

**ROAD MAP FOR
ACCELERATING THE ATTAINMENT
OF THE MDGs RELATED TO
MATERNAL AND NEWBORN HEALTH
IN AFRICA**

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EXECUTIVE SUMMARY

1. More than 15 years following the launching of the Safe Motherhood Initiative (SMI), the maternal and perinatal mortality levels in Africa have sadly continued to rise instead of declining. The average maternal mortality ratio in the African region has risen from 870 deaths per 100,000 live births in 1990 to 1,000 deaths per 100 000 live births in 2001. Africa has the highest newborn mortality rate estimated at 45 deaths per 1,000 live births.
2. Deeply concerned by the persistently high maternal and newborn morbidity and mortality, the Millennium Summit in 2000 developed the Millennium Development Goals (MDGs) and agreed to increase efforts to improve maternal health and reduce child mortality. In order to support countries in Africa to move towards the attainment of the MDGs, the African Regional Reproductive Health Task Force, held from 20-24 October 2003, in Dakar, called on all partners to develop and implement a Road Map for accelerated maternal and newborn mortality reduction.
3. Implementation of maternal and newborn health programmes in the region are confronted by many challenges, such as: (i) lack of national commitment and financial support, (ii) poor co-ordination amongst partners, (iii) poorly functioning health systems, with weak referral systems, especially during obstetric and neonatal emergencies, (iv) poor logistics for management of drugs, family planning commodities and equipment, (v) weak national human resource development and management, including the continuing brain drain of skilled personnel within and outside Africa, and from public to private sector; and unclear policies concerning practice regulation.
4. The Road Map offers a new and revitalised dimension of efforts. It provides a framework for building strategic partnerships for increased investment in maternal and newborn health at institutional and programme levels. Consensus amongst the major stakeholders at African regional level to support countries over the next eleven years using this Road Map is a breakthrough in maternal and newborn mortality reduction efforts. It offers an opportunity to all partners and programmes to focus on two major levels of care where the health sector can make a difference, namely: the health service delivery and community levels. The recognition of the inseparable dyad of the mother and newborn allows all partners to focus special attention on the availability of emergency obstetric and neonatal care, skilled attendance during pregnancy and childbirth, and family planning, and the essential equipment and supplies that will save the lives of women and newborns at all levels.
5. The general objective of the Road Map is to accelerate the reduction of maternal and newborn mortality towards the attainment of the MDGs in Africa. Its specific objectives are to: (i) provide skilled attendance during pregnancy, childbirth, and the postnatal period, at all levels of the health care delivery system, (ii) strengthen the capacity of Individuals, Families, and Communities to improve maternal and newborn health (MNH).
6. The proposed priority interventions include: (i) define minimum package of MNH and FP services at each level of the health care delivery system; (ii) review/revise national policies, norms and protocols using international evidence- based MNH and FP standards of care; (iii) upgrading of health services to ensure accessible, acceptable, quality essential MNH care; (iv) establishment of standards of care for Emergency Obstetric Care; (v) assessment and updating of pre-service training curricula in Emergency Obstetric Care; (vi) procurement of appropriate communication equipment including two-way radios and emergency transport means (vii)

capacity building of district health management teams in the integration of MNH programmes into SWAPs and PRSPs; (vi) strengthening of health information; (vii) organization of a regional summit on MNH; (viii) promotion of male involvement and establishment of community committees for MNH.

7. The follow-up steps include the: (i) organization of country-level stakeholders' meeting under the leadership of the Ministry of Health and the development of country-specific Road Map; (ii) selling of the Road Map by each agency in order to increase advocacy for MNH and FP, and mobilizing resources for its implementation; and (iii) signing up to the Road Map by all the heads of the agencies involved as a commitment to its implementation.

8. It is proposed that the implementation at country level be considered in 2 phases of 5 years each namely: Phase 1: 2004 – 2009; Phase 2: 2010 – 2014; and Final Reporting year: 2015. Indicators for monitoring and evaluation are proposed and will be adapted for country-level use. Annual country reports will be shared among partners and with the Regional Economic Communities and the African Union. All the partners will support the mid-term reviews and end of implementation evaluation at country level.

