THE MATERNAL HEALTH THEMATIC FUND

ANNUAL REPORT 2010

THE MISSION OF UNFPA

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

UNFPA - because everyone counts.

Cover Photo: Community Health Workers, Burkina Faso.
Photo by Brahima Bassane/FCI Burkina Faso.

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ACKNOWLEDGMENTS

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We thank our development partners for their collaboration and support in championing reproductive health issues, and for their technical contributions. They comprise the International Confederation of Midwives (ICM); the International Federation of Gynecology and Obstetrics; Columbia University's Averting Maternal Death and Disability Program; the University of Aberdeen; Johns Hopkins University Bloomberg School of Public Health; EngenderHealth; Family Care International; national and regional institutions; and the many members of the Partnership for Maternal, Newborn and Child Health and its Secretariat.

Finally, we thank the hardworking team of the UNFPA Sexual and Reproductive Health Branch and the Commodity Security Branch, other colleagues in the Technical Division, colleagues in the Resource Mobilization Branch and the Media and Communication Branch, and members of the Reproductive Health Inter-divisional Working Group for their commitment, solidarity and teamwork in promoting maternal and newborn health, and for providing inputs to this report.

We look forward to our continued productive collaboration in the future.

LIST OF ABBREVIATIONS AND ACRONYMS

AU	African Union
DHS	Demographic and Health Survey
G8	Group of 8
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4	"Health Four": World Health Organization, UNICEF, UNFPA and the World Bank
H4+	"Health Four+": H4 and UNAIDS
ICM	International Confederation of Midwives
ILO	International Labour Organization
IUD	Intrauterine device
MDG	Millennium Development Goal
MHTF	Maternal Health Thematic Fund
MMR	Maternal mortality ratio
MICS	Multiple Indicator Cluster Survey
NGO	Non-governmental organization
UNAIDS	Joint UN Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WFP	World Food Programme
WHO	World Health Organization

FOREWORD

by Werner Haug – Director, Technical Division, UNFPA

More than 100 countries worldwide have eliminated or nearly eliminated maternal mortality as a public health problem. In spite of this, there are still approximately 350,000 maternal deaths and over 1 million newborn deaths yearly in the world. For every woman who dies in childbirth, at least 20 more suffer injuries, infections or disabilities.

This reality could be averted with highly cost-effective and feasible interventions to prevent maternal and newborn mortality and morbidity. These interventions include general access to reproductive health (including family planning), a skilled birth attendant present at every delivery, access to emergency obstetric and newborn care when needed and HIV prevention. When adopted and scaled up with a rights-based and equity-driven approach, these have led to tremendous gains, proving that rapid progress is indeed possible.

UNFPA supports developing countries that are most in need of assistance —and furthest from achieving MDG 5 and universal access to reproductive health by 2015— through two important initiatives: the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and the Maternal Health Thematic Fund (MHTF).

Both initiatives, working together, are well-positioned to support the UN Secretary-General's Global Strategy for Women's and Children's Health, an unprecedented global-level commitment to advance the well-being of women and children. Their many achievements, outlined in this report, provide ample evidence that strong political commitment, adequate investments and partnerships are critical to achieving MDG5 and universal access to reproductive health.

UNFPA launched the MHTF in early 2008 as a contribution to the Joint United Nations Accelerated Support to Countries to Improve Maternal and Newborn Health Initiative. This endeavor is led by UNFPA, UNICEF, WHO and the World Bank, with the recent addition of the Joint UN Programme on HIV and AIDS (UNAIDS), a group also known as the Health Four Plus (H4+). Since 2009, the UNFPA-ICM Midwifery Programme and the Campaign to End Fistula have come under the MHTF umbrella.

Momentum is building around achieving MDG 5 and we face an unprecedented opportunity to tackle maternal mortality and morbidities head on. While much progress has been made, in many countries there is still far to go. I would like to take this opportunity to thank countries, donors, the H4+, other partner organizations and all colleagues for the continued collaboration to reach our shared goal.

Werner Haug
Director, Technical Division
UNFPA

EXECUTIVE SUMMARY

Over 100 countries have eliminated or nearly eliminated maternal mortality as a public health problem. Most of the remaining 358,000 maternal deaths and over 1 million immediate newborn deaths each year can be averted with highly cost-effective and feasible interventions. Nonetheless, with only a few years left to 2015, the endpoint for the MDGs, achieving Goal 5—to improve maternal health—remains a formidable challenge. It is a challenge that must be embraced, because doing so is vital for global health, as well as social justice and economic development.

Fortunately, momentum to address this long-neglected issue is now building, ushering in an unprecedented opportunity to take renewed actions to reach MDG 5. A number of interventions have been proven to produce tremendous gains, showing that rapid progress is possible. They include ensuring universal access to reproductive health care and family planning; having a skilled birth attendant, like a midwife, present at every delivery; providing access to emergency obstetric and newborn care; and preventing HIV.

UNFPA launched the Maternal Health Thematic Fund (MHTF) in 2008 as a contribution to the Joint United Nations Accelerated Support to Countries to Improve Maternal and Newborn Health initiative. This initiative is led by UNFPA, UNICEF, WHO and the World Bank, or H4, joined recently by the Joint UN Programme on HIV and AIDS (UNAIDS). All five organizations are commonly referred to as the H4+. Since 2009, the UNFPA-ICM Midwifery Programme and the Campaign to End Fistula have come under the MHTF.

Designed as a performance-based and MDG-driven mechanism focused on the poorest countries with the highest maternal mortality ratios, the MHTF is intended to:

1. Be strategic by addressing priority bottlenecks that are defined in national health plans and/or included under national commitments to the UN Secretary-General's Strategy on Women's and Children's Health, and that are hampering rapid national scale up of effective interventions and progress in maternal health;
2. Be catalytic in boosting ongoing UN country office efforts to strengthen national capacities to achieve universal quality maternal health care; and
3. Leverage global, regional, and national awareness and resources, and foster further national commitment and action.

The countries supported by the MHTF were selected on the basis of high levels of maternal mortality, agreement by the H4, the possibilities for synergies with the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), and the potential for leveraging additional resources.

To identify bottlenecks in maternal health care, UNFPA relies upon information from a variety of sources, such as the H4 mapping exercise to define which countries have the greatest need to reduce maternal mortality. Other sources of information include inception missions, country health indicators, population-based surveys (DHS, MICS), emergency obstetric and newborn care needs assessments, midwifery desk reviews and obstetric fistula needs assessments. Among the factors underlying high maternal mortality and morbidity are very low access to and uptake of family planning and/or emergency obstetric care, and weak overall health systems generally characterized by inadequate midwifery skills, poor service delivery, weak supply chains and limited financial investment.

Strategies to scale up maternal health in priority countries

Towards optimizing support to save and improve the lives of women and newborns, the MHTF fosters strategic and catalytic initiatives to bolster national health systems, and aims for rapidly expanding coverage of cost-effective interventions. These comprise:

- Family planning, in partnership with the GPRHCS, to increase capacities for expansion and address all aspects of a comprehensive national family planning programme, including policies and financing, service delivery, community mobilization and communication for social change;
- Skilled care during pregnancy, at delivery, and postpartum with special focus on midwifery through policies and regulations, education and strengthening of professional associations;
- Emergency obstetric and newborn care; and
- The Campaign to End Fistula, supporting prevention, treatment and reintegration for fistula patients.

The MHTF also focuses on improving the measurement of results through enhanced national health management information systems, and close monitoring and evaluation. It addresses the wider social and cultural determinants of maternal mortality and morbidity, such as child marriage, adolescent pregnancy and the low status of women. At the local and global levels, the MHTF emphasizes communication and advocacy to increase awareness, raise funds and spur action on all levels. It presents the voices of women affected by poor maternal health in forums where they can be heard by decision-makers.

UNFPA offices in MHTF-supported countries prepare draft annual work plans in collaboration with the Ministry of Health and other partners. The plans are peer-reviewed during annual meetings to add optimal value to national, H4+, other partners' and UNFPA's core contributions. Once approved, funds are provided and technical assistance requirements are identified. When required, staff posts are used to strengthen UNFPA country office capacities. Regular communications among country offices, regional offices and headquarters foster coaching; the meeting of technical assistance needs, including through South-South mechanisms; and the monitoring of programmatic and financial progress. Overall, a combination of modest, but well-focused financial resources, strengthened capacities, technical support, close coaching and partnerships, and monitoring enhances MHTF donor investments.

Key contributions and results in countries

During 2010, its second full year of operation, the MHTF had an operating budget of US $27 million and expenditures of $21M. It provided support to 30 countries **(Afghanistan**, **Bangladesh**, **Benin**, **Burkina Faso**, **Burundi**, **Cambodia**, **Chad**, **Côte d'Ivoire**, **Democratic Republic of the Congo**, **Djibouti**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Lao People's Democratic Republic**, **Liberia**, **Madagascar**, **Malawi**, **Mali**, **Mozambique**, **Namibia**, **Nepal**, **Niger**, **Nigeria**, **Rwanda**, **Sierra Leone**, **Sudan**, **Uganda**, **Yemen**, and **Zambia)**, and 12 additional countries for obstetric fistula only **(Cameroon**, **Central African Republic**, **Republic of Congo**, **Eritrea**, **Guinea**, **Guinea Bissau**, **Kenya**, **Mauritania**, **Pakistan**, **Senegal**, **Somalia** and **Timor-Leste).** The MHTF's geographic focus on high maternal mortality countries can be seen in Figure 1.

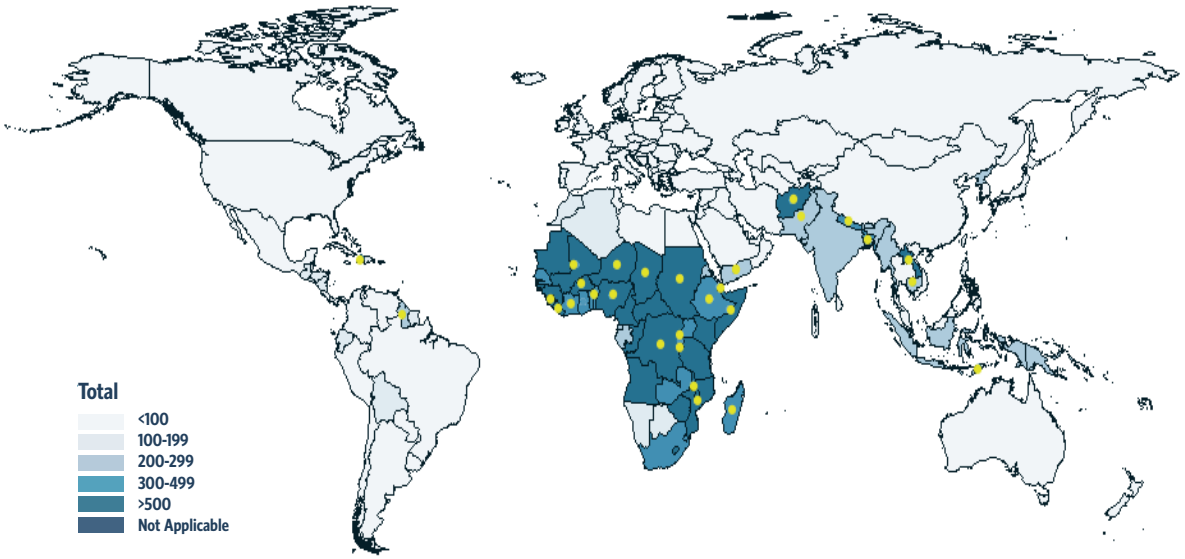

Figure 1: Geographic focus of the MHTF

Note: Dots represent MHTF-supported countries and shading represents the maternal mortality ratio per 100,000 live births.

The fund provides resources for priority areas in addition to UNFPA core and bilateral resources. Results for 2010 are presented here by the national outputs of the MHTF Business Plan. Given that UNFPA is working with governments and partners, the results should be understood as contributions to national efforts and not attributions solely to the work of UNFPA. Transformational changes to reduce maternal mortality and morbidity take time. It is encouraging that there are already tangible results in countries going through their second year of MHTF support.

OUTPUT 1.

An enhanced policy, political and social environment for maternal and newborn health and sexual and reproductive health.

Key activities and achievements in 2010 included:

- Development of communication packages (including short videos, fact sheets, policy briefs, etc.) in **Ethiopia**, **Malawi**, **Nigeria** and **Sierra Leone**, to be used with local constituencies and stakeholders to raise awareness, change policies, enhance budgets, and support national and local MDG 5 programmes;
- Contributions to launching the Campaign to Accelerate Reduction of Maternal Mortality in Africa, such as support for the Free Health Care Initiative launched in **Sierra Leone** and for the establishment of an inter-ministerial commission to reduce maternal mortality in **Benin**;
- Support for fistula advocates in 16 countries of the Campaign to End Fistula to sensitize communities, provide peer support, and advocate for improved maternal health at the community and national levels;
- Enhanced national media and political focus that highlighted maternal health, fistula and family planning—in emergencies such as in Haiti, the media used MHTF/UNFPA data and outreach; and
- Support to the development of national commitments to the UN Secretary-General's Strategy on Women's and Children's Health announced during the MDG Summit in September (see www.everywomaneverychild.org for country-specific commitments).

OUTPUT 2.

Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health (midwifery), emergency obstetric and newborn care, and obstetric fistula.

Key activities and achievements in 2010 included:

- National emergency obstetric and newborn care needs assessments in 10 countries that provided baseline data for advocacy and planning for expanded services (with 14 countries covered since the inception of the MHTF);
- Family planning needs assessments (**Benin**, **Burkina Faso**, **Mali** and **Senegal**) that revealed weaknesses in supply chain management, the unavailability of services in remote areas, and the effectiveness of outreach activities and steps to generate demand, and were used, jointly with GPRHCS, to improve planning and programming related to the regulatory environment, and supply and demand;
- Midwifery needs assessments and gap analyses in 14 countries, conducted with the ICM, which provided baseline data for improving midwifery education, policies and regulations and associations;
- The State of the World's Midwifery Report developed for launch in June 2011 to present information on midwifery in 58 priority countries; and
- Needs assessments for fistula carried out in 29 countries since the beginning of the Campaign to End Fistula

OUTPUT 3.

National health plans focus on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages between reproductive health and HIV to achieve the health MDGs.

Key activities and achievements in 2010 included:

- Strengthening of UNFPA country offices through the placement of international maternal and newborn health advisors in six priority countries (**Benin**, **Chad**, **Guyana**, **Madagascar**, **Namibia** and **Nigeria**), as well as 18 country-level midwifery advisors, three regional midwifery advisors, and two regional reproductive health advisors for Africa who helped mainstream sexual and reproductive health in national policies and strategies;
- Development of a national strategic plan for obstetric fistula such as in **Guinea** and **Niger**;
- Improved country proposals for MHTF as a result of the peer-review process;
- Dissemination of an internationally standardized, competency-based training manual for fistula treatment and care;
- Training of midwifery advisors on effective work planning, reporting, monitoring and evaluation, and a mid-year review of national midwifery programmes (such as in **Burkina Faso**, **Ethiopia** and **Ghana**);
- An in-depth gap analysis in the areas of midwifery education, policy and regulation and associations;
- Improved advocacy by women affected by insufficient maternal health services, including through enhanced work with fistula advocates and through the "Stories of Mothers Saved" project—carried out in partnership with the White Ribbon Alliance—where 139 women who barely survived pregnancy and childbirth told their stories; and
- Production of documentaries and news features like "Ghana: Midwives Deliver," "Saving Haiti's Mothers," "Guyana: Nurses on the Move" and many others that enhanced public and political support for

maternal health, and were broadcast by national and global television and radio networks, such as the BBC, National Public Radio (United States), CNN, ABC (United States), the Public Broadcasting System (United States) and Al Jazeera, as well as being used in political advocacy and donor events around the world.

OUTPUT 4.

National responses to the human resource crisis in maternal and neonatal health, with a focus on planning, and increasing the number of midwifery and other mid-level services.

Key activities and achievements in 2010 included:

- A Global Call to Action on Strengthening Midwifery by eight agencies developed at the Symposium on Strengthening Midwifery, which helped spur global momentum for scaling up midwifery in all countries with high rates of maternal mortality;
- Expanding midwifery support to new priority countries, including **Afghanistan**, **Bangladesh**, **Chad**, **Democratic Republic of the Congo**, **Lao People's Democratic Republic**, **Mali** and **Niger**;
- Creation of a master's degree in obstetrics and gynaecology to address career path issues for midwives, such as in Burkina Faso (Attaché de Sante en Gynécologie et Obstétrique) and in Uganda at Makerere University (Master of Science Program for Nursing and Midwifery); and
- Recruitment of new graduate midwives with commitments to serve in rural areas in **Zambia** (150 midwives) and **Sudan** (509 midwives in Kassala State and 215 midwives in White Nile State).

OUTPUT 5.

National equity-driven scale up of family planning, emergency obstetric and newborn care services, maternal and newborn health commodity security, and obstetric fistula services.

Key activities and achievements in 2010 included:

- More than 5,000 women treated for fistula, and more than 1,500 health-care personnel trained on fistula care;
- Launch of three year, direct-entry midwifery degree training programme and six-month post-basic training programme in midwifery for nurses in **Bangladesh**;
- The first three-year, direct-entry, diploma-level midwifery programme established at the newly created College of Nursing and Midwifery at the Juba Teaching Hospital in **Sudan**; and
- H4 missions in **Afghanistan** and **Bangladesh**—two of the six countries that account for half of all maternal deaths each year—followed by the creation of a coordinated plan to expand maternal health services.

OUTPUT 6.

Monitoring and results-based management of national maternal and newborn health efforts.

Key activities and achievements in 2010 included:

- Improved results-based planning and management, and improved monitoring of the results framework with the revision of indicators, baselines and targets (for 20 countries during the Joint Reproductive Health Thematic Funds Annual Planning Meeting);

- Monthly monitoring of country implementation rates, with feedback that resulted in better rates (such as in **Benin**, **Chad**, **Côte d'Ivoire**, **Niger**, **Sierra Leone** and **Sudan**);
- Innovation through a mobile-health project for tracking maternal deaths and the provision of commodities (**Mali**, **Madagascar** and **Benin**);
- The promotion of surveillance and reporting of maternal deaths using national health information systems (such as in **Cambodia** and **Madagascar**);
- A three-year, multi-country study (with Johns Hopkins University and WHO) to examine the post-operative prognosis, and long-term health and psychosocial outcomes of fistula patients following surgery; and
- The successful launch of the MHTF mid-term review and the UNFPA Thematic Evaluation on Maternal Health (results expected in 2011).

OUTPUT 7.

Leveraging of additional resources for MDG 5 from governments and donors.

Key activities and achievements in 2010 included:

- Contribution to the MDG performance fund in **Ethiopia** (US$1 million per year) towards expanding reproductive health care and the Health Extension Workers scheme;
- The adoption of the national Free Health Care Initiative in **Sierra Leone** following advocacy by the Campaign to Accelerate Maternal Mortality Reduction in Africa (assisted by UNFPA, UNICEF and other partners);
- MHTF support for emergency obstetric and newborn care needs assessments matched by significant contributions from UNICEF and partner governments;
- Inclusion of obstetric fistula clients in the Livelihood Empowerment Against Poverty Programme and the **Ghana** health insurance scheme, which facilitates access to treatment and care;
- Leveraging of US$3.5 million for the **Ethiopia** midwifery and fistula programme; and
- Support to the development of national commitments linked to the UN Secretary-General's Strategy on Women's and Children's Health (see www.everywomaneverychild.org for country-specific commitments).

Key contributions at regional and global levels

At the regional and global levels, the MHTF contributes through advocacy, partnerships, technical assistance and knowledge generation. Some of the main achievements in 2010 are highlighted here.

Regional advocacy and communication

Better positioning of issues related to women's and children's health beyond maternal mortality and morbidity occurred through:

- High-level consultations with the Asia Forum of Parliamentarians on Population and Development on family planning, maternal health and reproductive rights (in collaboration with UNAIDS, the United Nations Office on Drugs and Crime or UNODC, WHO and the International Labour Organization or ILO);
- Involvement of media experts in Asia and the Pacific on issues related to maternal health; and

- Coordination of activities as the secretariat for the global Campaign to End Fistula and the International Obstetric Fistula Working Group—representing over 50 national and international agencies—and support for the International Society of Obstetric Fistula Surgeons.

Global advocacy and communication

Key achievements included:

- Support of and high-level participation in the Women Deliver II conference, which had over 3,000 participants;
- Assistance to the Midwifery Symposium at Women Deliver II, which culminated in the Global Call to Action on Strengthening Midwifery Services by eight agencies (UNFPA, the ICM, WHO, UNICEF, the World Bank, the John Hopkins Program for International Education in Gynecology and Obstetrics, the Global Health Workforce Alliance and the International Federation of Gynecology and Obstetrics);
- Support to the UN Secretary-General's Global Strategy for Women's and Children's Health;
- Enhanced media coverage of maternal health and obstetric fistula issues, with English media coverage rising by 54 percent between 2009 and 2010 (based on Nexis.com), and UNFPA documentaries and video news releases reaching more than 500 million viewers and political decision-makers; and
- The UN General Assembly's adoption of a resolution calling for renewed focus on and resources for fistula, after the UN Secretary-General's report "Supporting Efforts to End Obstetric Fistula" noted great progress and the need for intensified action.

