12 months						
Percent of children <5 years with fever in last two weeks who were screened for malaria						
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						
Diarrhoea treatment: ORS						
Diarrhoea treatment: ORS + Zinc						
Adolescent Health						
Adolescent fertility rate						
Demand for family planning satisfied with modern methods among adolescent women						
HIV testing for adolescents						
Human papilloma virus (HPV) vaccine coverage among adolescents						
ANC4+ among adolescents						
Skilled attendant at delivery among adolescents						
Postnatal care for adolescent mothers						
Environmental Interventions						
Population using basic drinking-water services				*		

Population using basic sanitation services				#		
Population with hand washing facilities with soap and water at home						

***** The African Health Stats website records that “At least basic drinking water” reflects the proportion of the population using either a “basic drinking water service” (improved source, provided collection time is not more than 30 minutes for a roundtrip, including queuing) or a “safely managed drinking water service” (improved water source located on premises, available when needed and free from faecal and priority chemical contamination).

The African Health Stats website records “At least basic sanitation services” as the proportion of a population using either ‘a basic sanitation service’ (improved facilities not shared with other households) or a ‘safely managed sanitation service’ (improved sanitation service not shared with other households and where excreta are safely disposed of in situ or treated off site).

Annexure 4: African Health Stats Indicators

List of indicators

MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH

INDICATOR	CARMMA scorecard indicator	Long title and what this means
LIFE EXPECTANCY AT BIRTH	No	**Life expectancy at birth** is the number of years on average that a newborn could expect to live if they were to go through life exposed to the sex- and age-specific death rates that prevail at the time of their birth. This relates to a specific year and in a specific country, territory or geographical area.
MATERNAL MORTALITY RATIO	Yes	The **Maternal Mortality Ratio (MMR)** is the rate at which women die from maternal causes (any cause related to pregnancy, during childbirth, pregnancy or within 42 days of childbirth). It is measured as the number of maternal deaths per every 100,000 live births. A live birth refers to any baby that is born that shows signs of life outside of the womb. A maternal death refers to the death of woman while she is pregnant or within 42 days of childbirth, from any cause related to or aggravated by the pregnancy or its management. Maternal deaths exclude accidental or other non-related causes of death.
STILLBIRTH RATE	No	The **stillbirth rate** is the number of stillbirths per 1,000 total births, which includes live births and stillbirths. A live birth refers to any baby that is born that shows signs of life outside of the womb. Stillbirths can occur before childbirth (antepartum), or during labour or childbirth (intrapartum). Stillbirths, in many cases, reflect inadequacies in antenatal care coverage or in intrapartum care. For

		international comparison purposes, stillbirths are defined as third trimester foetal deaths (more than or equal to 1000g, or more than or equal to 28 weeks).
NEONATAL MORTALITY RATE	Yes	**Neonatal mortality rate** refers to the number of deaths of neonates (newborn babies) that occur between birth and the first completed 28 days of life. It is measured as the number of deaths in the first 28 days of life per every 1,000 live births in a given year or period. A live birth refers to any baby that is born that shows signs of life at birth.
INFANT MORTALITY RATE	No	The **infant mortality rate** is the probability that a child will die between the time of birth and exactly one year of age in a specific year or period; it is expressed per every 1,000 live births in that same year or period. A live birth refers to any baby that shows signs of life at birth.
UNDER-FIVE MORTALITY RATE	Yes	The **under-five mortality rate is** the probability of a child dying before reaching the age of five; it is expressed per 1,000 live births and is subject to current age-specific mortality rates. A live birth refers to any baby that shows signs of life at birth.
ANTENATAL CARE COVERAGE: 4+ VISITS	Yes	**Percentage of pregnant women who had at least 4 antenatal care (ANC) visits:** Antenatal care coverage (at least four visits) is the percentage of women aged 15 to 49 with a live birth in a given time period that received antenatal care four or more times. Available survey data on this indicator usually do not specify the type of the provider; therefore, in general, receipt of care by any provider is measured.
ANTENATAL CARE COVERAGE: 8+ VISITS	Yes	**Percentage of pregnant women who had at least 8 antenatal care (ANC) visits:** Antenatal care coverage (at least 8 contacts) is the percentage of women aged 15 to 49 with a live birth in a given time period that received antenatal care eight or more times. Available survey data on this indicator usually do not specify the type of the provider; therefore, in general, receipt of care by any provider is measured.