9. The success of the implementation of this Road Map will depend on the commitment of governments, Ministries of Health and all partners to invest in maternal and newborn health.

1. INTRODUCTION

More than 15 years following the launching of the Safe Motherhood Initiative (SMI), the maternal and perinatal mortality levels in Africa have sadly continued to rise instead of declining. Deeply concerned by the persistently high maternal and newborn morbidity and mortality, the Millennium Summit in 2000 developed the Millennium Development Goals (MDGs) and agreed to increase efforts to improve maternal health and reduce child mortality.

In order to support countries in the African region to move towards the attainment of the MDGs, the African Regional Reproductive Health Task Force, called on all partners to develop and implement a Road Map for accelerated maternal and newborn mortality reduction.

The following partners came together in Harare on 16 - 18 February 2004 to develop this Road Map: UNFPA, UNICEF, USAID, ADVANCE Africa, Engender Health, WAHO, MNH/JHPIEGO, CRHCS, FCI, FHI, RHRU Johannesburg, SARA/AED, SARA/PRB, Representatives of the Global Partnership of Safe Motherhood and Newborn Health, Representatives of the African Regional RH Task Force, Ministry of Health Officials from Tanzania and Zimbabwe, as well as representatives from WHO country offices, regional offices and headquarters in Geneva.

1.1. Current Situation

The average maternal mortality ratio in the African region has risen from 870 deaths per 100,000 live births in 1990 to 1,000 deaths per 100,000 live births in 2001. Of the estimated 529,000 maternal deaths that occur globally every year, 48% are in the African region, a region that constitutes only 12% of the world's population and 17% of all births in the world. Poor women in the region are especially vulnerable. In many countries in the region, between 25% and 33% of all deaths of women of reproductive age are the results of a complication of pregnancy or childbirth, whereas in industrialised countries the risk of maternal death is very low, estimated at 1%. The high fertility rates and low contraceptive use in the Africa contribute to this high risk. The lifetime risk of maternal death in the African region is estimated at 1:16 compared to 1:3500 in North America, 1:2400 in Europe, 1:160 in Latin America and the Caribbean, and 1:100 in Asia. For every maternal death, there are at least thirty women who suffer short or long term disabilities.

Approximately 13% of all maternal deaths occur among adolescents mainly as a result of complications of unsafe abortion. The majority of the disabilities, especially obstetric fistulas are also most prevalent in the adolescent age group. On average in Africa, a woman has had her first pregnancy by age 19. Fourteen million adolescents (15-19 years) in the world give birth annually, the majority (12.8 million) in developing countries. In spite of this, little attention is focused on married or pregnant adolescents. Compared with women in their twenties, adolescents are twice more likely to die during childbirth, and those that are 14 years and younger are five times more likely to die. The newborns of adolescents also have a higher incidence of low birth weight and neonatal mortality.

Africa has the highest newborn mortality rate estimated at 45 deaths per 1,000 live births compared with 34 in Asia, 17 in Latin America and 5 in developed countries. Given gross under-reporting and wide variations within countries, these figures are without doubt much higher.

Increasing numbers of maternal deaths in the region are due to indirect causes, such as HIV/AIDS, TB and malaria. Many pregnant women in Africa are being diagnosed with HIV. In regions of Southern, East and Central Africa, 20-30% of all pregnant women are infected. HIV infection transmission rates from mother to child range from 25% to 40% in some countries. Tuberculosis kills over 1 million women aged 18 – 45 years annually, of which 600 000 of these deaths occur in the African region. Malaria is a major cause of maternal anaemia, low birth weight and neonatal death.