Partnerships

The MHTF engaged in strategic partnerships with UN entities, academic and professional institutions, and non-governmental organizations (NGOs) that included:

- **Columbia University** (Averting Maternal Death and Disability Program) for providing technical support to national and regional institutions in conducting emergency obstetric and newborn care assessments in priority countries;
- The **ICM** for scaling up midwifery education, policies and regulations and associations in 22 priority countries;
- The **Johns Hopkins University Bloomberg School of Public Health** for a multi-country study to examine the post-operative prognosis, improvement in quality of life, social reintegration and rehabilitation of fistula patients in treatment centres in six countries (**Bangladesh**, **Benin**, **Ethiopia**, **Niger**, **Nigeria** and **United Republic of Tanzania**);
- The University of Aberdeen in collaboration with national institutions (**Burkina Faso**, **Morocco**, **Uganda**, **Tanzania**, **Bangladesh** and **Malaysia**) for strengthening capacities in monitoring and evaluating maternal and newborn programmes;
- The **International Federation of Gynecology and Obstetrics** for the roll out of a competency-based training manual for fistula surgeons, and a Centers for Disease Control and Prevention–led Indicator Compendium for Obstetric Fistula; and
- The **Woodrow Wilson Center** for maternal health policy debates.

Technical assistance (including national institutions and South-South collaboration)

This supported:

- A five-year review of the African Union's (AU) Maputo Plan of Action;
- The Pan-African Parliament on financing the outcome agreement of the AU Summit on Maternal, Newborn and Child Health;

- A series of emergency obstetric and newborn care need assessments with national institutions; and
- Selected country technical assistance with regional offices.

Knowledge generation

Activities involved:

- Contributions to the report: "Countdown to 2015: Taking stock of maternal, newborn and child survival," the MDG 2010 report, and the State of World Population report; and
- Conceptualization and development of the State of the World's Midwifery report.

Students at the UNFPA-supported Midwifery School of El Fasher in Sudan. The plastic doll is a teaching tool. Most of the students have been displaced by the war, and many of them formerly suffered from obstetric fistula. UNFPA supports the hospital's fistula-repair programme. Photo by Sven Torfinn/Panos.

Key challenges in 2010

These encompassed social and political contexts in countries with conflict, post-conflict or emergency situations, as well as limits on national technical and managerial capacities. Other constraints entailed UNFPA country office capacities, and technical assistance modalities and operations. A small funding base stands in the way of expanded support to a greater number of priority countries.

The way forward in 2011

In 2011, the MHTF will focus on the following priorities:

Policy and financing

- National commitments to MDG 5 and financial commitments contributing to the UN Secretary-General's Strategy for Women's and Children's Health;
- Enhanced accountability mechanisms at the country level;
- Supporting countries in leveraging additional resources through quality information and evidence-based needs assessments and plans;
- Enhancing communication and media outreach to raise awareness, enhance funding and spur action, particularly at the country level; and
- Expanding the donor base for the MHTF to better support all priority countries of the UN Secretary-General's Strategy on Women's and Children's Health.

Service delivery

- Strengthened evidence base for national maternal and newborn health-care plans and their implementation;
- Improved access and uptake of basic and comprehensive emergency obstetric and newborn care services, guided by equity and rights considerations; and
- Strengthened family planning efforts through support for policy development, service delivery and the stimulation of greater public demand for family planning.

Midwifery

- Working more closely with midwifery schools to help midwifery trainers and governments establish a recommended curriculum for midwifery, complementing UNFPA's focus on expanding enrolment, recruiting graduates to serve where they are most needed, and motivating midwives.

Obstetric fistula

- The mainstreaming of fistula programming into national plans;
- Better coordination of fistula interventions at country level with the establishment of national task forces;
- Actions to foster access to quality services in selected hospitals, and to prevent recurrence; and
- Expansion of national workforces for fistula repairs, and the encouragement of fistula champions and advocates.

Maternal and newborn health commodities

- Strengthening the procurement and supply chain management of maternal and newborn health-care commodities, and working with GPRHCS to expand the resource base for life-saving commodities.

Managing for results

- Capacity strengthening of countries, and UNFPA country and regional offices;
- Working with countries to ensure real-time and mandatory notification of maternal deaths, with feed-back loops to officials, key decision-makers, civil society advocates and the public;
- Continued strengthening of management for results, with a particular emphasis on improving national health management information systems and monitoring in line with national standards, H4+ guidelines and the MHTF results framework;
- Further improvement of implementation rates, particularly for fistula; and
- Innovations, including mobile health initiatives to improve service delivery and monitoring.

Overall, 2010 was a successful year for maternal health efforts, with a global community that is committed more than ever to securing additional financing and moving forward with actions to improve women's and children's health. Towards that end, the second full year of the MHTF has produced key results that lay a foundation for accelerated progress in expanding proven, highly cost-effective interventions that go far in reducing maternal mortality and morbidity.

INTRODUCTION

Transportation in remote and rural areas. Nepal.
Photo by UNFPA Nepal.

Manakala Darlami *lives in a remote village of Nepal. She is 21 years old and has been married since she was 16. After the birth of her first son, she became pregnant again within four months. Her husband could not stay with her as he had to return to work in India. Manakala had no access to health care and did not take iron folic acid tablets.*

On the morning of December 15, 2009, ...

...Manakala experienced pain, but was not concerned. She was home alone, and although the pain continued to increase, she did not call any neighbors for help. At 3 p.m., she delivered the first of her twin daughters without any assistance. Her sister-in-law came to her house, and five minutes later, she delivered her second daughter.

Unfortunately, Manakala was now bleeding profusely and feeling faint. Her sister-in-law called their neighbor, Shyamkala Darlami, who was on the village safe motherhood committee. But no vehicles could be found in the village to take Manakala to the hospital. Luckily, Shyamkala phoned for a vehicle, which 30 minutes later would take Manakala, her sister-in-law and Shyamkala to the United Mission Hospital, three hours away.

By now, due to profound blood loss, Manakala was in critical condition, and her chances of survival were slim. Two individuals stepped forward to donate blood for her. Manakala regained consciousness after five hours; her health gradually improved. The village safe motherhood committee brought her the twin daughters, so they could be with their mum in the hospital.

The story of Manakala Darlami was collected as part of the MHTF-supported "Stories of Mothers Saved" initiative, conducted in partnership with the White Ribbon Alliance for Safe Motherhood and UNFPA. Manakala's experience is common in high maternal mortality countries, underscoring the critical importance of the work of the MHTF.

UNFPA has launched two reproductive health thematic funds to accelerate progress towards MDG 5: the Maternal Health Thematic Fund (MHTF) and the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). The MHTF complements UNFPA's contributions of core resources, which are distributed to over 140 countries. The fund maintains a programmatic focus on the most effective interventions to reduce maternal mortality and morbidity (family planning, emergency obstetric and newborn care, and skilled attendance at delivery, the Campaign to End Fistula) and a geographic focus on countries currently furthest away from MDG 5.

Since late 2008, the MHTF has sought to boost progress in reducing maternal mortality and morbidity by supporting the poorest countries in implementing and scaling up maternal and newborn health interventions under national health plans and systems. The fund saw its second full year of operation in 2010. Since the UNFPA-ICM Midwifery Programme and the global Campaign to End Fistula were brought under the MHTF in 2009, it now supports 30 countries for midwifery and fistula, and an additional 12 countries for obstetric fistula only.

Tangible results in a number of countries are very encouraging. The first chapter of this annual report presents those achieved in 2010. The second and third chapters provide an in-depth review of the results of the Midwifery Programme and the Campaign to End Fistula, respectively, with examples of best practices and achievements from specific countries. The report ends with an outline of key priorities and the way forward in 2011.

CHAPTER ONE

MATERNAL HEALTH THEMATIC FUND OVERALL RESULTS

Community Health Workers, Burkina Faso.
Photo by Brahima Bassane/FCI Burkina Faso.

Among the eight MDGs, the fifth goal—to improve maternal health—has proven to be one of the most difficult to achieve. The goal entails two targets: target 5A, to reduce from a 1990 baseline the maternal mortality ratio by three-quarters by 2015, and target 5B, to achieve, by 2015, universal access to reproductive health. According to recently published estimates, the number of maternal deaths worldwide decreased by 34 percent from 1990 to 2008 (from around 546,000 deaths to 358,000 deaths). Sub-Saharan Africa and South Asia still account for 87 percent of the total.[1] The decline is encouraging, but the annual rate of reduction is well below what is required to achieve MDG 5A, so more effort is needed to sustain and accelerate this trend. The figures only illustrate part of the picture, as there are significant differences across and within countries.

Despite many challenges, including resource constraints, current evidence suggests that many countries have been able to cut maternal mortality in half in less than ten years. This should stimulate enthusiasm (from donors) and emulation (among least-developed countries), and confirms that reducing maternal and newborn mortality is possible and within reach even in resource-poor settings.

In September 2010, Secretary-General Ban Ki-moon launched the **UN Global Strategy for Women's and Children's Health**, a joint effort to accelerate progress towards the health-related MDGs. More than 300 organizations contributed to the strategy, which debuted at the MDG Summit in September in New York, with the support of world leaders. UNFPA is fully supporting implementation of the strategy, which further strengthens its targeted efforts to improve maternal and newborn health through the Maternal Health Thematic Fund (MHTF) and the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS).

Improving maternal health

Three key elements are widely regarded as most effective in reducing maternal mortality and morbidity: universal access to family planning, a skilled health professional at every delivery, and access to emergency obstetric and newborn care. These should be part of a broader set of interventions aimed at strengthening health systems, addressing demand, and factoring in the social determinants of maternal mortality, including gender inequality, low access to education, child marriage and adolescent pregnancy. The MHTF provides technical and financial assistance on all of these fronts in countries that have high maternal mortality and are furthest away from MDG 5. It focuses on maternal mortality and morbidity as entry points for universal access to reproductive health.

A strategic exercise conducted in 2010 aimed to sharpen the direction of the fund. Table 1 lists examples of specific interventions to be covered by the MHTF. Moving forward, the MHTF will focus on four key interventions: **family planning** (in synergy with GPRHCS); **emergency obstetric** and **newborn care**; **human resources for health**, **particularly midwifery**; and **obstetric fistula.**

1 Trends in Maternal Mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank: www unfpa.org/public/op/edit/home/publications/pid/6598.

Note on data sources: The sources used for preparing this report include reports submitted by 42 countries, UN estimates on Millennium Development Goal (MDG) 5, and a series of emergency obstetric and newborn care needs assessments conducted by national institutions under the stewardship of the Ministry of Health and with technical support from Columbia University under the Averting Maternal Death and Disability Program.

Table 1: Fine-tuning the MHTF strategy

WHO health system building blocks	MHTF strategies/interventions
Leadership and governance	Sexual and reproductive health policies and national commitments, equity focus in health plans, coordination mechanisms, evidence-informed communication
Service delivery	Needs assessments, community mobilization, scaling up of family planning, emergency obstetric and newborn care, midwifery
Health care workforce	Special focus on midwifery, task-shifting, community health workers, obstetric fistula workforce (repair, social rehabilitation)
Medical products and technologies	Essential medicines and supplies, midwifery anatomic models, emergency obstetric and neonatal care anatomic models, fistula surgical instruments, etc.
Information	National health information systems, maternal death audits, surveillance of maternal deaths, innovations, costing, accountability, research
Financing	Policies for reducing financial barriers, partnership, resources mobilization, leveraging resources

One of the fundamental principles underpinning the work of the MHTF is to back country-owned and country-driven development through the national health plan. In each country, the government identifies specific outputs and activities through a consultative process with key partners and stakeholders, and in close coordination with GPRHCS. Another important principle is sustainability, as the thematic funds are time-bound and need to put in place interventions that will last, including through cultivating the capacities of national mechanisms to improve maternal health.

Operations and countries supported in 2010

MHTF-assisted countries are selected on the basis of recommendations from UNFPA regional offices and on:

- High maternal mortality (over 300 deaths per 100,000 live births);
- The recommendations of the H4+, which initially identified 25 priority countries;
- Committed country teams (government and partners); and
- Support by the GPRHCS, to foster synergies between the two funds.

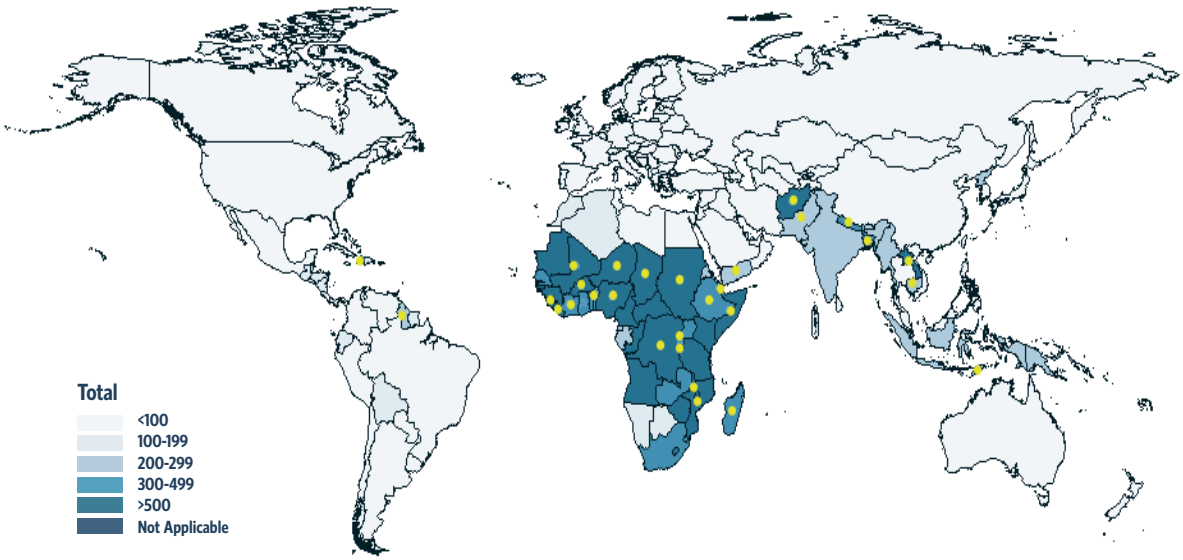

Figure 1: Geographic focus of the MHTF

Note: Dots represent MHTF-supported countries and shading represents the maternal mortality ratio per 100,000 live births.

Selected countries are invited to submit a proposal to the MHTF, which undergoes a peer review and amendments, if required. Once support begins, performance is closely monitored to ensure achievement of results. In 2010, all supported countries underwent a mid-year progress review. Table 2 shows the number of countries supported by the fund since its launch.

Table 2: Number of countries supported since the fund's launch

2008 launch	2009—First full year of operations	2010—Second year of operations
11 countries assisted by the MHTF	• **15** countries assisted by the MHTF, including those supported by the Midwifery Programme • **25*** countries supported by the fistula campaign (before integration)	• **30** countries assisted by the MHTF, including 22 supported by the Midwifery Programme • **42*** countries supported by the fistula campaign
	Expenditures: **$14.2M**	Expenditures : **$21M**

**The 25 and 42 countries include the 15 and 30 MHTF countries for 2009 and 2010, respectively.*

The seven country-level outputs of the MHTF

At the core of the MHTF Business Plan are seven essential country-level outputs, outlined below. The plan and its results framework will be revised in late 2011 to reflect the findings of the MHTF mid-term evaluation and the integration of the Midwifery Programme and the Campaign to End Fistula. The following pages provide details about each of the outputs and associated indicators to track progress, according to the MHTF results framework. The last section of the chapter focuses on regional and global contributions.

1. Enhanced policy, political and social environment for maternal and newborn health, and sexual and reproductive health.
2. Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health (midwifery), emergency obstetric and newborn care, and obstetric fistula.
3. National health plans focusing on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages between reproductive health and HIV to achieve the health MDGs.
4. National responses to the human resource crisis in maternal and newborn health, with a focus on planning and scaling up midwifery and other mid-level services.
5. National equity-driven scale up of family planning and emergency obstetric and newborn care services, maternal and newborn health commodity security and obstetric fistula services.
6. Monitoring and results-based management of national maternal and newborn health efforts.
7. Leveraging of additional resources for MDG5 from governments and donors.

COUNTRY RESULTS BY OUTPUTS

During 2010, its second full year of operation, the MHTF had an operating budget of US $27M and expenditures of $21M. Improving maternal health requires transformational changes at the policy, service delivery and community levels, which take time. Therefore, this section mainly presents results from the 15 countries that the MHTF has supported for at least two years (**Benin**, **Burkina Faso**, **Burundi**, **Cambodia**, **Côte d'Ivoire**, **Djibouti**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Madagascar**, **Malawi**, **Sudan**, **Uganda** and **Zambia**).

See the Annex of the report for summary tables of indicators for all MHTF countries during 2010.

OUTPUT 1.

An enhanced policy, political and social environment for maternal and newborn health and sexual and reproductive health.

Indicator: National comprehensive communication and advocacy strategy developed for sexual and reproductive health.

Out of 15 countries, 12 have developed a communication strategy. Only **Guyana**, **Haiti** and **Sudan** have not done so.

Indicator: Reproductive health coordination team in place, led by the Ministry of Health, and involving UNFPA and other multilateral, bilateral and civil society partners.

All 15 countries have a reproductive health coordination team in place. Through advocacy and policy dialogue, these mobilize political will, which, coupled with supportive legal, social and economic environments, is critical to achieving MDG 5.

Highlights

Policy environment: In 2010, the MHTF assisted **Benin**, **Cameroon**, **Central African Republic**, **Republic of Congo**, **Eritrea**, **Ethiopia**, **Gambia**, **Guinea Bissau**, **Kenya**, **Mauritania**, **Senegal**, **Sierra Leone**, **Uganda**, **Zambia** and **Zimbabwe** in launching the Campaign for Reducing Maternal Mortality in Africa, a joint AU Commission and UNFPA initiative to intensify implementation of the Maputo Plan of Action for the Reduction of Maternal Mortality in the Africa Region. During the Campaign in **Sierra Leone**, the government launched free health-care services for pregnant women, lactating mothers and children under the age of five.

Work with religious leaders and communities: In **Mauritania**, high-level advocacy with religious leaders, conducted with the support of the MHTF, led to the participatory development of two advocacy tools: Islam and Family Planning and Islam and HIV. Dissemination began in 2010 and will continue throughout 2011. In **Niger**, the "Schools for Husbands" initiative, which encourages men to support maternal and infant health, has proven very successful in generating demand for reproductive health services and products, as attested by changes in behaviours and reproductive health indicators (such as increased antenatal clinic attendance and condom use). These success stories highlight the importance of greater community involvement in general, and of men in particular, in contexts where socio-cultural factors significantly affect reproductive health choices.

Evidence-informed communication: In an effort to improve decision-making on maternal and newborn health at the country level, the MHTF initiated an evidence-informed communication project in **Ethiopia**, **Malawi**, **Nigeria** and **Sierra Leone**. This aims to regularly communicate to local constituencies and stakeholders through short videos, fact sheets, policy briefs, etc. The overarching goal is to raise awareness, change policies, increase budgets and support local programmes to achieve MDG 5.

OUTPUT 2.

Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health (midwifery), emergency obstetric and newborn care, and obstetric fistula.

Indicator: Up-to-date needs assessments for maternal and newborn health as part of the national health plan, which includes emergency obstetric and newborn care, family planning, midwifery and obstetric fistula services.

Emergency obstetric and newborn care needs assessment

It is critical to have up-to-date needs assessments in all reproductive health areas, especially for emergency obstetric and newborn care. To assist countries in planning and scaling up maternal and newborn services, UNFPA, in partnership with Columbia University (Averting Maternal Death and Disability Program) and UNICEF, has supported these national assessments. Each surveys health facilities to determine how many are providing emergency obstetric and newborn care, if they are adequately staffed (in terms of quantity and quality), if women with obstetric complications are actually using the facilities, and the quality of service provided.

Master of Science in Integrated Emergency Obstetrics and Surgery, Ethiopia. Photo by UNFPA Ethiopia.

The assessments:

- Serve as a baseline for the current level of service delivery in all districts of a country—future progress can be measured against this;
- Ensure a solid foundation for evidence-based advocacy and resource mobilization for emergency obstetric and newborn care; and
- Provide data for district micro-planning of priority facilities (health centres and district hospitals), covering the rehabilitation, improvement and consolidation of service delivery and quality of care.