		In 2016, the World Health Organization (WHO) recommended a new model of 8 ANC contacts (previously 4 ANC visits) during a woman's pregnancy to reduce perinatal mortality and improve women's experience of care.
BIRTHS ATTENDED BY SKILLED HEALTH PERSONNEL	Yes	**Proportion of births attended by skilled health personnel**: This indicator shows the percentage of births that take place in the presence of a skilled healthcare worker who is qualified to attend to births. The definition of a skilled birth attendant is an accredited health professional such as a midwife, nurse or doctor who has the necessary skills needed to manage normal pregnancy, childbirth and the period after the birth, and who is able to identify, manage and refer women and newborns if complications occur. Traditional birth attendants are not included.
POSTPARTUM CARE COVERAGE FOR MOTHERS	Yes	**Percentage of women age 15-49 years who received a health check within 2 days after delivery of their most recent live birth in the last 2 years:** The postpartum or postnatal period is the period immediately after birth until six weeks after birth. This indicator refers to the number of women in the early postnatal period (the first 48 hours after birth) who received a check-up. It is measured as the proportion of the total number of women aged 15-49 who had a live birth in the last 3-5 years prior to the survey, regardless of the place of delivery. The number of live births refers to any baby that is born that shows signs of life outside of the womb.
POSTNATAL CARE COVERAGE FOR NEWBORNS	No	**Percentage of newborns receiving a health check within two days after delivery**: Postnatal care coverage of newborns is the percentage of newborns (last live births) in the previous two years who received a health check from a health provider within two days after delivery. A live birth refers to any baby that is born that shows signs of life outside of the womb.
EXCLUSIVE BREASTFEEDING FOR INFANTS UNDER 6 MONTHS	No	**Percentage of infants 0—5 months of age who received only breast milk during the previous day**: This is the proportion of infants 0-5 months of age (from birth to less than 6 months) who are fed exclusively with breast milk. The indicator does include infants who 0-5 months of age who received ORS drops, and minerals, vitamins and medicines in syrup form, but no other food or water.

COVERAGE OF FIRST DOSE OF MEASLES VACCINATION	Yes	**Coverage of the first dose of the measles containing-vaccine (MCV1):** This is the number of surviving infants who have received one dose of vaccine against measles. The vaccine is usually given in combination with rubella (MR) or with mumps and rubella (MMR). In most immunisation schedules, this is given to children under 1 year, but some countries give it to older children. This indicator is expressed as a percentage of the corresponding mid-year population in a specific year and in a given country.
STUNTING – SHORT HEIGHT FOR AGE UNDER 5	Yes	**Proportion of under-fives falling below minus 2 standard deviations (moderate and severe) and minus 3 standard deviations (severe) from the median height-for-age of the reference population**: This is the percentage of children under the age of five whose growth in height is restricted by lack of adequate nutrition. Children under five that are 'stunted' are those who do not reach the minimum height in the healthy range for their age and gender. It includes the proportion of under-fives falling below minus 2 standard deviations (moderate and severe) and minus 3 standard deviations (severe) from the median height-for-age of the World Health Organization (WHO) Child Growth Standards among children under 5 years of age. Stunting can be caused by chronic malnutrition or poor health conditions over the long term.
WASTING – LOW WEIGHT FOR HEIGHT UNDER 5	No	**Prevalence of wasting (weight for height less than two standard deviations from the median of the WHO Child Growth Standards) among children under five years of age:** This is the prevalence of wasting (weight for height less than two standard deviations from the World Health Organization (WHO) Child Growth Standards median) for children less than five years of age. It includes the proportion of under-fives falling below minus 2 standard deviations (moderate and severe) and minus 3 standard deviations (severe) from the median weight-for-height of the World Health Organization (WHO) Child Growth Standards among children under 5 years of age.