1.2. Challenges

The efforts deployed since the launching of the SMI seem not to have yielded the expected results due to the many challenges confronting MNH programmes in the region. Most of the countries in the African region are poor and highly indebted. This limits the allocation of resources to health and in particular to MNH programmes. The growing poverty, especially among women, is a great obstacle limiting women's access to highly needed services. The situation is further aggravated by dwindling donor resources. Another serious challenge has been the numerous manmade and natural disasters in the region, such as civil conflicts, disease outbreaks, and floods that rapidly destroy infrastructure, disrupt services, divert resources and erode gains made in health in the past.

Some of the reasons for failure to significantly reduce maternal and neonatal mortality in the region include:

- lack of national commitment and financial support
- poor co-ordination amongst partners
- inadequate male involvement coupled with low status of women with poor decision making power
- growing poverty particularly among women
- lack of access to, availability and use of quality skilled care during pregnancy, childbirth and the immediate postnatal period
- focus on ineffective interventions, such as the risk approach
- poorly functioning health systems, with weak referral systems, especially during obstetric and neonatal emergencies
- weak national human resource development and management, including the continuing brain drain of skilled personnel within and outside Africa, and from public to private sector
- negative impact of the HIV pandemic on human and financial resources for MNH care
- poor logistics for management of drugs, family planning commodities and equipment
- unclear policies concerning practice regulation; and,
- harmful socio-cultural beliefs and practices.

If nothing is done to effectively address the above challenges, it is estimated that, over the next ten years, there will be at least:

- 2.5 million maternal deaths and
- 49.0 million maternal disabilities; resulting in
- 7.5 million child deaths

1.3. What is new with this Road Map?

The need to better plan, organise, manage, monitor and increase investments in maternal and newborn health programs, calls for a concerted approach on the part of governments and partners.

The Road Map offers a new and revitalised dimension of efforts. It provides a framework for building strategic partnerships for increased investment in maternal and newborn health at institutional and programme levels. Consensus amongst the major stakeholders at African regional level to support countries over the next eleven years using this Road Map is a breakthrough in maternal and newborn mortality reduction efforts.

It offers an opportunity to all partners and programmes to focus on two major levels of care where the health sector can make a difference, namely: the health service delivery and community levels. The recognition of the inseparable dyad of the mother and newborn allows all partners to focus special attention on the availability of emergency obstetric and neonatal care, skilled attendance during pregnancy and childbirth, and the essential equipment and supplies that will save the lives of women and newborns at all levels.

The Road Map is goal-driven and results-based with clear strategies, targets, benchmarks and timelines. The strategies are based on key evidence-based interventions that are known to be cost-effective and feasible in resource poor settings. No wheel is being reinvented, only proven interventions are identified for concerted action including joint planning and cost sharing, and rapid scaling up.

2. GOALS

The destination, following the Road Map, is the achievement of the Millennium Development Goals (MDGs) related to maternal and newborn health. The Road Map builds on the International Conference on Population and Development (ICPD) Programme of Action, the “Cairo+5” and the UN Millennium Summit agreements.

The internationally agreed goals and targets to achieve are:

Millennium Development Goals

Goal 5: Improve maternal health

- Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
- Indicator 17: 80 per cent of all births should be assisted by a skilled attendant by 2005, by 2010, 85 per cent, and by 2015, 90 per cent. Where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled health personnel by 2005, by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. (MDG indicator no. 17, and ICPD+5 para.64).¹

Goal 4: Reduce child mortality

- Target 5: Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate
- Indicator 14: Reduce infant mortality below 35 per 1000 live births by the year 2015.²

3. OBJECTIVES

3.1. General Objective

To accelerate the reduction of maternal and newborn mortality and the attainment of the MDGs in Africa

3.2. Specific Objectives:

- To provide skilled attendance³ during pregnancy, childbirth, and the postnatal period, at all levels of the health care delivery system
- To strengthen the capacity of Individuals, Families, and Communities to improve MNH

4.0 GUIDING PRINCIPLES

The following principles will guide the planning and implementation of the Road Map to ensure effectiveness and sustainability in Africa:

¹ Countries with intermediate mortality levels should aim to achieve a maternal mortality rate below 60 per 100,000 live births by 2015. Countries with the highest levels of maternal mortality should aim to achieve below 75 per 100,000 live births by 2015. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed. (ICPD para.8.21). By 2005, Where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled health personnel by 2005, by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. (ICPD+5 para. 64)

² Countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births by 2005. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births. (ICPD, para.8.16)

³ **Skilled attendance** refers to the process by which a pregnant woman and her infant are provided with adequate care during labour, birth, and the postnatal period, whether the place of delivery is the home, health centre, or hospital. In order for this process to take place, the attendant must have the necessary skills and must be supported by an enabling environment at various levels of the health care system, including a supportive policy and regulatory framework; adequate supplies, equipment, and infrastructure; and an efficient system of communication and referral/transport.

Secretariat Contact: Dr. Doyin Oluwole, Director DRH (oluwoled@afro.who.int)

- **Evidence-base:** Ensuring that the interventions are based on up-to-date evidence and are cost-effective.
- **Health systems approach:** Focusing on MNH delivery of care at all levels, using the primary health care as an entry point for engaging community resources and strengthening the referral system.
- **Complementarity:** Building on existing programmes and recognizing the comparative advantages of the different partners in the planning, implementation and evaluation of maternal and newborn health programmes.
- **Partnership:** Promoting partnership, coordination and joint programming among stakeholders including the private sector, professional associations and councils at all levels in order to improve collaboration, maximize resources, and avoid duplication.
- **Clear definition of roles and responsibilities:** Defining roles and responsibilities of all players in the implementation, monitoring and evaluation of the identified activities for increased synergy.
- **Appropriateness and Relevance:** Having a clear understanding of the status of maternal and newborn health in different countries, as well as the local perception in relation to maternal and newborn health.
- **Transparency and accountability:** Promoting a sense of stewardship, accountability and transparency on the part of the government as well as other stakeholders for enhanced sustainability.
- **Equity and accessibility:** Supporting scaling-up of cost-effective interventions that promote equitable access to quality health services with greater attention to the poor and vulnerable groups, especially in rural and under-served areas.
- **Phased planning and implementation at country level:** Promoting implementation in clear phases with timelines and benchmarks that enable re-planning for best results.

5.0 STRATEGIES

- **Improving the provision of, and access to, quality MNH care including FP services.** This includes increasing availability, accessibility, affordability and acceptability of quality skilled care, which encompasses MNH services including family planning, particularly to the poor and vulnerable population groups. It is crucial that a skilled attendant⁴ with the necessary skills is available to provide the essential services and that this person is supported by an enabling environment at various levels of the health system.
- **Strengthening the referral system.** This includes a functional referral system that effectively links all the different providers and levels of care in order to ensure timely and appropriate management of maternal or neonatal complications.
- **Strengthening district health planning and management of MNH care including FP services.** Building capacity of district health systems to plan, manage, monitor and evaluate MNH and FP services at the district and community levels in order to maximise the available resources and improve the quality of service delivery.
- **Advocating for increased commitment and resources for MNH and FP.** Bringing the burden of maternal and newborn morbidity and mortality to the attention of

⁴ A **skilled attendant** is a health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification and management or referral of complications in women and newborns.

Secretariat Contact: Dr. Doyin Oluwole, Director DRH (oluwoled@afro.who.int)

governments and stakeholders for increased commitment and allocation of resources necessary to provide skilled attendance, including using HIPC funds (though the PRSPS). Appropriate policies governing practice regulations and development of human resources with a supportive environment are crucial for increased access to, and availability of, emergency obstetric and neonatal care.

- **Fostering partnerships.** This entails fostering and establishing strategic partnerships to improve co-ordination and collaboration between partners and among programmes, as well as to galvanise resources for long-term sustainable action for MNH.
- **Promoting the household to hospital continuum of care.** Strengthening the capacity of women, their partners and families to ensure self-care in the home and to seek and reach health care facilities in a timely manner for improved pregnancy outcomes.
- **Empowering communities.** Using approaches and mechanisms, such as Behaviour Change Communication (BCC), communities should be empowered to define, demand and access quality skilled care through mobilization of community resources. Active participation of the community enhances self-reliance, ownership and sustainability of key actions.