Progress is measured by the production and dissemination of survey findings, and the use of survey results for district level upgrading of emergency obstetric and newborn care services. Examples of effective dissemination and follow-up are presented on page 32.

BOX 1 Status of emergency obstetric and newborn care needs assessments, December 2010

MHTF countries with needs assessment completed in 2009 (4 countries)
Cambodia, Ethiopia, Haiti and Madagascar

Countries with needs assessment completed in 2010, reports to be finalized (10 countries)
Afghanistan, Benin, Burkina Faso, Burundi, Côte d'Ivoire, Ghana, Guyana, Liberia, Malawi and Niger

Countries with ongoing discussions and planning for a needs assessment in 2011 (6 countries)
Bangladesh, Chad, Democratic Republic of the Congo (partial), Lao People's Democratic Republic, Nepal and Tanzania

Table 3 presents the main indicators of the needs assessments for **Cambodia**, **Ethiopia**, **Madagascar** and **Malawi.** The results clearly indicate why these countries experience very high maternal mortality. In all countries, the portion of health facilities that perform all functions to save the lives of women and newborns remains a challenge, ranging from 39 percent in Ethiopia to 79 percent in Cambodia. The main gap is at the basic functions level, with facilities that could offer all basic functions ranging from 2 percent in Madagascar to 19 percent in Cambodia. Data on the proportion of births with Caesarean sections, a proxy measure of the availability and uptake of comprehensive emergency obstetric and newborn

care, indicate that the countries surveyed are below the minimum of 5 percent. This means that many women needing Caesarean sections do not have access to such interventions, and most of them and their babies continue to die needlessly.

In **Cambodia**, 347 facilities were assessed, leading to the identification of 20 basic and 27 comprehensive emergency obstetric and newborn care facilities. This falls short of the recommended level of at least five facilities, including one for comprehensive care per 500,000 people. An additional 99 non-emergency obstetric and newborn care facilities will need to be upgraded to address this shortfall. Out of 24 provinces in Cambodia, 5 lack any kind of obstetric emergency services (basic or comprehensive), 2 lack comprehensive emergency obstetric and newborn care facilities, and 8 have no basic emergency obstetric and newborn care coverage. Emergency obstetric and newborn care facilities are poorly distributed, with most clustered around towns and cities. These factors, coupled with the low number of institutional deliveries overall, translate into a high unmet need for services.

Table 3: Sample indicators in priority countries and follow-up interventions

Emergency obstetric and newborn care indicators	Cambodia	Ethiopia	Madagascar	Malawi
Number of facilities assessed *	347	797	294	299
Availability of basic care	20 facilities (national minimum recommended: 105)	25 facilities (national minimum recommended: 591)	3 facilities (national minimum recommended: 155)	5 facilities (national minimum recommened: 105)
Availability of comprehensive care	27 facilities (national minimum recommended: 34)	58 facilities (national minimum recommended: 148)	19 facilities (national minimum recommended: 39)	42 facilities (national minimum recommended: 26)
Proportion of sub-national areas with the required number of facilities (recommended minimum is five, including one comprehensive facility, per 500,000 people)	1 out of 24 provinces meets the recommended minimum	1 out of 11 regions meets the recommended minimum	17 out of 111 districts meets the recommended minimum	2 out of 28 districts meets the recommended minimum
Proportion of all births in emergency obstetric and newborn care facilities,%	11.4	3	4.1	22
Met need for care, % **	12.7	3	9.6	22
Case fatality rate among women with direct obstetric complications in emergency obstetric care facilities (should not exceed 1%), %	0.8***	1.1	2.2	2
Neonatal mortality rate (intrapartum and very early neonatal death)	1.24 (per 1,000 deliveries)	62 (per 1,000 deliveries)	121 (per 1,000 deliveries)	37.1 (per 1,000 live births)
Proportion of births by Caesarean section as a proportion of all births (normal range is 5-15%), %	1.3	0.6	1.5	3.6

** Partially functioning facilities not included. These figures are based on signal function performance in the preceding three months.*

*** Number of women treated for direct obstetric complications at emergency care facilities over a defined period divided by the expected number of women who would have major obstetric complications.*

**** This meets the UN recommended level of 1 percent or less. However, because of under-reporting of deaths, this figure needs to be interpreted in the context of the previous indicators, which show that women are not utilizing emergency obstetric and newborn care services, and their need for care is not being met.*

Midwifery needs assessment

The midwifery needs assessments and gap analyses aim to:

- Establish baseline information on existing midwifery education, policy and regulation and association (pre-service training, essential competencies, well-equipped midwifery schools, trained midwifery tutors, supervision, recruitment, retention, motivation, association, certification and accreditation); and
- Conduct a modeling exercise on admission to midwifery schools, recruitment, deployment and retention, including costing.

Benin, **Burkina Faso**, **Burundi**, **Cambodia**, **Côte d'Ivoire**, **Djibouti**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Madagascar**, **Malawi**, **Sudan**, **Uganda** and **Zambia** have conducted midwifery needs assessments. With the MHTF programme launch in Asia in 2010, **Afghanistan**, **Bangladesh**, **India**, **Nepal** and **Pakistan** have conducted a gap analysis. Results from these assessments are being used for planning and programming.

Family planning needs assessment

The MHTF assisted the assessment of national family planning and sexual and reproductive health programmes in four West African countries: **Benin**, **Burkina Faso**, **Mali** and **Senegal.** The assessments aimed to identify bottlenecks in policies and health systems, and at the community level. They provide essential evidence, suggest critical interventions to remove the bottlenecks, and help accelerate stronger planning and programming. UNFPA partnered with EngenderHealth and national teams in each country on the assessments.

Desk reviews and interviews with key informants showed the need to bring services as close to the community as possible to increase access for the most vulnerable populations, which are often in rural and poor areas. Involving community health workers in the provision of family planning information and services has been successful in a number of places. The assessments also revealed the need for a comprehensive communication strategy with appropriate messages for target groups. Birth spacing to reduce infant and maternal mortality and morbidity was identified as a culturally and religiously acceptable and effective message, while the integration of family planning into post-partum and post-abortion care can provide key opportunities to increase the use of family planning. The security of family planning commodities remained a pressing priority. Task-shifting (where tasks are moved, where appropriate, to less specialized health workers), as well as improvements in the quantity and quality of training and supervision, were seen as key to improving human resources. The assessments repeatedly stressed that family planning and sexual and reproductive health programmes need to target men.

Highlights

Addressing career paths for midwives in Burkina Faso

The needs assessment in **Burkina Faso** revealed that the country has few midwives. More than 50 percent reside in the capital, while many provinces have fewer than five midwives. Another important issue is constant attrition, as midwives migrate to other professions (assistant ophthalmologist, assistant surgeon, assistant dentist, assistant epidemiologist, etc.) in order to gain a larger salary and qualify for a leadership position. The lack of a career path for midwives has been a major roadblock for the growth of the profession.

The midwifery association lobbied obstetricians, the school of nursing and the school of medicine for the creation of a master's degree for midwives. A two-year course is now in its second year, with huge demand—180 applications for only 10 places. Midwives say the degree and new opportunities it brings will help stop them from leaving the field.

Figure 2: Results of the needs assessment in Burkina Faso. Areas in red indicate provinces with fewer than five midwives.

OUTPUT 3.

National health plans focus on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages between reproductive health and HIV to achieve the health MDGs.

Indicator: Existence of national development plan for sexual and reproductive health package (including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care).

To ensure that countries have national development plans and other health or poverty reduction strategies where maternal and newborn care and broader sexual and reproductive health are well positioned, the MHTF in 2010 posted 7 international maternal and newborn health advisors in priority countries (**Benin**, **Chad**, **Ethiopia**, **Guyana**, **Madagascar**, **Namibia** and **Nigeria**), 18 midwifery advisors in individual countries, three regional midwifery advisors and two regional reproductive health advisors for Africa.

All countries engaged with the MHTF for two full years have national health plans, reproductive health strategies, poverty reduction strategies, etc. Only **Sudan** has not developed a national sexual and reproductive health strategy. **Cambodia** and **Guyana** do not have fistula in their national health plan and do not recognize it as a public health problem.

Indicator: National development plan for sexual and reproductive health package (including family planning, midwifery, obstetric fistula care, and emergency obstetric and neonatal care) is costed.

In 2010, only **Cambodia** and **Madagascar** developed a costed national operational plan for emergency obstetric and neonatal care, following a needs assessment. For advocacy purposes, a costing template has been developed to estimate funds for training, recruiting, deploying and retaining midwives in the 22 countries under the Midwifery Programme. National institutional capacities for costing need to be further expanded.

Highlights

Examples of national plans and strategies developed in 2010 with contributions from maternal health, midwifery and obstetric fistula advisors include the following.

In **Benin**, several comprehensive sexual and reproductive health strategies were finalized: a national communication strategy for maternal mortality reduction, a national strategy for institutionalizing maternal death audits, a national reproductive health commodities quality assurance strategy, a national strategy for repositioning family planning, a multi-sectoral strategy for adolescent and youth reproductive health, and a national strategy linking sexual and reproductive health and HIV. In **Burkina Faso**, an advocacy document was developed around the exemption of fees for maternity care as well as family planning. It was presented to the national cabinet. A national training module for emergency obstetric and newborn care was adopted, as was a standard supervision guideline for obstetric care, family planning, and the prevention of mother-to-child transmission of HIV.

For the last two years, with support from the MHTF, UNFPA in **Burundi** supported the national Sexual and Reproductive Health/HIV linkages within the national health plan. HIV testing was integrated in delivery units. In 2010, 97,559 tests were performed, up from 34,058 in 2009. An integrated document on therapeutic norms and procedures for the treatment and care of obstetric fistula has been instrumental in coordinating care in **Chad.** The MHTF provided technical support for finalizing **Ethiopia's** fourth Health Sector Development Programme, which is embedded in the five-year Poverty Reduction Strategy.

An action plan for strengthening the midwifery programme in **Bangladesh** was developed based on the "Strategic Direction Paper on Midwifery." Obstetric fistula, midwifery, and HIV and AIDS have been integrated in the next Health, Nutrition and Population Sector Program (2011-2015), and the Health and Population Sector Development Program. **Malawi's** Sexual and Reproductive Health Policy has integrated fistula as a thematic area. The goal is to reduce the incidence of obstetric fistula and guide its management. The policy states that all community members shall be made aware of how to prevent obstetric fistula and the availability of repair services, all women shall be encouraged to deliver under the care of skilled birth attendants, partographs shall routinely be used to monitor labour and promote timely action, and the management of labour—including early post-partum care—shall be geared to fistula prevention.

In **Afghanistan**, the revision of the Reproductive Health Policy and Strategy focused on male involvement, emergency care, obstetric fistula and gender-based violence, among other issues. The Ministry of Public Health and the H4+ developed a reproductive health framework and joint action plan. There was a revitalization of midwifery and nursing under the Directorate of the Ministry of Public Health, and the establishment of national coordination mechanisms for maternal and newborn health, obstetric fistula care, and monitoring and evaluation.

Sudan's National Midwifery Strategy has been developed and endorsed with support from UNFPA. Reproductive health, including family planning, is now integrated into **Guyana's** Family Health Training Manual, part of the standard curriculum for teaching maternal and child health in all training institutions.

OUTPUT 4.

National responses to the human resource crisis in maternal and neonatal health, with a focus on planning, and increasing the number of midwifery and other mid-level services.

Strengthening the health system cannot succeed without investment in the health workforce. In countries with high maternal mortality, implementation of strategies to improve maternal and newborn survival is hindered by the lack of essential health workers, particularly those with the skills to provide midwifery services. Midwifery has a unique role to play, because it addresses all key pillars of sexual and reproductive health (skilled attendance at birth, family planning, and provision of basic emergency obstetric and newborn care with a contribution to fistula prevention). It can also offer comprehensive sexual and reproductive health services, including the prevention and treatment of sexually transmitted infections, the prevention of mother-to-child transmission of HIV, the prevention of gender-based violence and female genital mutilation/cutting, and the supervision of community health workers.

The following pages focus on results in countries where the MHTF has operated for two full years, with particular respect to midwifery education, regulation and associations. For more on the Midwifery Programme and its indicators, please see the chapter on midwifery and the results framework templates in the Annex of the report.

Midwifery education

Indicator: National midwifery curricula based on WHO/ICM essential competencies.

Burkina Faso, **Cambodia**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Malawi**, **Sudan**, **Uganda** and **Zambia** have midwifery curricula that include WHO/ICM competencies. **Benin**, **Burundi**, **Djibouti**, **Guyana**, **Haiti** and **Madagascar** are updating midwifery curricula.

Indicator: Annual number of midwifery graduates from national midwifery training institutions.

Countries recording an increased number of midwifery graduates include **Burkina Faso** (237), **Burundi** (20), **Cambodia** (370), **Côte d'Ivoire** (327), **Djibouti** (40), **Ethiopia** (1225), **Ghana** (400), **Guyana** (100), **Madagascar** (140), **Malawi** (160), **Sudan** (1100), **Uganda** (372) and **Zambia** (385). In **Benin**, the school of midwifery reopened in 2010 after being closed for four years.

Midwifery regulation

Table 4 summarizes indicators related to midwifery regulation. Significant progress has been made. Apart from using ventouse, midwives from most countries are authorized to administer the core set of life-saving interventions. The main challenge, which is not specific to the midwifery profession, is a system for compulsory continuous education to maintain licenses for practice.

Table 4: MHTF indicators of midwifery regulation

Countries	Midwives authorized to administer core life-saving interventions (the seven basic emergency obstetric and newborn care functions)	Midwives benefit from systems for compulsory supportive supervision	Midwives benefit from systems for continued education	Country has a national midwifery council/ board (stand-alone or included in nursing)
Benin	Yes	Yes	Yes	Yes
Burkina Faso	Yes	Yes	Yes	Yes
Burundi	Yes	No	No	Yes
Cambodia	Yes	Partly	Partly	Yes
Côte d'Ivoire	Yes	Yes	Yes	No
Djibouti	Yes	Yes	Yes	No
Ethiopia	Yes	Partly	No	No
Ghana	Yes **	Yes	Yes	Yes
Guyana	Yes	Partly	No	No
Uganda	Yes	Yes	Yes	Yes
Madagascar	Yes	Yes	Yes	Yes
Malawi	Yes	Partly	Yes	Yes
Sudan*	Yes	Partly	Partly	No
Uganda	Yes	Yes	Yes	Yes
Zambia	Yes	Yes	Yes	Yes

** UNFPA has two offices in Sudan, in Khartoum and Juba.*
*** Authorized to perform all functions, including ventouse.*

Note: Partly means for some midwives, not systematically for all midwives, and also some functions, with the main missing function being ventouse. Haiti is not included in the table as the country, following the devastating 2010 earthquake, is currently focused on rebuilding efforts.

Midwifery associations

Indicator: Country has a national midwifery association.

A midwifery association empowers midwives and others with midwifery skills as advocates, and strengthens skills in communication, public health, management and strategic planning. Midwifery associations now exist in **Afghanistan**, **Bangladesh**, **Benin**, **Burkina Faso**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Guyana**, **Madagascar**, **Nepal**, **Pakistan**, **Uganda** and **Zambia.** Some play a positive role in building capacities and extending services. For example, the Ghana Nurses and Midwives Council and the Midwifery Association received visits from the Ethiopia Midwives Association to network and learn about experiences and best practices. In **Benin** and **Burkina Faso**, the celebration of the International Day of the Midwife was an opportunity for extending services for cervical cancer.

National workforce for fistula treatment

Indicators:

- Number of doctors trained in surgical obstetric fistula repair; and
- Number of health personnel trained in the management of fistula.

For more details, see the chapter on the Campaign to End Fistula.

Table 5: Fistula repair workforce in selected countries

Countries	Number of doctors trained in surgical obstetric fistula repair	Number of health personnel trained in the management of fistula
Benin	15	25
Burkina Faso	0	4
Burundi	0	3
Côte d'Ivoire	17	130
Djibouti	1	1
Ethiopia	15	30
Ghana	2	8
Madagascar	9	5
Malawi	2	42
Sudan*	2	40
Uganda	—	—
Zambia	6	152

** UNFPA has two programmes in Sudan, in Khartoum and Juba. Cambodia and Guyana do not recognize fistula as a public health problem. Advocacy using identified cases is underway to make the case for women who might be suffering silently.*

Highlights

The recruitment, retention, deployment, motivation and supervision of midwives remain serious challenges. In **Chad**, as a result of the 2010 midwifery assessment revealing that 50 percent of trained midwives have not been recruited, an advocacy plan has been developed to ensure that they are. In **Bangladesh**, a national action plan for strengthening midwifery has been prepared, providing guidelines to policymakers and programme managers in developing and implementing a four-year, direct-entry midwifery training programme and a two-year community midwifery education programme.

In **Sudan**, with the support of UNFPA, the long-term plan is to train more qualified midwives to gradually replace the village midwives currently providing delivery care throughout the country. Assistance was provided to start training midwives using the two-year curriculum in two states (Gadarif and Blue Nile). To address short-term needs, UNFPA representatives conducted advocacy through meetings with the Deputy Governor of Kassala State, the Ministry of Health and the Director General of the State Ministry of Health, which prompted the recruitment of 509 village midwives. **Sudan** has also launched the first three-year, direct-entry, diploma-level midwifery programme at the newly created College of Nursing and Midwifery at the Juba Teaching Hospital. In **Zambia**, UNFPA is supporting a bond mechanism with five schools (three in North Western Province and two in Luapula Province) to encourage newly graduated midwives to serve in remote and underprivileged areas for at least two years.

BOX 2 Motivating midwives in Côte d'Ivoire: *concours maternités accueillantes*

Since 2007, UNFPA, WHO, UNICEF, the National Planned Parenthood Association and the private sector has been supporting the Ministry of Health in **Côte d'Ivoire** through a contest called *concours maternités accueillantes*. Its objectives are to improve the environment and quality of care in maternities, and thus increase service utilization by communities, community participation in health-care delivery and community accountability for institutional delivery. Selection criteria have been developed jointly with health districts for service delivery, the use of services and the number of maternities to compete in the contest.

On the service delivery side, assessment criteria include the cleanliness of delivery rooms, post-delivery rooms, visitors' toilets, corridors, materials and equipment; the surroundings of the maternity; the existence of decontamination liquid in delivery rooms; the number of partographs correctly filled for the last 12 deliveries; the number of complete monthly activity reports transmitted to the district health management team; the consistency of antenatal care (through a fourth visit); the content of antenatal care (counselling, prevention of mother-to-child transmission of HIV, family planning, etc.).

For utilization of services, criteria for a chosen group of 10 women focus on correctly using health services during pregnancy. They include at least one quarterly antenatal visit, delivery at the maternity during the period of the contest, up-to-date immunizations (mainly tuberculosis for the newborn and tetanus for the mother and/or the baby), and a blood test.

Concours maternités accueillantes has generated great interest from communities, the health-care system and policymakers. It has contributed to sensitization and community accountability for quality maternal and neonatal care, and to better recognition and encouragement of midwives. The winners of the 2008 and 2009 contests appear on page 32, followed by some indicators of progress over the years. UNFPA, through the MHTF, intends to continue supporting such non-monetary motivational strategies that increase accountability for women's and children's health.

Côte d'Ivoire

The midwife of the rural maternity Bougrou in Gagnoa Health District and her nurse colleague celebrate the 2008 1st place prize with the Minister of Health (on the right side).

Progress of indicators in Bougrou Maternity

Years	2007	2008	2009	2010*
Antenatal care (fourth visit)	5%	13.8%	21.5%	20.4%
Maternal deaths	0	0	0	0
Stillbirths	3	11	2	2

** Year of post-electoral crisis*

Côte d'Ivoire

The midwife of the Bozi rural maternity in Bouaflé Health District and the community celebrate the 2009 1st place prize.

Progress of indicators in Bozi Maternity

Years	2007	2008	2009	2010*
Antenatal care (fourth visit)	7.5%	8.4%	22.2%	14.2%
Maternal deaths	0	0	0	0
Stillbirths	7	6	2	3

** Year of post-electoral crisis*

For more details on findings from needs assessments and actions taken, see the chapter on the Midwifery Programme.

OUTPUT 5.

National equity-driven scale up of family planning, emergency obstetric and newborn care services, maternal and newborn health commodity security, and obstetric fistula services.

Indicators for this output are provided in the results framework table in the Annex. The following paragraphs provide the reader with examples of effective dissemination and follow-up to the results of needs assessments in countries where they have been completed.

Needs assessment follow-up in Madagascar

With technical and financial support from UNFPA, **Madagascar** conducted a Demographic and Health Survey (DHS) in 2008-2009, and an emergency obstetric and newborn care needs assessment in 2009. The former focused on population-based use of services while the latter examined facility-based supply-side services. To optimize the use of resources and take advantage of the complementary findings of the two surveys, a joint dissemination was organized in 2010. It aimed to enhance ownership of the findings at the regional level, and facilitate the development of district emergency obstetric and newborn care micro-plans.