OVERWEIGHT – HEAVY FOR HEIGHT UNDER 5	No	**Prevalence of overweight (weight for height greater than two standard deviations from the median of the World Health Organization (WHO) Child Growth Standards) for children under five years of age**: This is the prevalence of overweight (weight for height greater than two standard deviations from the median of the World Health Organization (WHO) Child Growth Standards) for children under five years of age. Child overweight refers to a child who is too heavy for their height that results from energy intakes from food and beverages that exceed children's energy requirements.
SEXUAL AND REPRODUCTIVE HEALTH		
CHILD MARRIAGE BEFORE AGE 15	No	**Proportion of women aged 20-24 years who were married or in a union before age 15**: This indicator represents the proportion of women aged 20 to 24 who were married or in a union before the age of 15. This includes both informal and formal unions - that is, marriages. Informal unions are those in which a couple lives together for some time, intends to have a lasting relationship, but have had no formal civil or religious ceremony, also known as cohabitation.
CHILD MARRIAGE BEFORE AGE 18	Yes	**Proportion of women aged 20-24 years who were married or in a union before age 18**: This indicator represents the proportion of women aged 20 to 24 who were married or in a union before the age of 18. This includes both informal and formal unions - that is, marriages. Informal unions are those in which a couple lives together for some time, intends to have a lasting relationship, but have had no formal civil or religious ceremony, also known as cohabitation.
FEMALE GENITAL MUTILATION	No	**Proportion of girls and women aged 15-49 years who have undergone female genital mutilation**: Female genital mutilation (FGM) is defined by WHO as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons"

SEXUAL VIOLENCE BY AGE 18 – FEMALE	No	**Proportion of young women aged 18-29 years who experienced sexual violence by age 18:** This is the percentage of young women aged 18 to 29 who experienced sexual violence by 18 years of age.
SEXUAL VIOLENCE BY AGE 18 – MALE	No	**Proportion of young men aged 18-29 years who experienced sexual violence by age 18:** This is the percentage of young men aged 18 to 29 who experienced sexual violence by 18 years of age.
VERY EARLY CHILD BEARING UNDER AGE 16	Yes	This is the percentage of women aged 20 to 24 years who gave birth before age 16 years.
ADOLESCENT BIRTH RATE AGES 15 TO 19	Yes	This indicator represents the number of babies born to girls and women ages 15 to 19 each year. This is the expected number of girls and women that will become pregnant between the ages of 15 to 19 each year out of every 1,000 women and girls in that age group. This indicator is also referred to as the age-specific fertility rate.
HPV VACCINE COVERAGE	For consideration	**Proportion of girls vaccinated with 2 doses of HPV vaccine by age 15 years** HPV Vaccine coverage is the proportion of girls vaccinated with 2 doses of HPV vaccine by age 15 years (meta-data currently under development data will be available in early 2020). *[UNICEF hope to have HPV estimates produced before the end of 2019. (M.S. Diallo, UNICEF), specifically to align with MPoA: Proportion of girls vaccinated with 2 doses of HPV vaccine by age 15 years]*
CONTRACEPTIVE PREVALENCE RATE, MODERN METHODS	No	**Contraceptive prevalence rate, modern methods (% of women ages 15-49)** Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49.

DEMAND SATISFIED FOR MODERN CONTRACEPTION	Yes	Demand satisfied for modern contraception is the proportion of married or in a union (sexually active) girls and women aged 15 to 49 who have their need for family planning satisfied with modern methods. Total demand for family planning is the sum of the number of women aged 15 to 49 who are married or in a union and are currently using, or whose sexual partner is currently using, at least one method of contraception, and the unmet need for family planning
UNINTENDED PREGNANCY RATE	For consideration	**Unintended pregnancy rates per 1,000 women aged 15–44 years** *[WHO and Guttmacher have developed a protocol to estimate this and have tested it across 1990-2014 data. The next step is to generate country-level data. They are doing this now and anticipate data being produced in "early 2020". This indicator will be added when data are available.]*
ACCESS TO SRH CARE, INFORMATION AND EDUCATION	No	**Access to sexual and reproductive health care, information and education** Pending discussions and identification of indicator definition and source – re SDG 3.6.2: laws and regulations in place that guarantee women aged 15-49 access to sexual and reproductive health care
NATIONAL POLICY ON SEXUAL EDUCATION FOR YOUNG PEOPLE OR PERCENTAGE (%) OF PUBLIC SCHOOLS OFFERING SEXUAL EDUCATION	No	**Existence of National Policy, program or strategy on sexual education for young people** The Bureau of the 2nd STC on Health, Population and Drug Control have requested the inclusion of an indicator aligned to the MPoA objective of 'improving SRH information, education and communication' among young people. The Bureau continues to work with the AU Commission to identify an appropriate indicator.
CERVICAL CANCER SCREENING	For consideration	**Proportion of women aged 30−49 years who report they were screened for cervical cancer**
REPRODUCTIVE TRACT CANCERS	For consideration	**Indicator to track reproductive tract cancers to be identified:**