6.0 PRIORITY INTERVENTIONS

Objective 1: To provide skilled attendance during pregnancy, childbirth, and the postnatal period, at all levels of the health care delivery system

Strategy 1: Improving the provision of, and access to, quality MNH services including FP services.

Priority interventions:

- Define minimum package of MNH and FP services at each level of the health care delivery system including human resources, supplies, equipment, infrastructure, financial resources
- Review/revise national policies, norms and protocols using international evidence-based MNH and FP standards of care, and ensure their dissemination to all health care providers for their adoption and use
- Upgrade health services to ensure accessible, acceptable quality essential MNH care
- Establish standards of care for EmOC at all levels
- Assess training needs, train, retrain and update training in in-service programs to ensure that service providers at all levels of the health service delivery system have the appropriate competencies/skills, provider attitudes and ethics
- Assess and update pre-service training curricula and approaches to be in-line with international evidence-based standards of care
- Strengthen pre-service training institutions to provide the necessary skills and competencies
- Introduce and apply performance and quality improvement approaches to strengthen facility based service delivery including community participation and supportive supervision

Strategy 2: Strengthening the referral system

Priority interventions:

- Identify communication and equipment needs for referral system at community and district levels
- Procure and install appropriate communication equipment including two-way radios and emergency transport means
- Train providers in early recognition of complications and early pre-referral treatment (Emergency Triage Assessment and Treatment = ETAT)
- Train other resource persons (community health workers, ambulance drivers) in emergency response and preparedness
- Establish community emergency committees (to mobilize community resources for emergency transport, blood donors)

Strategy 3: Strengthening district health planning and management of MNH care and FP services

Priority interventions:

- Build capacity of district health management teams and national ministries of health, finance and planning in the integration of MNH programmes into SWAPs, PRSPs in order to access available in-country funds
- Strengthen the skills and capacity of District Health Management Teams in programme management, including monitoring and supervision
- Support health finance strategy design and implementation at district level
- Strengthen health information systems for improved decision making

Strategy 4: Advocating for increased commitment and resources for MNH and FP

Priority interventions:

- Support countries to update or revise existing advocacy tools to include health, economic and social benefits (e.g. REDUCE/ALIVE)
- Develop and implement advocacy plans for resource mobilization, policy change, and use existing fora for advocacy
- Establish an MNH day or week and support its commemoration
- Organize a regional summit on MNH

Strategy 5: Fostering partnerships

Priority interventions:

- Organize country-level stakeholders' meeting to develop country-specific Road Map
- Co-ordinate regularly planning, implementation, monitoring and evaluation of MNH activities with key stakeholders

Objective 2: To strengthen individual, family and community capacity to improve MNH

Strategy 1: Promoting the household to hospital continuum of care

Priority interventions:

- Provide outreach mechanisms from the health facility level to communities and households
- Support ministries of health to strengthen existing supervisory systems to link the formal health system to community based resource persons
- Establish community emergency committees to link with the formal health system
- Institute birth preparedness plans at community level, especially for very young adolescents

Strategy 2: Empowering communities**Priority interventions:**

- Advocate for increased community resources and investment in MNH and FP
- Promote male involvement as part of shared responsibility and collective action to improve household health seeking behaviour
- Develop the capacity of community groups to assume their roles as partners in improving MNH and FP

7. PRIORITY MNH AND FP SERVICES

7.1 The household and the community. Women, their families and the communities they live in all have an important role to play in ensuring safe pregnancy outcomes for the woman and the newborn, both in terms of self-care in the home and in seeking and accessing skilled care, especially when complications arise. The key elements of self-care in the home for the pregnant woman and the newborn include:

- proper diet and nutrition
- personal hygiene and healthy lifestyle, including planning for pregnancies to ensure wanted pregnancy
- timely decision making related to care seeking during pregnancy, childbirth and the postnatal period. This includes seeking antenatal care so that conditions detrimental to health can be identified and treated or treatment commenced and an appropriate plan for birth and after care can be developed. Developing a birth preparedness plan includes also planning for emergencies
- care of the newborn in the home includes: preparations for birth; good cord, eye care and general hygiene; keeping the baby warm and together with the mother; as well as promotion of early and exclusive breast-feeding

7.2 Primary health care level. The primary health care level is usually the first level of contact between women and the health care system (private or public). At this level, it is important that skilled care is provided. Primary health care must be able to deliver the essential package of MNH and FP services in full, which includes:

- Focused antenatal care (family planning, prevention of HIV in mother including VCT, prevention of mother-to-child transmission (PMTCT) of HIV, early disease detection such as the prevention and treatment of STIs/RTIs and malaria prevention and treatment, as well as tetanus immunization).
- Normal delivery including use of partograph and active management of third stage of labour, and manual removal of placenta.
- Care for mother and newborn in the postnatal period (warmth, cleanliness, resuscitation, and management of sepsis)

- Early initiation of exclusive breastfeeding.
- Early detection and timely referral with minimal first-line management of women and newborns with pregnancy-related complications.

7.3 Referral level care. It is estimated that approximately 15% of all pregnant women, will require access to specialized medical services for diagnosis and treatment of an underlying health problem or pregnancy and childbirth related complications. These women must be referred to a facility with the necessary drugs, equipment and skilled staff to manage such complications. Services that need to be provided at the first referral level include:

- Surgical procedures including Caesarean section
- Control of hemorrhage, including safe blood transfusion
- Manual vacuum aspiration,
- Assisted vaginal delivery,
- Treatment of eclampsia,
- Management of diseases that impact on pregnancy and birth.
- Management of complications in the newborn.

7.4 Referral systems. There must be an effective, efficient referral system linking all levels and in some cases between higher levels of care within the same facility where these exist. Such a system must include feedback to the original referring point or health professional, in order to foster an ethos of reflective practice and for strengthening continuity and quality of care. Key to a good referral system is the availability of emergency transport and good communication system for effective linkage between the different levels of service delivery to ensure timeliness and quality of care.

8. MONITORING AND EVALUATION

8.1 Indicators at country level

This is a collection of process indicators that countries may use to adapt their Health Information Systems to ensure quality, consistency and accuracy of data. Sources of data will be a combination of District Health Surveys, community surveys, facility and financial records. It is recommended in general, and as much as possible, that the data collected be grouped according to gender, age groups, income/wealth quintiles, geographical location (rural and urban), as well as ethnic groups.

Community indicators:

- Number of communities that have set up functional emergency preparedness committees and plans for MNH and FP.
- Number of pregnant women that have birth preparedness plans.
- Coverage of referrals to emergency sites.
- Knowledge of danger signs of obstetric and neonatal complications. (DHS)
- Number of district management task forces and committees with representation from communities.

Neonatal indicators:

- Neonatal mortality rates.

- Number of district hospitals that have a functional newborn resuscitation place in the delivery room.
- Number of early neonatal deaths (deaths within the first seven days of life).
- Postnatal care attendance rate.

Family Planning indicators:

- Contraceptive prevalence rate by method, by age group, by socio-economic quintiles
- Met need for FP by age group (DHS).

Maternal Health indicators:

- Maternal mortality ratio.
- Proportion of births assisted by a skilled attendant.
- Number of facilities offering Basic EmOC services.
- Number of facilities offering Comprehensive EmOC services.
- Proportion of deliveries taking place in a health facility.
- Coverage of met-need for obstetric complications (coverage of women with obstetric complications that have received EmOC out of all women with obstetric complications)
- Proportion of births by C-section.
- Obstetric Case Fatality Rate.
- Proportion of first level facilities (PHC) with 2 or more skilled attendants.

Increased political will and commitment indicators:

- Proportion of funds allocated to MNH and FP.
- Increase of funds allocated to MNH and FP.
- Number of countries that have included MNH and FP in the PRSPs
- Number of countries with policies for increased coverage for skilled care. .