Several institutions were involved with disseminating the surveys, namely, the Ministry of Public Health, the Ministry of Economy and Finance, the National Institute of Statistics and international technical/financial partners. In each region, about 35 regional planners and managers participated in the dissemination, which

took two days per region. All 22 regions were visited. The national emergency obstetric and newborn care plan was later revised to take into account suggestions from the regional level. The dissemination also encouraged the costing of the national operational plan and development of 22 micro-plans. According to the national plan, 22 health facilities will be upgraded to offer comprehensive emergency obstetric and newborn care, and 183 health facilities upgraded to the basic level.

UNFPA and its partners identified the most disadvantaged and most likely "quick-win" areas, supported facility upgrades and training of service providers, and backed the adoption of a new training curricula and the institutionalization of maternal death audits. A national maternal death audit committee was created, and tools have been established for auditing facilities and verbal autopsies. During 2010, the audits were introduced in four medical teaching hospitals, two regional hospitals and three district hospitals. Four sentinel surveillance sites were set up for verbal autopsies.

Overall, the joint dissemination of the DHS and needs assessment survey optimized the use of resources and strengthened ownership and the utilization of findings. Micro-planning proved to be feasible. Common understanding of emergency obstetric and newborn care terminology grew among regional planners and managers.

Madagascar also adapted a new emergency obstetric and newborn care training programme developed and validated by the Liverpool School of Tropical Medicine in collaboration with the Royal College of Obstetricians and Gynaecologists, and WHO. Pilot training took place in 2010, with the Averting Maternal Death and Disability Program providing support for monitoring and evaluation. One of the main advantages of the programme is its significantly shorter duration (three days versus two to four weeks previously). As a result, 167 service providers were trained in 2010, compared to only 24 in 2009. An evaluation showed that the training is effective and could significantly contribute to a rapid boost in training health providers in Madagascar.

Needs assessment follow-up in Ethiopia

Following the results of the emergency obstetric and newborn care needs assessment, the government of **Ethiopia** is investing on task-shifting. As previously mentioned, task-shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers, and is a critical strategy for improving the reach of comprehensive emergency obstetric and newborn care. In partnership with WHO and the World Bank, UNFPA provided financial and technical support to the government of Ethiopia for expanding the training of non-physician clinicians at Mekele, Hawassa and Jimma universities, and adding training at Harumaya and Gondar universities. In partnership with UNFPA, WHO, the World Bank and other partners, an incentive package has been developed for trainees to perform surgeries in remote areas after graduation.

Needs assessment follow-up in Cambodia

Cambodia's needs assessment identified a number of factors affecting the availability, functioning and utilization of emergency obstetric and newborn care services. First, there are no clear guidelines for service delivery, and standardized lists of equipment, supplies and essential drugs have not been developed. Equipment lists provided by the Ministry of Health are inadequate, and newly revised safe motherhood protocols need to be reviewed to ensure that they include best practices. The assessment revealed that 41 percent of health facilities are not administering parenteral antibiotics because they are not authorized to keep specific drugs in stock, and staff were not trained or authorized to provide life-saving signal functions. Upgrading health centres to a basic (and functioning) level will require a significant shift in policy. Health facilities are also critically understaffed, and health providers are not always available in the right number and with the right skills to provide good quality care. This information would not have been available without the assessment, and the good practices that followed would not have happened.

Under the leadership of the Ministry of Health, an expert was recruited to develop a costed emergency obstetric and newborn care improvement plan, as well as a monitoring tool to track services and

facility standards. A surveillance room for maternal deaths was established in early 2010, with monthly tracking and continuous mapping of maternal deaths. Figure 3 illustrates an example of mapping of maternal deaths, while Figure 4 presents the monthly trends in three provinces with the highest maternal mortality.

Scaling up fistula treatment and social reintegration

Scaling up fistula services requires functioning fistula referral centres, well-trained fistula surgeons and nurses, and rehabilitation centres. Important components of a fistula programme are the identification of cases, the referral to fistula centres and the creation of a supportive environment for women with fistula. Outreach through community mobilization, community radio, and local NGOs and fistula advocates are among the strategies used for the identification, self-notification and referral of fistula cases.

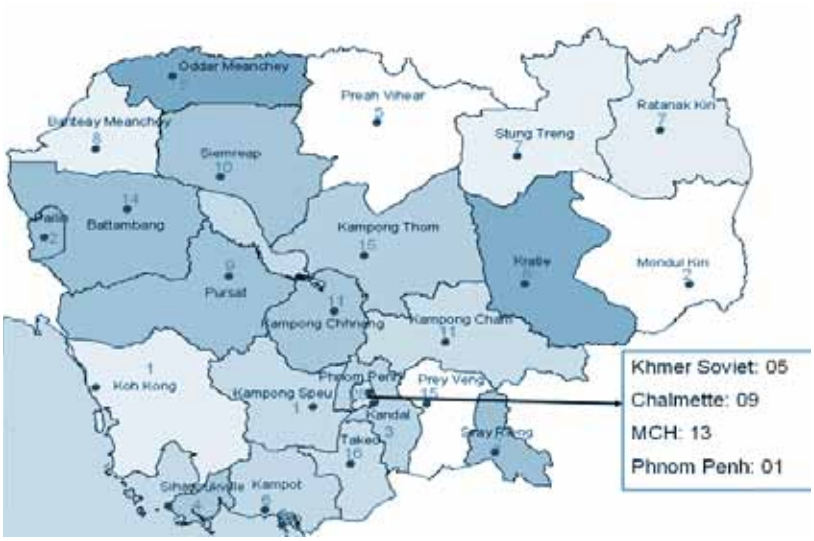

Figure 3: Mapping of maternal deaths in Cambodia

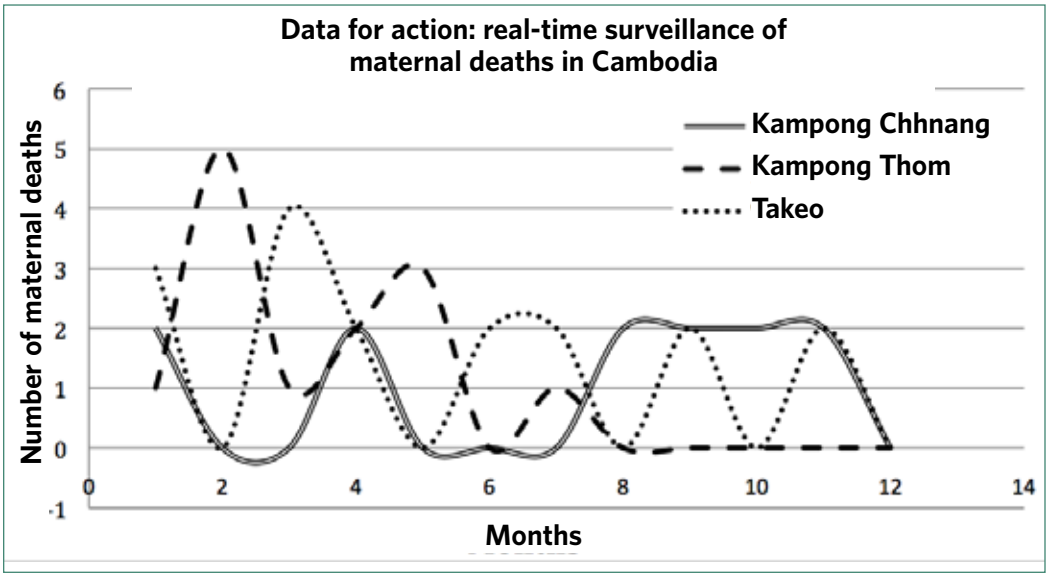

Figure 4: Real-time surveillance of maternal deaths in three provinces in Cambodia

Table 6: Fistula services and use in selected countries

Countries	Number of functioning treatment centres for fistula repair	Number of treatment facilities that offer social reintegration services	Number of women surgically treated for obstetric fistula per year	Number of women treated for obstetric fistula who have received social reintegration support
Benin	4	0	111	27
Burkina Faso	7	1	238	53
Burundi	1	0	20	0
Côte d'Ivoire	5	3	242	47
Djibouti	1	0	0	0
Ethiopia	4	2	1400	140
Ghana	9	0	79	30
Madagascar	6	6	100	100
Malawi	3	1	300	97
Sudan*	6	2	—	—
Zambia	5	0	378	—

** UNFPA has two programmes in Sudan, in Khartoum and Juba.*

Note: Haiti's earthquake disrupted all programming; the focus is on rebuilding efforts. Cambodia and Guyana do not recognize fistula as a public health problem.

Another important goal is economic and social reintegration after treatment for fistula. The Campaign to End Fistula has provided support for such opportunities, but only a few countries, such as **Bangladesh**, **Benin**, **Burkina Faso**, **Côte d'Ivoire**, **Guinea**, **Malawi**, **Niger**, **Pakistan** and **Sudan**, have developed this area of fistula programming.

For more details, see the chapter on the Campaign to End Fistula.

Procurement of essential medicines

Enlarging the provision of lifesaving maternal and newborn health commodities is a priority for UNFPA and the MHTF. Work with partners has emphasized the review and updating of lists of essential equipment, supplies and drugs.

Scaling up family planning

Post-abortion care: Most women who have undergone an induced abortion want to avoid or delay pregnancy, and for some women, emergency treatment of abortion complications may be one of their very few contacts with the health-care system. The opportunity to provide family planning information and services cannot be missed. In synergy with GPRHCS, and with financial contributions from the

MHTF, UNFPA co-organized an inter-regional meeting of key stakeholders from sub-Saharan Africa and the Arab states on "New Evidence and Strategies for Scaling-up Post-abortion Care."[2] Gynuity Health Projects, a New York-based NGO, supported the meeting. For two days in Alexandria, Egypt, it brought together more than 100 participants, including experts from different organizations with substantial experience in post-abortion care and national teams from 22 countries in both regions. A technical update was provided on treatment methods, integration of post-abortion care into other reproductive health services and the scaling up of strategies. Participants shared experiences on successes, challenges and lessons learned. Country teams developed national action plans to make post-abortion care more accessible to women and communities.
(See also: www.unfpa.org/public/cache/offonce/home/news/events/pid/5695).

Midwifery practice in Bangladesh. Photo by UNFPA Bangladesh.

Community mobilization: MHTF and GPRHCS support helped several countries pursue activities to generate demand for family planning in remote and rural areas—such as community mobilization, community radio broadcasts, outreach activities with mobile clinics and voucher schemes to access family planning.

Cervical cancer

With MHTF financial contributions, UNFPA organized the "Global Workshop on Programming Guidance for Cervical Cancer Prevention" in New York in December 2010. Experts in cervical cancer prevention programming from a number of organizations and national teams from 17 countries from all regions participated in a four-day meeting. Updated evidence on effective strategies to prevent human

2 UNFPA does not promote abortion as a method of family planning, and the legal status of abortion is the sovereign right of each nation.

papillomavirus (HPV) infection and progression to cervical cancer—including primary prevention with HPV vaccination, HPV screening methods and treatment technologies for precancerous lesions—were presented and discussed. Participants considered lessons from demonstration projects. The outcome of the meeting was a guidance document for programme managers to make cervical cancer prevention and control more accessible to women and communities, with an emphasis on expanding services (see also www.unfpa.org/public/home/news/events/pid/6859).

Highlights

In **Benin**, a pilot three-day outreach project supported by UNFPA resulted in 270 women receiving implants and 28 women receiving intrauterine devices (IUDs). The project will be scaled up in 2011.

In **Niger**, innovative strategies to stir demand for family planning have produced remarkable success. Supported by UNFPA, the US Agency for International Development and other partners, they include Aventures de Foula, a radio drama on family planning, unwanted pregnancies, female genital mutilation and HIV prevention that was broadcast nationwide and showed in theatres in nearly 200 villages in the Maradi region, one of the poorest areas of the country. Female community health workers took part in 180 community relays, and conducted doorstep sensitization and distributed family planning commodities. Ecoles des Maris involves men as actors of change and champions for universal access to reproductive health and rights.

These strategies have helped triple the use of family planning and antenatal care, and improved community accountability for maternal health. Use of family planning, antenatal care, skilled birth at delivery and immunization rates have improved, from 1.7 percent in 2006 to 17.2 percent, from 28.6 percent to 87.3 percent, from 8.5 percent to 25 percent, and from 45.6 percent to 107 percent, respectively.

BOX 3 Talking about family planning

Community sketches (Burkina Faso)

In **Burkina Faso**, communications around family planning included showing films, followed by community conversations and the sensitization of local leaders. More than 500 villages were covered. Subsequently, contraceptive prevalence rose from 26.6 percent in 2009 to 30.1 percent in 2010 (Annual Health Statistics).

BOX 4 Community outreach in Madagascar

Insertion of Implanon in Madagascar. Photo by UNFPA Madagascar

During 2010, with support from the MHTF and GPRHCS, and in partnership with Marie Stopes Madagascar and partners, **Madagascar** trained 292 health professionals and 988 community health workers to offer family planning services in hard-to-reach areas. Eleven medical teams, covering 22 regions of the country, provided long-term and permanent methods such as implants, IUDs and female sterilization. An outreach strategy combined with the availability of contraceptives and supply chain management have contributed to a marked increase in the number of female users of long-term methods. The number of Implanon users increased from 17,548 in 2009 to 25,581 in 2010. Utilization of IUDs rose from 7,314 in 2009 to 12,457 in 2010. The number of female and male sterilizations increased from 8,607 in 2009 to 8,896 in 2010, and from 226 in 2009 to 234 in 2010, respectively.

BOX 5 Working with fistula advocates

Fistula survivor **Gul Bano** is a resident of Kohadast, Turbat in Baluchistan, **Pakistan.** She was married when she was 13. She is happy to have regained her lost status in the eyes of her family, community and society after fistula repair. She has been an advocate and brought several women suffering from fistula to the Koohi Goth Hospital in Karachi.

Marietta Kiden comes from Nimule, a small village in southern **Sudan.** Marietta lived with fistula for 25 years before receiving treatment at Juba Teaching Hospital. Now an advocate, Marietta has been working with UNFPA in Southern Sudan to raise awareness on obstetric fistula. She tells other women about fistula and refers women for treatment at Juba Hospital.

Halimatou is from Kollo, **Niger.** She was married at the age of 13, remarried at the age of 18 and developed fistula after a painful obstructive labor that lasted three days. She was treated at the Dimol fistula referral centre in Niamey, and was offered a modest fund to start a revenue-generating activity. She speaks publicly, encouraging women with the condition to seek care.

Community mobilization for identification and referral of fistula victims

Several countries have developed community interventions to improve the identification of fistula survivors, care-seeking behaviors and services. In **Benin**, partnerships with 18 community radio stations, NGOs working on fistula referral and social reintegration, and community leaders have helped enhance understanding of and support for fistula survivors. For more on fistula initiatives, see Chapter Three on the Campaign to End Fistula and the summary results tables in the Annex.

BOX 6 Preventing fistula

In **Bangladesh**, an advocacy programme to prevent obstetric fistula, implemented by the Bureau of Health Education, has organized seminars and video shows. The Bangladesh Women's Health Coalition has been instrumental in community mobilization, and conducted a community meeting with 800 participants, including pregnant women, adolescents, imams, schoolteachers and community leaders. Fifteen community fistula survivors and advocates, who received training and were fully rehabilitated with the support of the MHTF, have started to conduct local advocacy to identify fistula cases and help link pregnant women with skilled birth attendants.

Photo by UNFPA RCI.

Ms. S. has lived with fistula for 12 years. Now cured, she is proudly marching in front of her peers to express her joy and to encourage other fistula survivors to openly speak about the condition because there is hope and treatment available.

Photo by UNFPA RCI.

Ms. Gnandja, 33 years old, lived with fistula for four months. She was treated and is now back in her family and reunited with her husband

BOX 7 Fistula social rehabilitation

In **Côte d'Ivoire**, a fashion show is periodically organized to celebrate obstetric fistula patients who have been successfully repaired. This pageant-like ceremony aims to demystify obstetric fistula in the public eye, to rebut stigma and misconceptions about the condition, and most importantly to comfort patients and help them regain hope. This is also an opportunity to motivate professionals who treat fistula patients, as they can see the change in the lives of women who underwent treatment and are reunited with their families. Many treated women become fistula advocates, peer educators, and sexual and reproductive health advocates keen to sensitize their communities.

OUTPUT 6.

Monitoring and results-based management of national maternal and newborn health efforts.

Indicator: Internationally agreed maternal and newborn health indicators integrated in national health management information systems.

Monitoring and evaluation is critical for the MHTF. In 2010, progress towards results-based management included contributions to the development of UNFPA's Evidence-Based Programming Guidelines. Systematic monthly monitoring of national implementation rates, feedback and oversight resulted in better implementation rates, while an innovative mobile health project tracked maternal deaths and the provision of commodities. Promoting surveillance and real-time reporting of maternal deaths in national health information systems in part entailed helping national systems acquire better capacities to generate quality data to track progress.

In 2010, the West Africa Health Organization convened a meeting of all heads of national health information systems and epidemic surveillance units in 15 member states (**Benin**, **Burkina Faso**, **Cape Verde**, **Côte d'Ivoire**, **Gambia**, **Ghana**, **Guinea**, **Guinea Bissau**, **Liberia**, **Mali**, **Niger**, **Nigeria**, **Senegal**, **Sierra Leone** and **Togo**). The meeting aimed to establish a forum for member states to regularly and systematically exchange epidemiological information and experiences with the management of health programmes. It promoted the integrated use of health information to prevent epidemics, and highlighted other measures for improving public health systems.

Since the MHTF supports 13 of the aforementioned countries, it engaged national officials on using national health information management systems for issues such as the routine tracking of existing maternal and newborn indicators, and the routine production of a regional bulletin for maternal health, including family planning. Under the leadership of the West Africa Health Organization, situation analyses and cross-country trend analyses of selected maternal and newborn health indicators and MDG indicators for health facilities are under way, to foster the use of local data and complement household survey data and analysis.

Indicator: Mandatory notification and surveillance of maternal deaths.

Surveillance systems need to systematically chronicle maternal mortality so that it is no longer a silent killer of women. Without weekly and monthly monitoring, health teams cannot be held accountable, communities cannot take appropriate measures and the effectiveness of maternal health interventions remains difficult to establish. Only six of the countries supported by the MHTF (**Burundi**, **Cambodia**, **Ethiopia**, **Ghana**, **Malawi**, and **Zambia**) currently have a mandatory notification of maternal death policy, although institutional maternal deaths are captured by national health information systems in all countries. Surveillance has started in only a handful of countries (**Cambodia**, **Madagascar**). The example of Cambodia described under Output 5 illustrates a good practice and was disseminated to all MHTF priority countries for replication, with financial and technical support from the MHTF.

Indicator: Routine practice of maternal death audits/reviews, confidential enquiries.

Benin and **Madagascar** have completed the development of strategies to audit maternal deaths in institutions, a process that will lead to routine and mandatory maternal death audits/reviews in all comprehensive emergency obstetric and newborn care facilities. In **Malawi**, a National Maternal Death Audit led to a comprehensive set of recommendations to districts on strategies to improve maternal health and enhance reporting procedures for maternal deaths.

Indicator: Evaluations and results-based management.

The MHTF, in collaboration with UNFPA's Evaluation Branch, successfully launched the **MHTF Mid-term Evaluation** and the **UNFPA's Maternal Health Thematic Evaluation.** The latter will assess to what extent UNFPA's assistance has been relevant, effective, efficient and sustainable in contributing to the

improvement of maternal health over the last 10 years. The Mid-term Evaluation covers the MHTF's programmatic directions at national, regional and global levels. It considers internal coordination and management mechanisms, effectiveness, efficiency, and the sustainability of technical and financial support. The results of the evaluations are expected at the end of 2011.

BOX 8 Institutionalization of maternal death audits in Madagascar

In 2010, the Ministry of Public Health in Madagascar, supported by UNFPA and WHO, started a pilot project to assess the feasibility of three key interventions: maternal death audits for health facilities, verbal autopsies (also called community-based maternal death audits) and sentinel surveillance of maternal mortality. The three interventions are vital for institutionalizing maternal death audits.

A National Maternal Death Audit Committee was set up with members from the Ministry of Health, professional associations, universities, NGOs and international technical/financial partners. It developed tools for both kinds of audits. Potential trainers from the Ministry of Health and hospitals were identified and trained in auditing facilities, while community actors (including community health workers, traditional leaders and district medical officers) learned how to conduct community-based audits.

Following the training, maternal death audits were introduced in nine reference hospitals, and a system for the surveillance of maternal mortality was set up in four sentinel sites (health districts). Thirty cases of maternal deaths were reviewed. The Ministry of Health carried out a national Confidential Enquiry into Maternal Death. Three categories of factors responsible for maternal deaths were identified. They related to service providers, administrative factors, and families and communities. Sub-optimal quality of care was the main provider-related shortfall. Administrative gaps included a lack of qualified health-care providers, transport, communication, equipment, drugs and consumables. Family and community factors were late arrival in health facilities and deliveries by traditional birth attendants. For each case of maternal death, recommendations were made and implemented.