		This data is not currently tracked – for consideration by STC and for TWG to take forward. [African Health Stats TWG to discuss and consider creating small working group to consider and develop]
HEALTH SYSTEMS AND POLICIES		
CHILDREN UNDER 5 WITH DIARRHOEA RECEIVING ORS	No	**Percentage of children under-five with diarrhoea receiving oral rehydration salts (ORS) in the last 2 weeks** This is the percentage of children under five years of age (0-59 months) with diarrhoea in the last two weeks who are receiving oral rehydration salts (ORS), which are fluids made from ORS packets or are pre-packaged ORS fluids.
CHILDREN UNDER 5 WITH ARI TAKEN TO A HEALTH PROVIDER	No	**Percentage of children born in the five years preceding the survey with acute respiratory infection taken to a health facility** Care seeking for pneumonia for children under 5 is the percentage of children born in the five years preceding the survey with acute respiratory infection taken to a health facility.
NEW HIV INFECTIONS	No	**HIV incidence per 1000 population (adults 15-49 years)** This indicator is defined as the number of new HIV infections per 1,000 person-years among the population that is not infected, aged 15-49 years. This is the number of new cases per population at risk in a given time period, referred to as the incidence rate. The uninfected population is the total population minus the people living with HIV.
ANTIRETROVIRAL TREATMENT COVERAGE	No	**Proportion of adults and children living with HIV receiving antiretroviral treatment** This indicator refers to the percentage of children and adults currently receiving antiretroviral therapy (ART) at the end of the reporting period among the number of those who are living with HIV in the same period. The World Health Organization recommends that all people living with HIV should receive treatment.

ANTIRETROVIRAL MEDICINE COVERAGE HIV POSITIVE PREGNANT WOMEN	No	**Percentage of pregnant women living with HIV who received antiretroviral medicine to reduce the risk of mother-to-child transmission of HIV** The indicator measures the percentage of pregnant women living with HIV who received antiretroviral medicine among the estimated number of pregnant women living with HIV, to reduce the risk of mother-to-child transmission (PMTCT) of the virus.
CONDOM USE	No	**Proportion of adults (15-49y) reporting condom use at last higher-risk sex (with a non-marital, non-cohabiting partner)** This indicator measures the percentage of people who have had sexual intercourse with a partner who they were not married to or living with in the last 12 months and who used a condom in their last encounter compared with the number of respondents who had a sexual partner who they are not married to or living with in the last 12 months. This indicator measures progress towards preventing exposure to HIV through unprotected sexual intercourse among partners that are not married to each other or living together.
NEW TB INFECTIONS	No	**Tuberculosis incidence per 100,000 population** Tuberculosis (TB) incidence is the estimated number of new and relapse TB cases - specifically all forms of TB, including cases in people living with HIV infection - that arise in a specific year, expressed as a rate per 100,000 population.
NEW MALARIA INFECTIONS	No	**Malaria incident cases per 1,000 persons per year** This is the number of confirmed new cases of malaria reported each year per every 1,000 people.
CHILDREN UNDER 5 WHO SLEPT UNDER BED NETS	No	**Percentage of children under five years old who slept under an insecticide-treated mosquito net the previous night** This is the percentage of children under five years of age (0-59 months) with diarrhoea in the last two weeks who are receiving oral rehydration salts (ORS), which are fluids made from ORS packets or are pre-packaged ORS fluids.