8.2 Indicators for measuring progress of the Road Map

- Number of regional partners that have signed the Road Map
- Number of countries that have an inter agency task force for the implementation of the Road Map.
- Number of countries that have budgeted joint plan of action for implementation of the Road Map
- Total resources mobilized for the Road Map.

9. FOLLOW-UP ACTIONS

Several follow-up steps are critical to the implementation of the Road Map both at regional and country levels. They include:

- **Country-level stakeholders' meeting:** Under the leadership of the Ministry of Health, a national stakeholders' meeting similar to the regional one will be conducted. All relevant partners including professional associations will participate in the meeting, and be involved in the implementation. Using the generic Road Map, each country will develop its own Road Map choosing the relevant interventions that are likely to make the most impact, with timelines, indicators and benchmarks. The output of the country-level stakeholders' meeting will be a joint plan of action for the country with budget provision and technical assistance from all partners.

- It is proposed that the implementation at country level be considered in 2 phases of 5 years each namely:

Phase 1: 2004 – 2009

Phase 2: 2010 – 2014

Final Reporting year: 2015

- Country annual reports will be shared among partners and sent to the Regional Economic Communities such as the Economic Community of West African States (ECOWAS), the Southern African Development Community (SADC), Eastern African Community (EAC); as well the Regional Committee of the Health Ministers and the African Union.
- Mid-term reviews and end of implementation evaluation will be planned at country level, and supported by all partners.
- **Selling of the Road Map:** Each agency has made a commitment to use every available opportunity to sell the Road Map in order to increase advocacy for MNH and FP, and mobilize resources for its implementation.
- **Commitment of all Partners:** All Regional heads of participating agencies and organizations will sign up to the Road Map as a commitment to its implementation (see attached list).
- **Resource Mobilization:** Every government and its partners will make definite efforts to mobilize resources for the implementation of the Road Map towards the attainment of the MDGs related to MNH.

10. CONCLUSION

The Road Map is expected to impact the health and survival of mothers and their newborns as a means of attaining the MDGs. This calls for rapid and accelerated scaling-up of proven interventions detailed above.

The success of the implementation of this Road Map will depend on the commitment of governments, Ministries of Health and all partners to invest in maternal and newborn health; improved planning, organization and management of services; adequate funding of the identified interventions; and, a close monitoring of progress.

11. HIGH LEVEL PERSONS TO SIGN THE FINAL DOCUMENT

ROAD MAP FOR ACCELERATING THE ATTAINMENT OF THE MILLENNIUM DEVELOPMENT GOALS (MDGs) RELATED TO MATERNAL AND NEWBORN HEALTH IN AFRICA

We, the undersigned, strongly support the goals and objectives of the Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn mortality in Africa, and will take whatever action is required, within the purview of the respective organizations and institutions we represent, to disseminate and support the implementation of this Road Map.

March 2004

Dr. Ebrahim M. Samba
Regional Director
WHO/AFRO

Mme Fama Hana BA
Director of the African Division
UNFPA

Mme Rima Salah
Regional Director
UNICEF-WCARO

Per Engebak
Regional Director
UNICEF- ESARO

G. T. Nankani
Regional Vice President of Africa
World Bank

Dr E. Ann Peterson
Assistant Administrator
Bureau of Global Health, USAID

Dr Kabba T. Joiner
Director General
West African Health Organization

Dr Steven Shongwe
Executive Regional Secretary
Commonwealth Regional Health
Community Secretariat

Prof. Helen Rees
Director, RH Research Unit
University of Witwatersrand
South Africa

Stephen Moseley
President
Academy of Educational
Development

Jill Sheffield
President
Family Care International

Leslie Mancuso
Chief Executive Officer
JHPIEGO

Dr Ayo Ajayi
Regional Director SSA
Population Council

Anne Tinker
Director, Saving Newborn Lives
USA

Dr Amy E. Pollack
President
Engenderhealth