This successful pilot project played a key role in institutionalizing maternal death reviews in Madagascar. The early involvement of decision makers from the Ministry of Health, hospital directors and community leaders were important determinants of success. The next step involves documenting lessons learned from the sentinel sites and scaling up the intervention to other regions of the country.

Highlights

With the support of the MHTF, three countries (**Mali**, **Benin** and **Madagascar**) have developed proposals to use mobile phones for tracking maternal deaths and the stocking of commodities (see picture below for a schematic description of the system). In **Mali**, in partnership with the Government and UNICEF, the MHTF is helping to implement a surveillance system to provide data for timely action to improve maternal and newborn health.

SMS sender | Receiver and database | Weekly maternal mortality report

Figure 5: Tracking maternal mortality

OUTPUT 7.

Leveraging of additional resources for MDG 5 from governments and donors.

Indicator: Leveraging resources for sexual and reproductive health.

The success of the MHTF is measured in part by its capacity to leverage resources from governments and donors. The increased visibility of maternal health issues through media coverage, partnerships, and greater understanding among governments, civil society organizations, the general public and the private sector can galvanize support for action. Through the **Campaign to Accelerate Maternal Mortality Reduction in Africa**, and the **UN Secretary-General's Global Strategy for Women's and Children's Health**, several countries in 2010 made financial commitments to improve maternal health.

Indicator: Share of government expenditure for health (through national health accounts).

To plan and use resources effectively, and to ensure accountability and track government commitments, it is important to partner with stakeholders to conduct national health accounts (and reproductive health sub-national accounts). Investments in strengthening national capacities to conduct these exercises are also essential. Apart from **Burkina Faso**, **Ethiopia**, and **Malawi**, this accountability mechanism, which focuses on information on resources spent, is not in place in many countries.

Highlights

UNFPA remains grateful to the core supporters of the MHTF, which include Austria, Finland, Ireland, Luxembourg, The Netherlands, Norway, Spain and Sweden. Under the auspices of the UN Secretary-General's Global Strategy for Women and Children, and the H4+, additional resources were leveraged to support maternal and newborn health in 2010. In **Cameroon**, successful advocacy through the launch of the Campaign to Accelerate Maternal Mortality Reduction in Africa has resulted in a 28 percent increase in the budget for reproductive health. In the **Republic of Congo**, the World Bank has agreed to contribute to the financing of activities such as emergency obstetric and newborn care needs assessments, and the supply of products for reproductive health. In **Ghana**, UNFPA advocacy helped include obstetric fistula clients in the Livelihood Empowerment Against Poverty Programme and the Ghana health insurance scheme. In **Niger**, as part of the government's strong commitment to reproductive health, Caesarean sections and services for antenatal care, family planning, cervical cancer and children under five are eligible for fee exemptions. In **Sierra Leone**, the government launched the Free Health Care Initiative, which provides free health-care services to pregnant women, lactating mothers and children under the age of five.

BOX 9 Community-based health insurance in Djibouti

Community based health insurance (*mutuelle*) in Djibouti has allowed more and more rural communities to join together to mitigate health-related out-of-pocket expenditures through a solidarity scheme and risk pooling. Since October 2008, this initiative has had a positive impact on rural women, who have been able to access health facilities to monitor their pregnancies and give birth. In 2010, UNFPA, the World Food Programme (WFP) and the Ministry of Health signed an agreement to provide additional support to these communities.

Community workers identified from among former traditional birth attendants and women leaders have been trained to educate rural populations about monitoring pregnancies, the importance of going to a health facility during childbirth and the immediate post-delivery period, and family planning. They have also learned to recognize complications and pregnancies at risk, and to guide and help refer pregnant women. UNFPA has supported training, monitoring and evaluation activities, while WFP contributed through its Food for Work programme. The initiative has captured the attention of national authorities, furthering its expansion.

Significant donor pledges were made in support of maternal and newborn health at the 2010 G8 Muskoka Summit. In Ethiopia, the MHTF contributed $1 million a year towards scaling up Ethiopia's Health Extension Workers programme, while UNFPA helped leverage $3.2 million from Sweden for Ethiopia's midwifery programme. MHTF support for emergency obstetric and newborn care needs assessments was matched by significant contributions from UNICEF and partner governments to conduct the surveys in 10 countries in 2010.

Regional and Global Outputs

UNFPA's global and regional branches conduct global advocacy; broker partnerships; provide technical assistance and capacity strengthening, including through South-South collaboration; and help generate knowledge. All of these activities foster country-level results.

Regional communication and advocacy

In 2010, UNFPA, Women Deliver, and other partners assisted the AU to undertake a five-year review of the Maputo Plan of Action, which culminated in the July 2010 AU Summit on Maternal, Infant and Child Health. Twenty-nine Presidents and Heads of Government reiterated their commitments and recommended extending the Maputo Plan of Action for five years to allow for intensified efforts to achieve the health-related MDGs. As part of efforts to secure financing, UNFPA supported a follow-up meeting of chairs of budget and finance committees from national parliaments with the Pan-Africa Parliament. The meeting issued a Pan-African parliamentary framework to increase domestic resources for health.

In Asia, high-level consultations on family planning, maternal health and reproductive rights took place through the **Asia Forum of Parliamentarians on Population and Development** (in collaboration with UNAIDS, UNODC, WHO and ILO). They have helped to better position issues related to women and children's health.

Global communication and advocacy

Media outreach

Communication and media outreach on reproductive health issues is a key priority for UNFPA and its thematic funds. In 2010, the health of women and their newborns took centre stage not only in political forums like the G8 and UN General Assembly, but also in the media and UNFPA-supported civil society and celebrity initiatives. Global English media coverage of MDG 5 and maternal health went up by 54 percent from 2009 to 2010 (based on Nexis.com).

The MHTF supported documentaries and video news releases that reached more than 500 million viewers and political decision makers through global broadcasts and other screenings. Documentaries and news features like "Ghana: Midwives Deliver," "Saving Haiti's Mothers," "Guyana: Nurses on the Move" and many others were broadcast on national and global television and radio stations like the BBC, National Public Radio (United States), CNN, ABC (United States), the Public Broadcasting System (United States) and Al Jazeera. Women's health and MDG 5 were the topics most covered by the media at the UN MDG Summit in September and the Women Deliver II conference in June. News about the substantial decline in global maternal mortality received good media attention—both from global media outlets and those in many high-burden countries.

UNFPA was actively involved in communication and media initiatives linked to the UN Secretary-General's Global Strategy for Women's and Children's Health; the H4+; Women Deliver II; "Stories of Mothers Saved"; Countdown to 2015; The Global Campaign for the Health MDGs; the Partnership for Maternal, Newborn and Child Health; and Every Mother Counts.

Panel Discussion at Women Deliver 2010. Photo by Moises Saman.

Hearing women's voices: The MHTF seeks to elevate the voices of women who experience poor maternal health so that governments and other decision makers hear what they have to say. In 2010, this entailed increased work with fistula survivors in communities and countries, and at the global level. The fund supported the powerful UNFPA-White Ribbon Alliance advocacy initiative "Stories of Mother Saved," which features 139 women from remote communities in 28 countries throughout the world who have barely survived pregnancy and childbirth. They tell their stories about why they did NOT die, about what interventions work, and about what they would do to improve maternal health if they were Heads of State. Compelling multi-media material from the initiative has been used and repackaged in various ways, and the work will continue in 2011 with a specific focus on stories from midwives.

During the **Women Deliver II** conference, attended by 3,400 people from 146 countries, UNFPA convened a Midwifery Symposium with partners. With support from the MHTF, this ensured that the voices of midwives, fistula survivors and other women affected by poor reproductive health were heard throughout the conference. Messages from the conference echoed through other major events in 2010, helping to spur global and national commitments and actions.

Artists raise awareness: There was a renewed UNFPA effort in 2010, supported by the MHTF, to work with artists to raise awareness about maternal health. The fund continued engaging with model, filmmaker and maternal health spokesperson Christy Turlington Burns on her Every Mother Counts campaign. MDGfive.com is a new online and offline community of filmmakers, musicians, poets, authors and other artists who raise awareness about improving maternal health.

Partnerships

The MHTF engages in strategic partnerships that provide technical assistance to country offices. Partners comprise other UN organizations, academic institutions, professional groups and NGOs:

- **Columbia University**, **New York** (Averting Maternal Death and Disability Program) offers technical support for emergency obstetric and newborn care assessments in priority countries.
- The **ICM** helps scale up midwifery education, regulation and associations in 22 priority countries (see Chapter Two).
- **Johns Hopkins University Bloomberg School of Public Health** supports a cross-country study on post-operative prognosis, improvements in quality of life, social reintegration and the rehabilitation

of fistula patients after surgical repair in treatment centres in six countries: **Bangladesh**, **Benin**, **Ethiopia**, **Niger**, **Nigeria** and **Tanzania**.

- The **University of Aberdeen** collaborates with national institutions in **Bangladesh**, **Burkina Faso**, **Morocco**, **Tanzania** and **Uganda** to bolster capacities for monitoring and evaluating maternal and newborn programmes. This partnership will evolve as the university moves into a quality assurance role.
- The **International Federation of Gynecology and Obstetrics** is assisting with the Indicator Compendium for Obstetric Fistula, and the Competency-Based Training Manual for fistula surgeons.
- The **Woodrow Wilson Center** supports maternal health policy debates to focus the attention of the US Congress, scientists, technical institutions, NGOs, policymakers and health professionals from developing countries on important maternal health issues. The goal is to promote dialogue and understanding of cutting-edge research, and successful and innovative fieldwork, and to share lessons on health financing, health service delivery, community mobilization, family planning, maternal health in post-conflict and post-disaster settings, etc.

Resource mobilization

In 2010, representatives from donor governments, the private sector and foundations participated in the MHTF annual progress review, where colleagues from Burkina Faso and Ghana showcased strong achievements. A special effort was made to brief parliamentarians from key countries on the MHTF. Study tours for parliamentarians to visit programmes in MHTF countries enhanced understanding and support. UNFPA continues to collaborate with several important private sector donors, including Johnson & Johnson, Virgin Unite and Zonta International, to support fistula programmes in targeted countries.

Technical assistance and capacity strengthening

Technical assistance has involved review meetings with countries and regional offices related to capacity building and joint planning. It contributed to the five-year review of the Maputo Plan of Action, and to efforts by the Pan-Africa Parliament around financing the outcome agreement of the AU Summit on Maternal, Newborn and Child Health.

Opportunities in 2010 to strengthen capacities came through countries conducting emergency obstetric and newborn care needs assessments, a joint thematic funds planning meeting, the post-abortion care workshop described under output 5, the provision of midwifery advisors in selected countries in Africa and in Asia, the special fistula session at the 11th Congress of the African Society of Obstetricians and Gynecologists in **Gabon**, and the roll-out of the "Fistula Indicator and Competency Based Training Manual" for fistula surgeons during the third conference of the International Society of Obstetric Fistula Surgeons in **Senegal**.

South-South collaboration: Wherever possible, capacity strengthening took place through South-South collaboration. In the **Central African Republic**, experts from **Mali** trained fistula surgeons. **Eritrea** received support from the **Ghana** and **Nigeria** fistula programmes; a team from the Ministry of Health observed fistula repair hospitals and related rehabilitation and reintegration interventions. **Madagascar's** senior maternal health advisor supported **Haiti** after its emergency, and a mission of fistula surgeons went to **Niger**. **Ethiopia** sent a mission to **Ghana** to learn about midwifery regulation and associations, and **Sudan** welcomed a mission of fistula surgeons from **Ethiopia**. The **Sudan** Country Office hosted a team of health professionals from **Yemen** led by the federal Ministry of Health. They made field visits to the Abbo fistula centre and social rehabilitation and reintegration centres, and learned from the national fistula coordinating team in **Sudan**. A surgical team from **Zambia** conducted a field visit to the world-renowned Hamlin Fistula Hospital in **Ethiopia** to learn about their successful programme model. Fistula experts from **Bangladesh** provided support to **Timor Leste** to treat women and girls suffering from fistula and train local providers in fistula care. Finally, the International Council on Management of Population Programmes, based in **Malaysia**, guided advocacy on family planning in Asia and the Pacific.

CHAPTER TWO

STRENGTHENING MIDWIFERY:
THE SUREST WAY TO REACH MDG 5

First year students at the Gode Midwifery School in the Somali region, Ethiopia.
Photo by UNFPA Ethiopia.

Introduction

The Midwifery Programme, launched in 2008 by UNFPA and the ICM, and now fully integrated into the MHTF, continued to make major strides in 2010. It raised the visibility of midwifery globally, and drew the attention of policymakers, planners and donors to the major role of midwives in providing critical, life-saving interventions (basic emergency obstetric and newborn care) that help avert maternal and newborn deaths and disabilities. There is growing global recognition that strengthening health systems and addressing critical human resource shortages ultimately lead to declines in maternal and newborn deaths, and help achieve universal access to reproductive health.

Investing in midwifery can yield vast returns towards achieving MDG 5. A well-skilled midwifery workforce can help avert roughly 80 percent to 90 percent of maternal deaths, particularly when midwives are trained and authorized to practice life-saving techniques. Midwives also have a critical role to play in newborn care and averting early newborn deaths, contributing toward MDG 4, and can be the first health-care providers to detect HIV in pregnant and non-pregnant women, and prevent mother-to-child transmission of the virus, contributing toward MDG 6. Furthermore, midwives can provide general and sexual and reproductive health information and education, family planning services and counselling, antenatal care, services to prevent and treat malaria, tetanus and congenital syphilis prevention, treatment of sexually transmitted infections and post-abortion care.

The Midwifery Programme is particularly critical because many developing countries still do not adequately acknowledge and support the profession of midwifery. Midwives often have low status and receive little recognition, a situation aggravated by the fact that some countries are still investing in the training of lower-level cadres of health workers, who, unlike certified midwives, are not able to carry out life-saving interventions. The education of midwives has often been ignored, regulatory mechanisms are weak, and the absence of midwifery associations undercuts the ability of midwives to voice their professional concerns. The result has been insufficient investment in crucial areas such as midwifery training, supervision, recruitment, deployment and retention.

The Midwifery Programme continues its efforts to address all these issues. It aims to have skilled attendance at birth in low-resource settings by developing a sustainable midwifery workforce. To support this goal, it has sought to establish a critical mass of national and regional midwifery advisors who provide strategic direction and assist national efforts. National capacity development focuses on developing midwifery education, training and accreditation mechanisms; promoting midwifery associations; strengthening regulatory mechanisms; and advocating midwives as key to achieving MDGs 4 and 5. The programme also addresses policy issues linked to the retention and deployment of midwives, their distribution and supportive supervision skills. It helps review and revise midwifery curricula to include all essential WHO/ICM competencies; equip midwifery schools; improve midwifery facilities; and make the case for creating a midwifery council or board to regulate midwifery and ensure midwives have requisite and up-to-date skills.

Generous and continued financial support to the MHTF from donors, including Austria, Finland, Ireland, Luxembourg, the Netherlands, Norway, Spain and Sweden, allowed the Midwifery Programme in 2010 to consolidate gains, address challenges, and expand to select additional countries in South Asia and Africa. In 2010, approximately $5.5 million from the MHTF was spent on midwifery activities.

A 2010 highlight was the launch of a major global multilateral partnership to strengthen midwifery. UNFPA, the ICM, WHO, UNICEF, the World Bank, the Johns Hopkins Program for International Education in Gynecology and Obstetrics, the Global Health Workforce Alliance, and the International Federation of

Gynecology and Obstetrics launched a Global Call to Action at the Midwifery Symposium held during the Women Deliver II conference in Washington, D.C.. They urged governments to improve midwifery education and training in all essential competencies (see Box 1); build up professional associations; develop regulatory frameworks; and establish adequate retention and deployment policies. The partners are now working together on generating data on midwifery, which will be published as the State of the World's Midwifery report in 2011.

BOX 1 Essential WHO/ICM midwifery competencies

- Midwives have the requisite knowledge and skills from the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns and childbearing families.
- Midwives provide high-quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.
- Midwives provide high-quality antenatal care to maximize health during pregnancy, including early detection and treatment or referral of selected complications.
- Midwives provide high-quality, culturally sensitive care during labour, conduct a clean and safe delivery, and handle selected emergency situations to maximize the health of women and their newborns.
- Midwives provide comprehensive, high-quality, culturally sensitive postnatal care for women.
- Midwives provide high-quality, comprehensive care for the essentially healthy infant from birth to two months of age.
- Midwives provide a range of individualized, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss where it is not against the law.

Programme countries

The Midwifery Programme is now active in 22 high maternal mortality countries, following its 2010 launch in **Afghanistan**, **Bangladesh**, **Nepal** and **Pakistan**. While 17 countries fall under the UNFPA/ICM umbrella of technical support, 5 additional countries supported through the MHTF are also significantly engaged in strengthening midwifery services. There are now 18 country and three regional midwife advisors providing technical guidance on strengthening and expanding midwifery to ministries of health and other stakeholders in 16 countries.

The programme operates in 12 countries in Africa (**Benin**, **Burkina Faso**, **Burundi**, **Chad**, **Côte d'Ivoire**, **Democratic Republic of the Congo**, **Ethiopia**, **Ghana**, **Madagascar**, **Malawi**, **Uganda** and **Zambia**), two in Latin America (**Guyana** and **Haiti**), two in the Arab States (**Djibouti**, and northern and southern **Sudan**) and six in Asia (**Afghanistan**, **Bangladesh**, **Cambodia**, **Lao People's Democratic Republic**, **Nepal** and **Pakistan**). Seventeen of the 22 countries receive direct technical support from the ICM regional midwife advisors (**Afghanistan**, **Bangladesh**, **Benin**, **Burundi**, **Burkina Faso**, **Chad**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Djibouti**, **Guyana**, **Madagascar**, **Nepal**, **Pakistan**, northern and southern **Sudan**, **Uganda**, **Zambia**). In the other five countries, close synergies have been established with the joint UNFPA/ICM Programme.

Activities and results in 2010

Country activities and results

This section describes country results according to MHTF outputs and indicators relevant to the Midwifery Programme. Selected country highlights illustrate major achievements in advocacy, needs assessments and gap analyses, as well as midwifery education, the strengthening of midwifery regulation and association.

OUTPUT 1.

An enhanced policy, political and social environment for maternal and newborn health and sexual and reproductive health.

Indicator: National comprehensive communication and advocacy strategy developed for sexual and reproductive health.

All programme countries celebrated the International Day of the Midwife in 2010, which gave visibility to the essential role of midwives in reducing maternal and newborn mortality and morbidity. For the first time, then-UNFPA Executive Director Thoraya Ahmed Obaid and ICM Secretary-General Agneta Bridges gave a joint statement on the Day. Around the world, under the slogan "the world needs midwives now more than ever," the Day featured processions and marches, debates on midwifery, articles in leading newspapers, television documentaries and advocacy activities with political leaders.

Highlights

In **Afghanistan**, under the leadership of the Afghan Midwives Association, 15 provinces and more than 3,000 midwives and other health-care providers, including officials from the Ministry of Public Health, celebrated the Day. The association presented awards to midwives for outstanding achievements.

"No woman should die trying to give life. Increased investment is needed to provide midwifery skills and life-saving services, and to make midwives a priority within health programmes, policies and budgets."

Thoraya Ahmed Obaid, then-UNFPA Executive Director, in her message on the International Day of the Midwife.

In six regions and health districts, **Burkina Faso's** Association of Midwives organized free screenings for cervical cancer and sensitization on family planning and HIV prevention for more than 800 women. With the support of senior midwives, 180 midwifery students practiced their skills in pelvic examination, active management of the third stage of labor, insertion of implants and HIV counseling.

The Day was celebrated in five UNFPA intervention areas in **Côte d'Ivoire**, with the attendance of the Minister of Health and Public Hygiene. In addition, 450 women learned about the benefits of early cervical cancer screenings; 115 women agreed to be screened.

The **Cambodia** Midwifery Association and Cambodia Midwifery Council brought together around 400 midwives, representatives from health professionals' organizations and development partners, and the Minister of Health to mark the day. The Minister of Health later offered an office to the association and council, and supported the inclusion of their activities in the ministry's Annual Operational Plan.

In **Guyana**, secondary school students participated in a public exhibition and discussion session with midwives as part of activities hosted by the Guyana Nurses Association. Students learned about the role of midwives in providing quality care during pregnancy and childbirth, and about the requirements for becoming a trained midwife. In **Ghana**, a health walk, accompanied by a brass band supported by the Queen Mother's Association and religious groups, brought midwives and students onto the streets. A 500-person strong durbar of the chiefs, chaired by the Paramount Chief of the Area and the People

of Hohoe, informed people about the benefits of midwifery. In **Sudan**, celebrations in five UNFPA-supported focal states generated increased political commitment, particularly to the recruitment of trained midwives in the health system.