NON-COMMUNICABLE DISEASES

MORTALITY FROM NON-COMMUNICABLE DISEASES	No	**Probability of dying from any cardiovascular disease, cancer, diabetes or chronic respiratory disease between age 30 and exact age 70 (%)** Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease is the probability of dying between the ages of 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases. It is defined as the percentage of 30-year-old-people who would die before their 70th birthday from cardiovascular disease, cancer, diabetes, or chronic respiratory disease, assuming that they would experience current mortality rates at every age and would not die from any other cause of death, such as injuries or HIV/AIDS. The probability of dying is the likelihood that an individual would die between two ages given the current rates of mortality at each age.
SUICIDE MORTALITY RATE	No	**Suicide mortality rate (per 100,000 population)** Suicide mortality rate is defined as the number of suicide deaths in a year, divided by the population and multiplied by 100,000.
CURRENT TOBACCO USE AMONG FEMALES AGED 15 AND OVER	No	**Age-standardised prevalence of current tobacco use among females 15 years and older** Age-standardised prevalence of current tobacco use among females 15 years and older is defined as the percentage of the female population aged 15 years and over who currently use any tobacco product whether smoked or smokeless on a daily / non-daily basis or occasional smoking. "Tobacco smoking" includes cigarettes, cigars, pipes or any other smoked tobacco products.
CURRENT TOBACCO USE AMONG MALES AGED 15 AND OVER	No	As above for males

HARMFUL USE OF ALCOHOL AGED 15 AND OVER	No	**Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol** Total alcohol per capita consumption (APC) is defined as the total (sum of the recorded APC three-year average and the unrecorded APC) amount of alcohol consumed per adult (15 years and older) over a calendar year, in litres of pure alcohol.
HEALTH FINANCING		
EXTERNAL HEALTH EXPENDITURE AS A % OF CURRENT HEALTH EXPENDITURE	No	**External Health Expenditure (EXT) as a % of Current Health Expenditure (CHE)** This is the share of overall current health expenditure that is financed through external grants flowing through government or non-governmental services.
GOVERNMENT HEALTH EXPENDITURE AS % CURRENT HEALTH EXPENDITURE	No	**Domestic General Government Health Expenditure (GGHE-D) as % of Current Health Expenditure (CHE)** This is the share of overall current health expenditure that is spent by government, excluding services that are funded by external grants, even when they flow through government.
GOVERNMENT HEALTH EXPENDITURE AS % GENERAL GOVT EXPENDITURE	Yes	**Domestic General Government Health Expenditure (GGHE-D) as % of General Government Expenditure (GGE)** This indicates the share of the total government budget that is allocated to the health sector, excluding capital expenditure and services that are funded by external grants, even when they flow through government.
GOVERNMENT HEALTH	No	**Domestic General Government Health Expenditure (GGHE-D) as % of Gross Domestic Product (GDP)**

EXPENDITURE AS % OF GDP		This describes public expenditures on health as a share of the economy as measured by GDP (excluding external grants and capital expenditure).
CURRENT DOMESTIC GOVERNMENT EXPENDITURE PER CAPITA	No	**Domestic general government health expenditure (GGHE-D) per capita in purchasing power parity international dollars** This indicates how much is spent by government on health per person in a country (excluding external grants and capital expenditure). In order to allow a fair comparison between countries, amounts are standardised and converted into a notional currency, international dollars, to take account of the different costs of services in different countries.
OUT-OF-POCKET HEALTH EXPENDITURE AS % CURRENT HEALTH EXPENDITURE	No	**Out-of-pocket expenditure on health as a percentage of current expenditure on health (OOP % CHE)** This indicator estimates how much households spend on formal or informal fees at the time of using health services, or as co-payments, when their health insurance or government funding does not cover the full costs of care. This is another indicator of financial protection, giving some indication of whether households have to purchase additional services.
PERCENTAGE OF NATIONAL HEALTH BUDGET ALLOCATED FOR REPRODUCTIVE HEALTH	To be added in future	**Percentage (%) of national health budget allocated for reproductive health [preliminary]** This is the percentage of government spending on health dedicated to reproductive health (covering Maternal conditions, Perinatal conditions, Contraceptive management - family planning - and unspecified reproductive health conditions). It excludes reproductive health services that are funded by development partners, even when they flow through government.
COMMUNICABLE DISEASES		
DENSITY OF PHYSICIANS	Yes	**Density of physicians per 10,000 population**