Midwife establishing bonding between mother and child at Georgetown Public Hospital Corporation. Photo by Mandy La Fleur. Guyana.

In **Uganda**, the Campaign for the Accelerated Reduction of Maternal Mortality in Africa was launched during the Day at the main national sports stadium. Over 15,000 delegates were present, including members of the AU, Ugandan parliamentarians, Ministry of Health officials, and the First Lady of Uganda, Mrs. Janet Museveni, as guest of honor. **Zambia** also marked the Day in conjunction with the launch of the Campaign for the Accelerated Reduction of Maternal Mortality in Africa. It was the first time that midwives received major visibility at a state function.

Djibouti had a week of activities, including medical caravans offering maternal health services in five regions. Sensitization sessions on the midwifery profession and reproductive health care took place in community development centres and schools.

Other 2010 advocacy activities included production of a poignant documentary entitled "Midwives Deliver." Filmed in the Upper East Region, Northern Region and Greater Accra Region of Ghana, it was produced by the award-winning filmmakers at Engel Entertainment. The documentary depicts the challenges and rewards of investing in midwifery. It premiered at the Midwifery Symposium at the Women Deliver II conference. One of the featured midwives, Madame Mary Issaka, won the Midwife Champion of the Year Award of the Johns Hopkins Program for International Education in Gynecology and Obstetrics. (For more on the film, see http://video.unfpa.org/).

This and other documentaries and news features, such as "Saving Haiti's Mothers," increased public and political attention to midwifery. These were broadcast on national and global television stations, and used in political advocacy and donor events.

OUTPUT 2.

Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health (midwifery), emergency obstetric and newborn care, and obstetric fistula.

Indicator: Up-to-date needs assessments for maternal and newborn health as part of the national health plan, which includes emergency obstetric and newborn care, family planning, midwifery and obstetric fistula services.

Needs assessments and desk reviews on midwifery have been completed in 10 countries (**Burkina Faso**, **Burundi**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Madagascar**, **Uganda** and **Zambia**). These establish baseline information on prevailing standards of midwifery training, legislative and regulatory environments, and the status of professional midwifery associations. Gap analyses on education, association and regulation were completed in **Afghanistan**, **Bangladesh**, **Nepal** and **Pakistan. India** and **Bhutan**, although not financially supported by the MHTF, have technical linkages with the Midwifery Programme and participated in the analyses.

Highlights

Programme countries have used the findings derived from needs assessments and gap analyses to make improvements in critical areas. In **Sudan**, a National Midwifery Strategy, developed in 2009 and based on the findings of the needs assessment, was operationalized through a shift from training only village midwives to training a new cadre of skilled birth attendants. Midwifery mapping has been conducted at local levels, and further needs assessments are ongoing and are at various levels of completion. In **Uganda**, the Midwifery Improvement Plan developed in 2009 on the basis of the needs assessment has significantly contributed to promoting quality midwifery training and service provision, and strengthening the Uganda Nurses and Midwives Council to effectively perform its mandated roles.

In **Afghanistan**, a curriculum for a direct-entry programme on midwifery is being devised, faculty development is underway, bridging programmes are planned and the zero draft of the Midwifery Act has been completed. **Bangladesh** established a national Midwifery Action Plan in 2010 and set up a midwifery association. The Bangladesh Nursing Council has become the Bangladesh Nursing and Midwifery Council, and the Directorate of Nursing has become the Directorate of Nursing and Midwifery, with a separate unit for midwifery. In **Nepal**, qualified teachers are being prepared to teach community-oriented, competency-based midwifery services.

OUTPUT 3.

National responses to the human resource crisis in maternal and newborn health, with a focus on planning and scaling up midwifery and other mid-level services.

Education, regulation and associations enable midwives to best perform their functions.

Midwifery education

Indicators:

- National midwifery training institutions with curricula based on WHO/ICM essential competencies adopted and implemented;
- Annual number of midwifery graduates from national midwifery training institutions;
- Midwives authorized to administer the core set of life-saving interventions (all seven basic emergency obstetric and newborn care functions); and
- Proportion of midwives benefiting from systems for compulsory in-service supportive supervision.

BOX 2 Leveraging resources

In **Ethiopia**, following the results of an MHTF-supported gap analysis conducted in 2009 in seven midwifery training institutions, the Midwifery Programme helped secure $3.2 million from the Swedish International Development Cooperation Agency for improving the coverage of skilled attendance at birth. These additional funds will help to:

- Increase the capacities of training institutions to produce highly trained and competent midwives;
- Strengthen midwifery associations;
- Bolster regulatory standards and monitoring systems for quality midwifery services;
- Improve access to quality fistula care services (both curative and rehabilitative); and
- Increase availability of high-quality reproductive health services for women, men and young people.

The MHTF also received $4 million in additional year-end funding from Sweden for strengthening midwifery globally and nationally.

The UNFPA Country Office in **Bangladesh** has raised an additional $140,000 from the United Kingdom's Department for International Development to build up two midwifery training centres in 2011.

The Midwifery Programme focuses on strengthening existing midwifery schools through the provision of equipment, books and training models, or establishing new schools where none exists. It helps ensure that competency-based midwifery curricula are in place and promotes curriculum revision to include all essential WHO/ICM competencies. Other activities entail enhancing in-service training, particularly in emergency obstetric and newborn care, and developing the teaching skills of midwifery faculty. In 2010, substantial results were achieved in these areas, but significant challenges remain and need to be urgently addressed. Several countries do not recognize an independent cadre of midwives or include midwifery with nursing. There is limited recognition of specific midwifery competencies. Pre-service training is inadequate and often contains insufficient clinical instruction. There is an absence of regionally standardized curricula, and a lack of higher education (degree) programmes for career advancement. Few midwiferyschools are well equipped, and they tend not to be well distributed to cover all population groups. Not enough competent, well-skilled and experienced midwifery tutors are available.

Figure 1 illustrates results achieved in 2010 under the indicator on the number of midwifery training institutions with curricula based on WHO/ICM essential competencies. The figure does not include all 22 countries covered by the Midwifery Programme. It highlights overall, although not uniform, progress, bearing in mind that the supported countries are at different stages and joined the programme at different times.

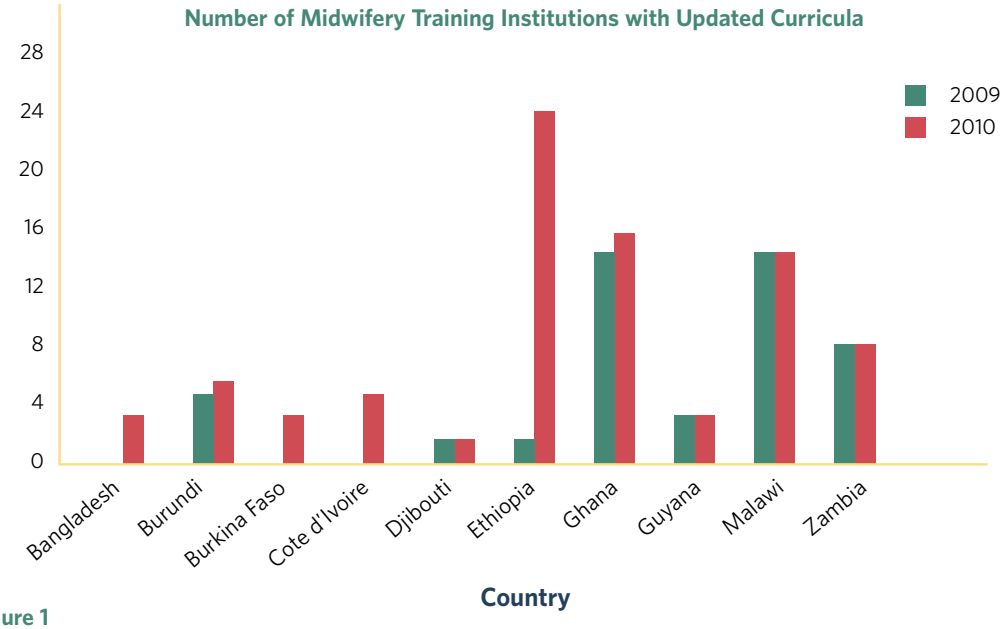

Figure 1

National curricula based on all seven essential midwifery competencies have been developed and implemented in 13 countries (**Afghanistan**, **Benin**, **Burkina Faso**, **Cambodia**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Malawi**, **Sudan**, **Uganda** and **Zambia**). In **Ethiopia**, which has received a significant amount of funding and technical assistance, the number of midwifery training institutions with revised curricula has increased dramatically from one to 23, with a concomitant increase in the number of midwifery graduates from 2,500 to 3,900 (a 56 percent increase). In **Bangladesh**, where previously there were only community midwives—a cadre of certified midwives did not exist—there are now three midwifery training institutions with updated curricula, from none in 2009.

Figure 2 illustrates results achieved in 2010 on the indicator for the annual number of midwifery graduates. The figure indicates overall progress, with variations linked to different country contexts. In **Ghana**, the annual number of midwifery graduates has not changed between 2009 and 2010 (327 graduates). In northern and southern **Sudan**, the number has increased by 45 percent, from 756 to 1,100, although these are village midwives. The National Midwifery Strategy, which includes training of certified midwives, was adopted in 2010.

Figure 2

Highlights

In **Burundi**, emergency obstetric and newborn care equipment has been distributed to paramedical schools. **Ethiopia** added 20 midwifery training institutions that have been provided with books and will soon be equipped with anatomical models. Ghana distributed medical equipment to 14 midwifery schools; **Guyana** provided teaching aids and supplies to three schools. In **Sudan**, UNFPA and WHO equipped the library and lab of the newly established Juba College of Nursing and Midwifery, and rehabilitated and equipped three midwifery schools in the states of White Nile, Kassala and Gadarif. **Madagascar** distributed anatomical models and books on paramedic training to six institutions. **Uganda** has equipped six of its 33 public and private not-for-profit training schools with skills labs.

Côte d'Ivoire has developed a plan for integrating emergency obstetric and newborn care modules in the trainings offered at the National Training Institute. During 2010, 15 teachers from Abidjan, Korhogo and Bouaké gained skills in emergency obstetric and newborn care. Four practical training rooms at the school have been equipped with teaching aids and anatomical models for instruction in emergency obstetric care. In addition, 327 newly qualified midwives gained skills in family planning, clinical emergency obstetric care and the prevention of mother-to-child transmission of HIV through a two-month internship prior to their field assignments. **Ethiopia** conducted emergency obstetric and newborn care training for 24 tutors, and the Amhara Regional Midwifery Association trained 32 midwives in neo-natal resuscitation. **Madagascar** introduced emergency obstetric and newborn care training at six institutions. **Benin** trained 16 midwives, including some from the private sector, on using obstetric vacuums. **Zambia** trained 25 midwifery tutors on selected family planning issues through co-funding with the East Central and Southern African College of Nursing. The college also provided support for 16 midwives to learn about the active management of the third stage of labour, and for midwifery mentorship training for 13 midwives.

Cambodia has developed its first bachelor's programme in midwifery, a major step in assisting the Ministry of Health to produce more skilled midwives who themselves can become qualified tutors and help address the current shortage of professionals. In November 2010, hands-on training and coaching on the emergency obstetric and newborn care training curricula was provided to 18 midwives expected to act as master trainers. Five regional training centres offered midwifery training to 835 students in 2010. A large increase in midwifery students since 2008, up from 335 that year, is largely attributable to the new three-year, direct-entry midwifery training programme funded by the German Trust Fund and government midwifery incentive payments.

In **Lao People's Democratic Republic**, professional midwifery training has been reinstated after more than two decades. An elementary national licensing examination, as a basis for a regulatory system, has been introduced.

In **Haiti**, intensive discussions with the Ministry of Health have taken place on new policies in midwifery training, particularly the launch of a four-year, direct-entry bachelor's programme. There are plans to create a Health Sciences University Centre, which would bring nursing and midwifery schools together with medical schools.

In **Uganda**, the School of Health Sciences has developed a master programme in Nursing and Midwifery at Makerere University. In **Ghana**, a curriculum has been drafted for a bachelor's programme expected to commence in 2011, in collaboration with the Ministry of Health and the Kwame Nkrumah University of Science and Technology. **Ethiopia** has revised its four-year bachelor curriculum to include emergency obstetric and newborn care. **Zambia** has revised its Enrolled Midwifery and Registered Midwifery curricula to include all WHO/ICM essential competencies. **Madagascar** has revised its curriculum in emergency obstetric and newborn care. **Uganda** has evaluated its 15-year-old Enrolled Comprehensive Nursing and Registered Comprehensive Nursing programme. In northern **Sudan**, basic midwifery training supported 70 village midwives and 50 skilled birth attendants. A bachelor-of-science curriculum has been finalized.

A six-day Effective Teaching Skills Workshop was organized in **Ethiopia** for 20 midwifery tutors from four teaching institutions. **Burundi** likewise hired a consultant for training teachers and supervisors of midwifery training institutions, and **Zambia** conducted a six-day training for 26 midwifery tutors, clinical

instructors and preceptors to improve their effectiveness as mentors. In **Bangladesh**, the Bangladesh Nursing Council organized a month-long course for trainers of qualified nurse-midwives with WHO and UNFPA support. The trainers are equipped to provide six months of advanced, in-service training to existing nurse-midwives. Based on the findings of a gap analysis, the government, working with stakeholders and support from the ICM, has drawn up a clear road map for a midwifery programme. It provides guidelines to policymakers and programme managers on implementing the three-year, direct-entry midwifery programme and a two-year, community midwifery education programme.

BOX 3 Ethiopia: in a deprived area, partnerships make a difference

The Somali region in **Ethiopia** has many reproductive health problems. The skilled birth attendance rate is only 0.6 percent, and the Caesarean section rate is 0.1 percent. The case fatality rate is 14 percent. About 60 midwives serve a population of 4.4 million people (2008 Population and Housing Census); 28 of the midwives graduated in 2009. The situation is worse in Gode Woreda (District), situated in a conflict zone 580 kilometres away from the Regional Health Bureau. Gode has one district hospital and a clinic.

Since partnerships are essential to improving maternal health, UNICEF, UNFPA, WFP, the Regional Health Bureau and the District Health Office are working together to reduce maternal mortality. WFP is providing food to women in the maternity waiting home. With assistance from UNFPA and UNICEF, the Regional Health Bureau recently established the Gode Nursing and Midwifery School, and has almost finished renovating a college of Nursing and Midwifery. There are currently 41 midwifery students and 6 midwifery instructors providing services at the maternity unit and antenatal clinic. To support these efforts, the Midwifery Programme has donated midwifery books and helped the Gode Maternity Waiting Home cater to pregnant women who live far from the hospital and may not be able to travel at night due to a curfew. A campaign by the District Health Office has helped to increase the number of women coming for antenatal care and delivering at the health facilities. (See photo on page 46).

In **Ghana**, a carefully selected group of midwives serving in remote and hard-to-reach areas of the Western and Central Regions attended an intensive ten-day, life-saving skills training on prevention and management of obstetric and neonatal emergencies. **Uganda** supported in-service training of 58 clinical officers and midwifery tutors, including clinical preceptors from 29 of its 33 training schools. The project also supported the pre-service training of 34 midwives committed to assignments in underserved and hard-to-reach districts. **Burkina Faso** conducted tutor trainings on HIV and prevention of mother-to-child transmission of HIV. **Benin** carried out a training-of-trainers workshop on family planning for 27 participants, including from the private sector, from five health zones. Seventeen midwives were trained in active management of the third stage of labour. In **Guyana**, special support was provided to improve the quality of supervision and mentoring of student midwives. Midwifery tutors participated in an educational and planning session on supportive supervision to strengthen clinical practice and instruction, and conducted supervisory field visits to midwifery students in communities and at clinical sites.

Midwifery regulation

Indicators:

- Midwives authorized to administer the core set of life-saving interventions (the seven basic emergency obstetric and newborn care functions); and
- Country has a national midwifery council or board—standalone or included in nursing.

To ensure quality of care, the midwifery workforce should be properly regulated, with standards and codes of ethics enforced through proper legislation. Midwives are now authorized to administer all life-saving

interventions (the seven basic emergency obstetric and newborn care functions) in 10 countries (**Afghanistan**, **Benin**, **Burkina Faso**, **Côte d'Ivoire**, **Djibouti**, **Ethiopia**, **Ghana**, **Haiti**, **Madagascar** and **Malawi**). For an overview of selected midwifery indicators, see the table at the end of this chapter.

BOX 4 Launch of a three-year, direct-entry diploma in midwifery in southern Sudan

Ravaged by decades of civil war, Sudan has one of the world's highest maternal mortality ratio. A severe shortage of midwives means over 90 percent of births occur at home with either traditional birth attendants or other semi- or unskilled professionals. Motivated by the need to improve this situation and to make progress towards achieving MDGs 4, 5 and 6, several NGOs, development partners and donors came together to support the Ministry of Health in establishing the **Juba College of Nursing and Midwifery** at the Juba Teaching Hospital.

The first **three-year**, **direct entry diploma in nursing** and **diploma in midwifery** were offered to students. The partners included UNFPA, the Real Medicine Foundation, the Japan International Cooperation Agency, WHO and St. Mary's Isle of Wight.

The college opened in May 2010. Thirty-nine students are enrolled—20 nursing and 19 midwifery students. A national principal heads the college; one national tutor and three international tutors are part of the faculty. The Japan International Cooperation Agency has constructed a brand new school building with classrooms, a skills lab and a library. UNFPA and WHO donated books and equipment. Two practicum sites have been identified.

UNFPA and the Real Medicine Foundation are providing project management support and have hired five qualified midwifery tutors and other personnel. St. Mary's Isle of Wight is assisting through nursing and midwifery volunteers.

Challenges in this area stem from weak or non-existent regulatory and legislative frameworks; lack of recognition of midwifery as an autonomous profession; lack of harmonized standards; lack of recognition of the importance of life-saving midwifery competencies; unclear (or nonexistent) licensure and credentialing policies; and the lack of distribution, deployment and retention policies for midwives. So far, there are no regulatory mechanisms for midwifery in **Afghanistan**, **Ethiopia** and **Sudan**. Similarly, lack of midwifery representation in the Bangladesh Nursing Council affects all aspects of midwifery services and the workforce.

Highlights

While substantial work remains to be done, systematic advocacy has led to results. In **Ghana**, the strategic plan for nursing and midwifery has been finalized. A desk review of existing regulations governing midwifery culminated in a national seminar to improve the standards of practice and develop a code of conduct.

Support to the Nurses and Midwives Council has backed the development of a uniform and comprehensive code of ethics. Through persistent advocacy with the Ghana Health Services, for the first time midwives are heading maternity units in health centres, district hospitals, and regional and teaching hospitals in the 10 regions of the country.

In **Afghanistan**, a four-day midwifery strategic planning workshop discussed the needs and priorities of the midwifery profession. A comprehensive strategy has been designed for professional development, and towards the establishment of the Afghanistan Midwifery and Nursing Council. In **Pakistan**, the gaps identified in a 2010 survey have been shared with the Pakistan Nursing Council, Aga Khan University, and the Midwifery Department and Association of Pakistan, with a strategic planning workshop slated for 2011.

Both the **Cambodia** Midwifery Association and Cambodia Midwifery Council have worked on strategic planning, legislation and regulation. The council is now fully operational following the creation of its Strategic Plan 2010-2015 and internal regulations.

In **Côte d'Ivoire**, 20 women leaders (heads of unions, associations and branches of the National Training Institute) were trained in professional regulation for the establishment of the College of Midwives. A technical working group has been set up to create the Order of Midwives. The group has developed terms of reference for draft legislation governing the order.

UNFPA supported the **Uganda** Nurses and Midwifery Council to develop its strategic plan and conduct supportive supervision visits to training schools. In **Zambia**, efforts are still underway to change the General Nursing Council to the General Nursing and Midwifery Council. Newly appointed nursing/midwifery officers received an orientation on nursing and midwifery monitoring tools.

In **Guyana**, technical assistance and support were provided to the Nursing and Midwifery Department of the Ministry of Health and the General Nursing Council to develop key regulatory documents, including a draft code of ethics for midwives and draft minimum competency standards for midwives.

In **Burkina Faso**, five regional branches of the Midwifery Council have been established, and a code of ethics prepared. A code of ethics has been prepared and distributed in **Burundi**. In **Benin**, the national training supervision guide for midwives has been disseminated in the five health zones. **Madagascar** is in the process of finalizing national policies on training and regulation.

In **Lao People's Democratic Republic**, 140 new graduates completed the first-year, post-basic community midwifery programme, and underwent a formal national licensing exam as part of the quality assurance mechanism and regulatory system introduced with MHTF support. This is the first time that such a licensing examination has been used in the country.

Midwifery regulations are also being reviewed in **Haiti**, together with the Family Health Director, to include all seven essential basic emergency obstetric and newborn care functions in pre-service training.

Midwifery association

Indicator:

- Country has a national midwifery association.

Midwifery associations foster the profession and express the voices of midwives to policymakers. The Midwifery Programme helps them develop their capacities by examining their governance structures; exploring ways to enhance membership; and improving decision-making, networking, management, communication, strategic planning and leadership skills. Midwifery associations are now present in 17 countries (**Afghanistan**, **Bangladesh**, **Benin**, **Burkina Faso**, **Burundi**, **Cambodia**, **Chad**, **Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Guyana**, **Haiti**, **Madagascar**, **Pakistan**, **Nepal**, **Uganda** and **Zambia**). For an overview of selected midwifery indicators, see the table at the end of the chapter.

Challenges to midwifery associations centre around a lack of power, leadership and credibility to promote the profession and ensure professional development; low membership; lack of resources (human, material and financial); limited management and administrative skills; frequent disputes among members; the domination of the nursing profession and a lack of regional midwifery alliances.

Highlights

In **Guyana**, a rejuvenated Nursing and Midwifery Association adopted a Constitution in 2010 and continued to mobilize midwives to join as members, including through field visits. Membership has increased; midwifery focal points have been selected for each region. The association actively participated in the review of the draft Nursing and Midwifery Act, and played a central role in an emergency obstetric and newborn care needs assessment.

New midwifery associations were launched in **Nepal** and **Bangladesh**. In **Ethiopia**, the Ethiopian Midwives Association, which now has 720 of the estimated 2,050 midwives in the nation as members, finalized and disseminated a five-year strategic plan. A five-day leadership training course was organized for National Executive Board members from three regional branches to reflect on leadership and management. Four members of the association participated in a study tour to the **Ghana** Nurses and Midwives Council and Association.

Support provided to the Ugandan Midwives Association helped develop its five-year strategic plan and organize the ICM Africa conference in Kampala. Work is ongoing in northern **Sudan** to assist the current association to be fully registered and recognized as a midwives' organization. In **Zambia**, in lieu of an established association, an interest group of 200 midwives coordinates midwifery interests under the Nursing Association. A proper association is now being formed, with a constitution under development. A private midwives association has been established in **Benin**. In **Burkina Faso**, a new association of student midwives was launched during the International Day of the Midwife.

Regional activities and results

For the Midwifery Programme, one of the most significant regional achievements in 2010 was its official launch in the South Asia region, which took place in March and coincided with the South Asia Midwifery Strategy Planning Workshop in **Bangladesh**. The workshop focused on identifying gaps and challenges, and defining strategies for midwifery education, regulation and associations.

Other regional achievements entail advocacy, technical assistance, knowledge sharing, and partnerships.

Advocacy

The Second ICM African Midwives Conference was held in **Uganda** on the theme of "African Midwives United towards Contribution to the Achievement of MDGs." The conference issued a communiqué advocating for an enhanced role for midwives in maternal and newborn care, and greater harmonization of midwifery training and services.

The visibility of the Midwifery Programme grew through the East Central and Southern African College of Nursing Conference in Zambia. The meeting highlighted the need for the ICM to do more to strengthen midwifery in the sub-region, supported by strong and steady advocacy at various levels.

Technical assistance and knowledge sharing

The Midwifery Programme continues to expand the capacities of its country midwife advisors, as they are responsible for working with stakeholders in strengthening the national midwifery agenda. The Mid-Year Progress Review and Technical Capacity Building Workshop of Country Midwife Advisors took place in Burkina Faso, with over 45 participants from 20 countries, and the participation of representatives from regional partners, such as the West African Council of Nurses, the Federation of Associations of Midwives from Central and West Africa, and the East Central and Southern African College of Nursing.

The meeting considered the Mid-Year Progress Review of the Midwifery Programme, and trained advisors on effective work planning, reporting, monitoring and evaluation. Technical sessions were held on midwifery shortage estimation and training costing; standardized equipment/tools; strategic planning for improved associations and regulations; gender mainstreaming in midwifery and the role of midwives in addressing female genital mutilation/cutting.

Country midwife advisors from **Benin**, **Burkina Faso**, **Ethiopia** and **Zambia** participated in a post-abortion care meeting in Egypt, and received technical updates on treatment methods, integration of post-abortion care into other reproductive health services, and scale up strategies.[1]

Partnership

Partnership with the East Central and Southern African College of Nursing grew through a follow-up meeting organized by the ICM in coordination with member countries to determine possibilities for generating a harmonized regional curriculum based on the essential WHO/ICM competencies. A document under development is expected to serve as a blueprint for developing culturally sensitive curricula for midwifery training.

Collaboration with the West African College of Nurses and West African Health Organization gained further momentum in 2010 with follow-up discussions on the development of templates to enable midwifery systems across the sub-region to work together. Critical areas of discussion include the harmonization of educational policies, effective teaching of professional ethics and strengthened clinical training.

Global activities and results

A number of high profile global events highlighted the significance of midwifery in achieving MDG 4 & 5. They achieved results through advocacy, partnerships, and the generation of essential data for planning and advocacy.

Advocacy and partnership

Participation in major global events drew attention of policy makers, planners and donors towards the vital need to strengthen the profession. Significant conferences in 2010 where the programme was presented included Women Deliver II, the Global Maternal Health Conference, the Global Health Council's 37th Annual Conference, and the AU Pre-Summit held before the 15th AU Ordinary Summit of the Assembly of Heads of States.

Leading up to **Women Deliver II**, a two-day Symposium on Strengthening Midwifery was organized by UNFPA and the ICM, in collaboration with WHO, UNICEF, the World Bank, the Global Health Workforce Alliance (GHWA), the Johns Hopkins Program for International Education in Gynecology and Obstetrics (Jhpiego), and the International Federation of Gynecology and Obstetrics (FIGO), with the participation of the White Ribbon Alliance and the Partnership for Maternal, Newborn and Child Health. Over 200 midwives, programme managers and policymakers attended the symposium, which raised awareness on links between midwifery and the MDGs.

Eight organizations (UNFPA, the ICM, WHO, UNICEF, the World Bank, GWHA, Jhpiego, and FIGO) endorsed a Global Call to Action at the symposium (see http://www.unfpa.org/public/news/pid/5845). It urges governments to make advances in increasing midwifery education and training in all essential competencies; strengthening professional midwifery associations; developing regulatory frameworks; and establishing adequate retention and deployment policies. The symposium paid tribute to two senior midwives, Ruth Lubic from the United States and Imtiaz Kamal from **Pakistan**. Mary Issaka, a community midwife from **Ghana**, received the Midwife Champion of the Year Award from the Johns Hopkins programme.

1 UNFPA does not promote abortion as a method of family planning. The legal status of abortion is the sovereign right of each nation.

BOX 5 A champion for midwifery

The Program for International Education in Gynecology and Obstetrics, a global health non-profit affiliated with Johns Hopkins University, presented the international Midwife Champion of the Year Award to Mary Issaka, a senior staff midwife from Bolgatanga, Ghana. Issaka was nominated by UNFPA for her work in the Bongo District. A 53-year-old midwife who completed her midwifery training in 1997, Mary Issaka has dedicated herself to improving the health of her community. Through her work and activities, she has helped save hundreds of lives.

BOX 6 The UN Secretary-General's Global Strategy for Women's and Children's Health and its relevance to midwifery

Through a concerted effort by UNFPA and its partners, 25 developing countries in September 2010 made concrete commitments for what they will do to improve women's and children's health under the UN Secretary-General's Global Strategy for Women's and Children's Health. Twenty-five more countries will follow in the summer of 2011.

Afghanistan has pledged to increase the proportion of deliveries assisted by a skilled professional from 24 percent to 75 percent through strategies such as increasing the number of midwives from 2,400 to 4,556, and raising the proportion of women with access to emergency obstetric care to 80 percent. **Bangladesh** has committed to doubling the percentage of births attended by a skilled health worker by 2015 through training an additional 3,000 midwives. Ethiopia has agreed to increase the number of midwives from 2,050 to 8,635 by 2015. **Burkina Faso** will develop and implement a plan for human resources for health, and construct a new public and private school for midwives by 2015.

To read more about the UN Secretary-General's Global Strategy for Women's and Children's Health, please go to www.everywomaneverychild.org/.

Generation of essential data

Data on midwifery personnel and services need to measure quality and distribution to ensure that every woman receives adequate care. Current data, even when available, are not always credible and reliable. To rectify this problem in countries with high rates of maternal and newborn mortality, a new publication, the State of the World's Midwifery, is being developed. The first of its kind, the report will facilitate improvements in midwifery by providing new information and data gathered from 58 countries in all regions of the world, and by examining the most relevant issues related to midwifery and the delivery of quality services.

The publication is the result of an international collaboration among UN organizations, NGOs and donors: UNFPA, the ICM, UNICEF, WHO, the World Bank, the International Federation of Gynecology and Obstetrics, the Global Health Workforce Alliance, the Partnership for Maternal, Newborn and Child Health, Ipas, the International Confederation of Nursing, the White Ribbon Alliance, and the governments of France, Germany, the Netherlands, Norway, Sweden, the United Kingdom and the United States.

BOX 7

A Global Call to Action

A GLOBAL CALL TO ACTION: STRENGTHEN MIDWIFERY TO SAVE LIVES AND PROMOTE HEALTH OF WOMEN AND NEWBORNS (*6 June 2010)*

Maternal Mortality: Still the greatest health and gender inequity in the world
We, midwives and other health professionals of the world and development partners, gathered here on the occasion of the Women Deliver Conference in Washington DC, June 2010, share the view that bold and unprecedented action is required to achieve Millennium Development Goal (MDG) 5: *Improve Maternal Health* and the newborn component of MDG4: *Reduce child mortality*. Today 99 per cent of maternal and newborn deaths occur in developing countries. Each year more than two million women and newborns die needlessly due to preventable causes related to pregnancy, childbirth and post-partum conditions. Millions more suffer disabilities. When a woman dies, her children are less likely to receive nutritious food and education. Saving women's lives and improving their health are key to achieving all of the MDGs.

We know what to do – it is a cost-effective investment
There is international consensus on the set of evidence-based and cost-effective solutions required to ensure that *every pregnancy is wanted, every birth is safe and every newborn is healthy.* Central to these interventions is a high quality workforce supported by a functioning health system. Midwives, as part of this workforce, provide the continuum of care needed by pregnant women and their newborns from the community to the hospital level.

Midwives and midwifery services save lives and promote health
Up to 90 per cent of maternal deaths can be prevented when midwives and personnel with midwifery skills are authorized and supported by the health system to practice their full set of competencies, including basic emergency obstetric and newborn care. In addition midwives improve the sexual and reproductive health of individuals and couples, including adolescents, by providing family planning services and counseling, and HIV prevention, including the prevention of mother-to-child transmission of HIV. According to the World Health Organization (WHO), some *334,000 midwives are needed* to fill the gaps in high-mortality countries by 2015.

A Call to Action to strengthen midwifery services
We pledge to join forces with governments, civil society, and other partners to continue supporting implementation of World Health Assembly Resolution 59.27 on Strengthening nursing and midwifery and initiating a global movement to strengthen midwifery services. This will ensure rapid progress in achieving MDG 5 and contribute to the achievement of MDGs 4 and 6 (to reduce child mortality; and combat HIV/AIDS, malaria, and other diseases). In response to the UN Secretary General's Joint Action Plan for Women's and Children's Health, we call on all governments to increase investments in midwifery services now and to make this a high priority at the UN Summit on the Millennium Development Goals in September 2010 and beyond.

We call on governments to address the following vital areas:

1. **Education and training—Provide** education and training in the essential competencies for basic midwifery practice. Build institutional capacity, including strengthened clinical training, post-graduate programs and research. Increase South-South collaboration to expand the production of midwives with evidence-based quality training.

2. **Legislation and Regulation—Strengthen** legislative and regulatory frameworks to ensure midwives have appropriate standards of practice and are regulated to practice their full set of competencies as defined by the WHO and the International Confederation of Midwives (ICM). Also, ensure immediate notification of maternal deaths.

3. **Recruitment, retention and deployment—Implement** national, costed health workforce plans and strengthen management capacities of Ministries of Health regarding training, recruitment, retention and deployment of the midwifery workforce, as per *The 2008 Kampala Declaration and Agenda for Global Action on Health Workers* and which is vital to increasing access to midwifery services for poor and marginalized women.

4. **Association—Strengthen** national professional midwifery associations to promote the profession, improve standards of care, participate in policy making at regional and national levels, and establish closer collaboration with other professional organizations, especially obstetric and pediatric societies.

Finally, we call on development partners – particularly the G8 and G20 – to provide long-term support to countries seeking to strengthen midwifery services by investing in a midwifery workforce as a fundamental step towards a functioning primary health care system that can deliver for women and newborns, fostering a healthier future for all.

Website: http://www.unfpa.org/webdav/site/global/shared/documents/events/2010/midwifery/Joint_Statement_Symposium_on_Strengthening_Midwifery_Final_04JUN2010.pdf

BOX 8 The State of the World's Midwifery report

Presenting the upcoming *State of the World's Midwifery* report

The health of women and their newborns took centre stage in global development discussions in 2010, when the United Nations Secretary-General launched the 'Global Strategy for Women's and Children's Health'. While millions of women, newborn and children still die needlessly and the closely linked Millennium Development Goal 5 (improve maternal health) and Millennium Development Goal 4 (reduce child mortality) remain the least advanced of the MDGs, progress is finally underway and the world has gathered to accelerate action and save lives.

The role of skilled birth attendants, in particular midwives and others with midwifery competencies, is widely acknowledged as being crucial to addressing maternal and newborn mortality and morbidity, and to promoting women's and children's health. In addition to evidence accumulated over time from Sweden, the United Kingdom, Australia, New Zealand, the Netherlands and France, quality midwifery is a well-documented component of success in saving the lives of women and newborns, promoting their health and spurring development in countries like Sri Lanka, Malaysia, Tunisia and Thailand.

However, recent analyses show that both midwifery personnel and services are unequally distributed – between countries as well as within countries. Hence, it is time to take stock and document the situation in countries with high maternal and newborn mortality. This will be presented in a new publication entitled ***The State of the World's Midwifery***.

The report, which will be the first of its kind, is intended to facilitate midwifery strengthening around the world. It will provide new information and data gathered from 60 countries in all regions of the world, to:

- examine the number and distribution of health professionals involved in the delivery of midwifery services;
- explore emerging issues related to education, regulation, professional associations, policies and external aid;
- analyse global issues regarding health personnel with midwifery skills, most of whom are women, and the constraints and challenges that they face in their lives and work; and
- call for accelerating investments for scaling up midwifery services, as well as "skilling up" the respective providers.

The report will include statistical tables and applicable global standards, collating relevant midwifery information into one reference document.

Behind ***The State of the World's Midwifery*** stand some of the key international partners involved in maternal and reproductive health, with a specific focus on midwifery. This initiative builds on earlier collaboration and engagement including the 'Global Call to Action' issued at the Symposium on Strengthening Midwifery in Washington DC in June 2010.

The report will be released at the Triennial Congress of the International Confederation of Midwives in Durban, South Africa, 20 June 2011. Ministers of Health gathered at the World Health Assembly in Geneva, May 2011 will be invited to attend a briefing prior to its publication and launch. The report is aimed at policy-makers and programme managers (including ministers, advisers and local champions) development partners, aid organizations and all midwifery service providers.

For further information, please contact the Coordinator, Vincent Fauveau: fauveau@unfpa.org.
For media and communication purposes, please contact Katja Iversen: iversen@unfpa.org.

Overall programme management and coordination

UNFPA manages the Midwifery Programme with inputs from ICM technical advisors. UNFPA and ICM country and regional midwife advisors provide technical assistance to governments and stakeholders. Eighteen country midwife advisors are based in **Bangladesh**, **Benin**, **Burundi**, **Burkina Faso**, **Chad**, **Côte d'Ivoire**, **Democratic Republic of the Congo**, **Djibouti**, **Ethiopia**, **Ghana**, **Haiti**, **Nepal**, **southern Sudan**, **Uganda** and **Zambia**. They are situated in the UNFPA country office or the ministry of health, and review, advise on, advocate for, and help develop national policies and programmes. They work with all relevant stakeholders linked to midwifery education, regulation and associations. The recruitment process for an advisor for northern Sudan has just been completed.

The ICM has three regional midwife advisors providing technical support for Anglophone and Francophone Africa, the Arab States and Asia. A regional advisor for Asia joined the team in 2010 and is currently operating from India. The advisors are supported and supervised by an international advisor from the ICM who also offers technical guidance and support to country offices.

At the ICM, programme management is under the direction of the ICM Secretary-General. At UNFPA, a programme coordinator based at UNFPA headquarters in New York globally coordinates and steers the Midwifery Programme with the MHTF coordinator, two senior maternal health advisors, and a monitoring and evaluation officer. UNFPA's chief of the Sexual and Reproductive Health Branch and the MHTF coordinator provide final approvals. The programme coordinator, with the ICM international midwife advisor, leads and strategically guides the team of advisors to plan and conduct activities to achieve programme goals.

In 2010, one core steering group meeting was held in **Burkina Faso** to discuss progress and challenges in staffing and communications, and outline key work plan priorities and strategies for Asia and Africa, including partnerships and participation in global and regional events in 2011. Members of the group also met during the Midwifery Symposium and at the Global Maternal Health Conference to discuss programme issues.

In addition, the ICM's international midwife advisor and UNFPA's midwifery coordinator held meetings at ICM headquarters to discuss and coordinate programmatic and communication issues. They took the opportunity to hold strategic discussions with the ICM Secretary-General on continued collaboration and future activities.

As per the terms of agreement with Sweden and the Netherlands, a progress review meeting was organized with donors. They commended the programme and encouraged discussions on possible future funding options.

The ICM programme office in Ghana locally recruited a bilingual administrative secretary (English and French) to provide secretarial and administrative support to the administrative officer. The Asia regional midwife advisor assumed her post in June to support South Asian countries.

Two newsletters were produced and widely disseminated among country offices, stakeholders and donors to inform them about progress and to share knowledge. The mid-year progress review meeting also fostered knowledge sharing, and programme coordination and harmonization.

Technical assistance and programme monitoring

The 18 country midwife advisors provide intensive technical support at the national level to assist in strengthening all aspects of midwifery (education, regulation and associations, as well as delivery of quality services). Monitoring activities are integral to the programme. They are carried out through periodic field monitoring visits by country, regional and international midwife advisors, the monitoring and evaluation advisor, a midwifery programme coordinator and the MHTF team. There is quarterly financial monitoring by ICM and UNFPA country offices. Quarterly and annual country office reports on activities and finances are assessed against approved annual work plans.

In 2010, ICM international and regional midwife advisors made field visits to eight countries for monitoring and technical assistance. Their visits offered technical assistance on starting a bachelor's degree midwifery programme in **Ghana**; celebrating the International Day of the Midwife; reviewing curricula; evaluating the Comprehensive Nursing and Midwifery Programme in **Uganda**; and documenting the history of midwifery and mentoring guidelines for young midwives. At the request of the UNFPA office in **Chad**, the ICM regional midwifery advisor worked with a team of stakeholders to support a midwifery action plan. The Asia regional midwife advisor followed up on gap analysis results with country visits to **Afghanistan**, **Bangladesh** and **Pakistan**. She participated in an H4+ mission organized in Afghanistan, and provided recommendations on midwifery education, regulation and associations. **Afghanistan** is scaling up a community midwives programme and developing midwife-led maternity care in Kabul. The UNFPA midwifery coordinator visited **Sudan** to assess the midwifery programme and made detailed recommendations regarding the prioritization of activities.

Country midwife advisors made regular programme monitoring visits to midwifery schools and associations, and held discussions with ministries of health. In **Ghana**, the advisor visited 6 out of 14 midwifery training schools in three regions (Eastern, Ashanti and Brong-Ahafo). The visits helped monitor the proper use of anatomic models for simulations, and their durability and appropriateness for teaching and learning. The models appear to have been very beneficial, as indicated by the increased percentage of students who recently passed their final exams. The community midwifery programme introduced in 2008 at southern **Sudan's** national training institute in Kajo Kechi was assessed in 2010 by the Ministry of Health with support from the Liverpool Associates in Tropical Health. A team of experts, including the international country midwife advisor, subsequently visited to follow up on the implementation of recommendations.

In 2010, a review of midwifery programme indicators began in collaboration with the ICM. These should be revised in 2011 based on lessons learned in the first two years of programme, to more effectively guide monitoring and capture results.