		This is the number of health workers per 10,000 population in a given national area. The density of physicians is defined as the number of physicians including generalists and specialist medical practitioners per 10,000 population in the given national area.
DENSITY OF NURSES AND MIDWIVES	Yes	**Density of nurses and midwives per 10,000 population** This is the number of health workers per 10,000 population in a given national area. The density of nursing and midwifery personnel is defined as the number of nursing and midwifery personnel per 10,000 population in the given national area.
DENSITY OF PHARMACEUTICAL STAFF	Yes	**Density of pharmaceutical staff per 10,000 population** This is the number of health workers per 10,000 population in a given national area. The density of pharmaceutical personnel is defined as the number of pharmacists, pharmaceutical, technicians/assistants and related occupation personnel per 10,000 population in the given national area.
QUALIFIED OBSTETRICIANS – TOTAL NUMBER	Yes	**Number of licensed qualified obstetricians actively working** This is a count of the total number of licensed, qualified physician obstetricians.
BIRTH REGISTRATION	Yes	**Proportion of children under five years of age whose births have been registered with a civil authority** This is the proportion of children under five years of age whose births have been registered with a civil authority.
DEATH REGISTRATION		**Death registration data that are at least 75% complete** The registration of deaths in the civil registration system that has occurred to the members of the population of a particular country in which 75% of deaths have a vital registration record.

AT LEAST BASIC DRINKING WATER SERVICES		**Proportion of population using safely managed or basic drinking water services** Drinking water services refers to the accessibility, availability and quality of the main source used by households for drinking, cooking, personal hygiene and other domestic uses. 'At least basic drinking water' is the proportion of a population using either a 'basic drinking water service' (improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing) or a 'safely managed drinking water service' (improved water source located on premises, available when needed and free from faecal and priority chemical contamination). Improved facilities include piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater and packaged or delivered water.
AT LEAST BASIC SANITATION SERVICES		**Proportion of population using safely managed sanitation services, including a handwashing facility with soap and water** Sanitation services refer to the systems used to separate human excreta from human contact at all steps of the service chain from toilet capture and containment through emptying, transport, treatment (in-situ or offsite) and final disposal or end use. 'At least basic sanitation services' is the proportion of a population using either a 'basic sanitation service' (improved facilities not shared with other households) or a 'safely managed sanitation service' (improved facility not shared with other households and where excreta are safely disposed of in situ or treated off-site). 'Improved' facilities include flush or pour flush to piped sewer systems, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs.
OPEN DEFECATION		**Proportion of population practising open defecation** This is the proportion of the population practicing open defecation. Open defecation is defined as the disposal of human faeces in fields, forests, bushes, open bodies of water, beaches or other open spaces, or with solid waste.

HEALTH FACILITIES PROVIDING INTEGRATED SRH SERVICES	Yes	**Proportion of health facilities providing integrated sexual and reproductive health services** Integrated services measures the proportion of health facilities that provide postpartum, post-abortion and/or HIV services that also provide clients who use those services with contraceptive information and care. *Source: To be confirmed, currently indicator is based on an aspirational indicator defined by The Guttmacher Institute: https://www.guttmacher.org/report/sexual-and-reproductive-health-and-rights-indicators-sdgs*
MATERNAL DEATHS REVIEWED	To be considered	**The proportion of maternal deaths reviewed in the country in the last year** This indicates measures the number of maternal deaths reviewed in the country in the last year as a proportion o the total number of the estimated maternal deaths in the country. This gives an indication of the status of implementation of Maternal Death Surveillance and Response systems. *(data source: MMEIG estimates of maternal deaths, new estimates to be released in July 2019)*
EXISTENCE OF NATIONAL REPRODUCTIVE CANCER POLICY	No	**The existence of a national reproductive cancer policy** *Requested by Bureau, indicator to be discussed, defined and data source identified by TWG*
IMPLEMENTATION OF AMRH FRAMEWORK	No	**Implementation of the African Medicines Regulatory Harmonisation (AMRH) Initiative** Through the African Medicines Regulatory Harmonization (AMRH), regional economic communities and organizations are supported to develop and implement Medicines Regulation Harmonization (MRH) projects that enable member states to harmonise technical requirements and standards, jointly assess applications and inspect manufacturing sites, and streamline decision making processes.