Key challenges and lessons learned

While the Midwifery Programme has gained visibility through its achievements, many challenges remain. Beyond those noted earlier in this chapter, these include:

- A lack of political will and understanding of the advantages of investing in midwives;
- Weak implementation and coordination capacity of the ministries of health in several countries;
- A limited number of qualified staff and low staff motivation, combined with high rates of attrition among experienced staff;
- Delays in recruitment of midwifery advisors in critical countries like Madagascar and Sudan, although most vacancies have now been filled;
- Dominance of nursing, with midwifery subsumed under nursing association/unions;
- A lack of regional midwifery associations/alliances;
- A lack of common education and regulation standards;
- Poor coordination and lack of synergies among international partners supporting midwifery— a multitude of NGOs, donors and stakeholders carry out many piecemeal activities without systematic coordination;
- Global standards and a global midwifery services framework, urgently needed by countries, are still in the process of being finalized by the ICM and WHO; and
- Scarcity of material, human and financial resources, and presence of competing priorities.

Some key lessons learned entail the need to:

- Foster a supportive policy environment, including through global, regional and national advocacy around the recognition and promotion of midwifery;
- Further advocate for stronger national ownership;
- Integrate and mainstream the Midwifery Programme under the MHTF into existing national programmes and UNFPA-led initiatives on comprehensive sexual and reproductive health, family planning, HIV, prevention of mother-to-child transmission of HIV, gender-based violence, female genital cutting, and adolescent sexual and reproductive health to achieve maximum synergies and sustainability;
- Provide technical assistance to country midwife advisors in strengthening pre-service systems through their annual work plans;
- Use and apply the data emerging from the ongoing emergency obstetric and newborn care needs assessments for work prioritization;
- Establish regional and international networks for regional standardization of midwifery curricula through recognized nursing and midwifery networks, and according to ICM/WHO essential midwifery competencies;
- Strengthen in-service training for improving clinical and basic emergency obstetric and newborn care capacities of midwives and pre-service clinical practice;
- Establish mentoring programmes for improving the skills of student midwives;
- Advocate for higher education for midwifery in countries without diploma or degree programmes;
- Support country efforts to improve standards in midwifery regulation and services through policies and strategic plans;
- Identify and evaluate performance-based incentives for midwives to serve in areas where there is greatest need;
- Develop criteria for recognizing midwifery champions and deploy them to promote midwifery;
- Establish networks with relevant local and international partners involved in strengthening maternal and newborn care;
- Advocate for professional recognition of midwifery through participation in regional and international conferences;
- Initiate peer exchange/pairing/mentoring programmes among midwifery associations in selected target countries;
- Advance synergies and integration with various global and regional initiatives on sexual and reproductive health, including those of the H4+, the Campaign to Accelerate Maternal Mortality Reduction in Africa and the AU; and
- Map all midwifery initiatives at the country level, and forge partnerships to build synergies and sustainability.

Future work plan

Based on emerging needs and lessons learned, the following areas are priorities for the Midwifery Programme in 2011:

- Develop a detailed programme guidance note for all countries providing strategic directions and necessary tools to build midwifery at the country level;
- Strengthen and scale up the programme in all MHTF countries;

- Carry out advocacy initiatives, including celebration of the International Day of the Midwife and participation in the ICM Triennial Congress;
- Further strengthen global, regional and national partnerships, and enhance collaborative work with maternal, newborn and child health partners, such as Columbia University's Averting Maternal Death and Disability Program, WHO, the John Hopkins Program for International Education in Gynecology and Obstetrics, the International Federation of Gynecology and Obstetrics, UNICEF and NGOs such as Ipas;
- Build country level technical capacities in midwifery education, regulation and associations;
- Identify midwifery champions;
- Develop the capacities of national midwife advisors;
- Integrate midwifery within all elements of the sexual and reproductive health, and gender equality agendas; and
- Promote sustainability through integration in country programmes, resource mobilization at the country level, synergies with national partners, and promotion of midwifery in national human resource plans for maternal and newborn health.

Conclusions

In the year ahead, UNFPA will continue to play a major leadership role, in collaboration with the ICM, in mobilizing resources, and building synergies with global, regional and national partners. There will be strong emphasis on strengthening national technical capacities, and harmonizing education and regulation standards. Good practices will be identified and disseminated, and South-South collaboration fostered. The Midwifery Programme under the MHTF will grow to include at least 30 countries—a three-fold increase since its inception three years ago.

Selected indicators for the 22 MHTF Countries* under the Midwifery Programme in 2010

Indicator	Results in 2009-2010	Remarks
Up-to-date needs assessment/gap analysis - completed in 14 countries (out of 17 countries under the umbrella of the joint UNFPA/ICM Programme)	*Completed in:* Afghanistan, Bangladesh, Burkina Faso, Burundi, Côte d'Ivoire, Ethiopia, Ghana, Guyana, Haiti, Madagascar, Nepal, Pakistan, Uganda, Zambia	Pending in: Benin, Chad, Djibouti, Sudan, although in northern Sudan, a midwifery mapping for Blue Nile State has been completed
National midwifery curricula based on all seven essential midwifery competencies	*Developed and in use in:* Afghanistan, Burkina Faso, Cambodia, Côte d'Ivoire, Benin, Ethiopia, Ghana, Guyana, Haiti, Malawi, North Sudan, Uganda, Zambia	Developed and in use in: Afghanistan, Burkina Faso, Cambodia, Côte d'Ivoire, Benin, Ethiopia, Ghana, Guyana, Haiti, Malawi, North Sudan, Uganda, Zambia
Midwives authorized to administer all life-saving interventions (seven basic emergency obstetric and neonatal care functions)	*Effective in:* Afghanistan, Benin, Burkina Faso, Côte d'Ivoire, Djibouti, Ethiopia, Ghana, Haiti, Madagascar, Malawi	In Djibouti and Madagascar, midwives are not authorized to administer forceps delivery. In Uganda, midwives are not authorized to perform forceps delivery and vacuum extraction, but they do perform all other interventions. In Zambia, the new revised curriculum (to be implemented in 2011) provides for all seven essential competencies
Countries with a midwifery council (either stand alone or as part of a nursing council)	*Present in:* Benin, Burkina Faso, Cambodia, Ghana, Madagascar, Malawi, Uganda, Zambia	In Côte d'Ivoire and Djibouti, the establishment of an independent Midwifery Council is planned for 2011
Countries with midwifery associations	*Present in:* Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Ethiopia, Ghana, Guyana, Haiti, Madagascar, Pakistan, Nepal, Uganda, Zambia	In Uganda and Zambia, the midwifery association is part of the nursing association. Djibouti has plans for a midwifery association in 2011. In Guyana, a constitution for the new midwifery association was developed in 2010, and membership tripled from 33 in 2008 to 130 in 2010. The association in Haiti has experienced setbacks after the earthquake

** **Africa**: Benin, Burkina Faso, Burundi, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Madagascar, Malawi, Uganda, Zambia. **Arab States**: Djibouti, Sudan. **Asia-Pacific**: Afghanistan, Bangladesh, Cambodia, Lao People's Democratic Republic, Nepal, Pakistan. **Latin America and Caribbean**: Guyana, Haiti.*

CHAPTER THREE

UNFPA'S LEADERSHIP OF AND CONTRIBUTION TO THE CAMPAIGN TO END FISTULA

Fatima Adam, the recipient of a successful fistula operation, in Niamey, Niger on 16 December 2009. The fistula program in Niger is supported by the UNFPA.
Photo by Tomas van Houtryve. Niger.

"In an unequal world, the most unequal of unequals are the women and young girls with obstetric fistula."

R. F. Zacharin

Introduction

Obstetric fistula is a severe morbidity caused when a woman or girl suffers from prolonged obstructed labour, and is unable to access emergency obstetric care–notably, Caesarean section, in time. Fistula embodies the challenges that persist in reducing maternal mortality and morbidity, especially among the poorest. With timely access to skilled attendance at birth and emergency obstetric care, these injuries can be prevented. Yet, tragically, the condition affects an estimated more than 2 million women and girls in developing countries, with as many as 100,000 new cases occurring each year.

UNFPA and its partners launched the global Campaign to End Fistula in 2003 as an attempt to redress the unacceptable and neglected health, human rights and equity dimensions of obstetric fistula. While fistula is nearly unheard of in industrialized countries, it tragically persists in poorer regions. The ultimate goal of the Campaign is to make fistula as rare in developing countries as it is in the developed world.

Since the start of the Campaign, UNFPA has helped over 20,000 women and girls access fistula treatment and care. Campaign partners have supported many more. Figure 1 (below) shows the MHTF countries where UNFPA is supporting programmes to end fistula.

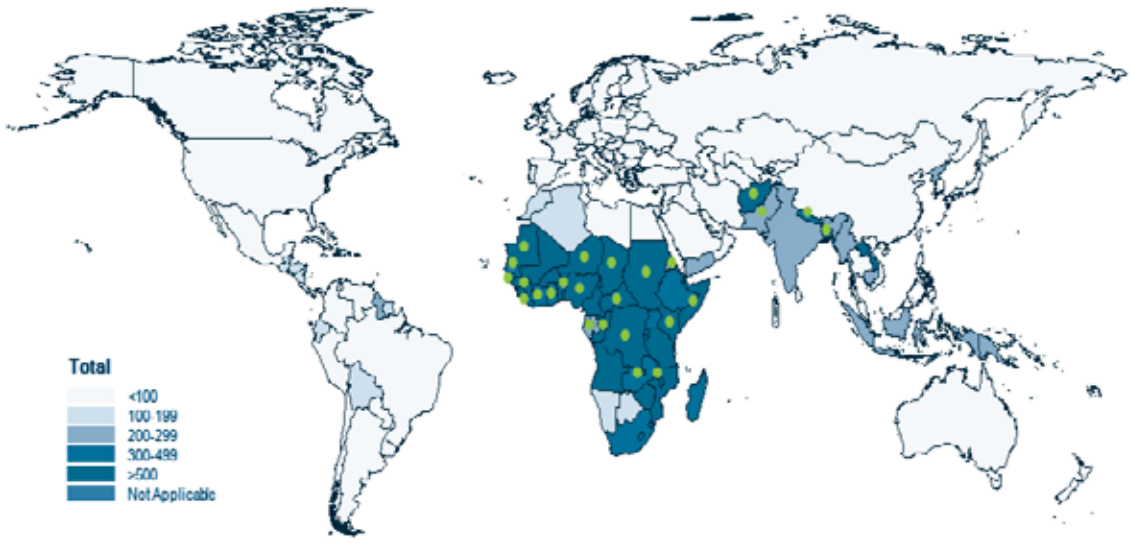

Figure 1: Geographic focus of countries where UNFPA is supporting programmes to end fistula

Note: Green dots represent countries with fistula programmes and colors represent maternal mortality ratio per 100,000 live births.

BOX 1 Campaign Partners

Addis Ababa Fistula Hospital / Hamlin Fistula International

African Medical and Research Foundation

American College of Nurse-Midwives

Babbar Ruga Fistula Hospital

Bangladesh Medical Association

Bill and Melinda Gates Institute for Population and Reproductive Health

CARE

Centers for Disease Control and Prevention

Columbia University's Averting Maternal Death and Disability Program

East, Central and Southern Africa Association of Obstetrical and Gynaecological Societies (Uganda)

EngenderHealth

Equilibres & Populations

Family Care International

Fistula Foundation

Fistula Foundation Nigeria

Geneva Foundation for Medical Education and Research

Good Works Group

Healing Hands of Joy

Health and Development International

Human Rights Watch

International Forum of Research Donors

International Confederation of Midwives

International Continence Society

International Federation of Gynecology and Obstetrics

International Urogynaecological Association

International Society of Obstetric Fistula Surgeons

International Women's Health Coalition

Johnson and Johnson

Johns Hopkins Bloomberg School of Public Health

London School of Hygiene and Tropical Medicine

Médecins Sans Frontières

Mercy Ships Sierra Leone - Aberdeen Clinic and Fistula Centre

Obstetrical and Gynecological Society of Bangladesh

'One by One' Project

Operation OF

Pan African Urology Surgeons' Association

Psychology Beyond Borders

Population Media Center and Population Institute

RPMM

Société Africaine de Gynécologie et Obstétrique

Société Internationale d'Urologie

South East Fistula Centre

Uganda Childbirth Injury Fund

United Nations Foundation

UNFPA

United Methodist Church

United States Agency for International Development

University of Aberdeen

Voluntary Service Overseas

White Ribbon Alliance

Women's Dignity Project

Women's Health Coalition

Women's Hope International

Women and Health Alliance International

WHO

Worldwide Fistula Fund

According to an independent evaluation in 2010, the Campaign has achieved strong successes in raising the visibility and knowledge of obstetric fistula worldwide. More measures to prevent fistula are needed to eliminate the problem, however. National and international capacities must grow—treatment has been an important focus of national programmes supported through international cooperation, but capacities to sustain and expand these are not yet sufficient. The evaluation recommended increased assistance by the international community and deeper national political commitment to define appropriate responses, including prevention and social reintegration measures.[1]

As home to the global secretariat of the Campaign to End Fistula, UNFPA recognizes that "it takes a village" to solve the problem. Partnerships are at the heart of the Campaign. While the present report focuses on UNFPA's role, many partners from around the world have contributed enormously to advancing the cause (see Box 1). A number of governments are engaged in national efforts to eradicate fistula. The Campaign's many donors include Canada, Iceland, Luxemburg, Norway and Spain. Additional donors comprise Johnson & Johnson for support of fistula programmes in **Cote d'Ivoire**, **Eritrea** and **Liberia**; the United Nations Human Security Trust Fund for aid to **Nigeria** and **Pakistan**; Virgin Unite for support in **Nigeria**; the Women's Missionary Society, African Methodist Episcopal Church for assistance in **Ghana**; Zonta International for support in **Liberia**; and Americas for UNFPA and the many individual donors who help fund the Campaign globally.

Mbiyavanga Helene, 27, had fistula surgery through a UNFPA supported project at the St. Joseph Hospital, in Kinshasa. Photo by Robin Hammond/Panos, DR Congo.

The Campaign to End Fistula: key strategies

Strengthening health systems: UNFPA and the Campaign aim to integrate fistula within broader sexual and reproductive health policies and programmes, and make fistula an entry point for advocating that policymakers and key stakeholders take steps to improve maternal and newborn health and survival. These efforts are guided by WHO's six building blocks for health systems: service delivery, the health workforce, health information systems, access to essential medicines, financing, and leadership and governance. Table 1 highlights UNFPA's and the Campaign's contributions to these in terms of obstetric fistula.

1 Details of the report may be found at: http://www.unfpa.org/public/cache/offonce/news/pid/5822.

Table 1: Contributions to strengthening health systems

WHO health system building blocks	Campaign to End Fistula/ UNFPA contributions related to obstetric fistula
Service delivery	• Obstetric Fistula Orientation Note for UNFPA fistula programmes developed and disseminated • Internationally standardized competency-based training manual on fistula treatment and care developed • Timely access to maternity services through community-based maternity waiting homes • Maternal death and "near miss" reviews to improve quality of maternity care • Shifting from fistula camps to ongoing, holistic fistula services integrated into strategically selected hospitals • Fistula prevention (including reoccurrence), treatment and rehabilitation services through health facilities and community-based initiatives
Health workforce	• Health workforce available to provide quality fistula repair, care and management • Facilitation of skills development and knowledge sharing in collaboration with the International Society of Obstetric Fistula Surgeons, the International Federation of Gynecology and Obstetrics, and the ICM • Prevention of fistula through quality skilled birth attendance and emergency obstetric care in partnership with UNFPA's Midwifery Programme
Health information systems	• Inclusion of obstetric fistula in DHS, the Multiple Indicator Cluster Survey (MICS) and other household surveys • Inclusion of obstetric fistula in national health information systems • Development of the Obstetric Fistula Compendium of Indicators • Development and dissemination of tools for data collection and analysis at facility level • Operational research to guide obstetric fistula programmes
Access to essential medicines	• Quality essential medical and surgical equipment and supplies available • Refurbishment of health facilities and fistula treatment centres • Access to essential reproductive health commodities such as family planning methods and key life-saving drugs, equipment and supplies through UNFPA's Global Programme on Reproductive Health Commodity Security
Financing	• Costing of fistula plans as part of reproductive health plans • Policies to reduce financial barriers for access to fistula prevention, repairs, post-treatment social reintegration, follow-up, and elective Caesarean sections for subsequent pregnancies among fistula survivors • Innovative financing mechanisms for access to quality maternal/newborn health services (including transportation)
Leadership and governance	• Advocacy, awareness-raising and resource mobilization • National Task Forces for fistula (under and in collaboration with maternal and newborn health task forces) • Collaboration with governments to integrate fistula into national plans • Partnerships with governments, civil society, and international and national NGOs

Addressing social determinants: Socio-cultural and gender norms, in many cases, are among the broader underlying factors that put women and girls at risk for fistula, and contribute to their chances of death and disability during pregnancy and childbirth. Without promoting gender equity and the empowerment of women and girls, nations will struggle to end such tragedies. Strategies such as preventing child marriage and pregnancy, and discouraging female genital mutilation will help alleviate some of the risk factors relating to childbirth.

In **Niger**, the government has made gender equity; access to reproductive health, including maternal health; and zero tolerance of violence against women and girls constitutional rights. Given the influence of societal, cultural and gender norms, UNFPA recognizes that it is crucial to engage community and religious leaders, men and boys in advancing women's and girls' well-being, including through the prevention of fistula. In the **Central African Republic**, advocacy efforts sensitized community and religious leaders about fistula. **Côte d'Ivoire** held sensitization workshops for religious and traditional leaders, as well as journalists and animators. **Eritrea** conducted advocacy meetings with nearly 400 policymakers, health workers and managers, and community leaders on maternal mortality and prevention of obstetric fistula. Sixteen journalists in **Liberia** learned to serve as fistula advocates by disseminating information about causes, prevention and available management services.

Contributions and results at country level

The Campaign to End Fistula is an integral part of the MHTF's strategic efforts to reduce maternal and newborn mortality and morbidity. It contributes to all seven MHTF outputs, as summarized in Chapter One of this report. The following pages detail the Campaign's achievements under each.

OUTPUT 1.

An enhanced policy, political and social environment for maternal and newborn health and sexual and reproductive health.

Indicator: National comprehensive communication and advocacy strategy developed for sexual and reproductive health.

In **Ghana**, advocacy efforts on behalf of fistula survivors paid off, resulting in a commitment from the National Health Insurance Scheme to fast-track registration of fistula clients. In **Mauritania**, UNFPA partnered with the NGO Health South to co-fund a project aimed at the secondary prevention of fistula, including by improving access to emergency obstetric care.

Community partnerships are critical in reaching out to women in need. In **Benin**, UNFPA is collaborating with three NGOs to actively identify women suffering from obstetric fistula, and refer them to services and care. A network of NGOs and organizations active in the fight to end fistula was created. **Niger's** national fistula eradication network partnered with the NGO Solidarité to conduct sensitization Campaigns, and offer care and treatment to fistula-affected women. Strengthened ties with the media and opinion makers increased mobilization around fistula-related issues in **Bangladesh**, **Burkina Faso**, **Democratic Republic of the Congo**, **Ethiopia**, **Kenya**, **Liberia**, **Niger**, **Senegal** and **Tanzania.**

Communication initiatives with fistula survivors and advocates focused on training and enhanced visibility of their work. At Women Deliver II in Washington, D.C., UNFPA convened a panel of reproductive health advocates, two of whom were fistula survivors: Ms. Sarah Omega from **Kenya**, and Ms. Awatif Altayib from **Sudan.** Prior to the panel, all advocates participated in communication training, which helped prepare them to speak in public and effectively respond to media queries. Their testimonies touched participants deeply and led to moving reports by journalists who attended.

Ms. Omega and Ms. Altayib had the opportunity to meet high-level authorities, including Her Royal Highness Crown Princess Mary of Denmark, and briefed members of the U.S. Congress on fistula. Ms. Omega also participated in advocacy to encourage U.S. funding and support for maternal health and MDG 5. Throughout

the year, she responded to interview requests by the media and donors, contributed to specialized blogs and participated in a UNFPA video production.

A number of countries have used film to sensitize their populations about fistula. **Madagascar** produced a film to document good practices related to eradicating fistula. In **Niger**, UNFPA, with the NGO Health and Development International and Cinema Numérique Ambulant, funded sensitization sessions including airing a film on fistula in several local languages. Showings were followed by debates about the causes and consequences of fistula. Opinion leaders and health workers participated in the sessions, which reached several thousand people.

BOX 2 Ambassadors of Hope

Ms. Sarah Omega, one of the Kenyan "Ambassadors of Hope"—a UNFPA-sponsored initiative aimed at sensitizing communities about the challenges faced by women living with fistula—has always been an example of hope and strength. Her continuous advocacy work has led her to travel around the globe to participate in international conferences, UN high-level meetings and political briefings to fight for better health conditions and the empowerment of women, both key elements to help make fistula a problem of the past.

In 2010, she raised her voice again. During Women Deliver II, Ms. Omega told her story to hundreds of people—a story of suffering and courage that brought tears to the eyes of those who were able to hear her testimony.

Ms. Omega's collaboration was central to a successful effort to document the work against fistula in Kenya. With her support and in partnership with media and technical teams from Africa and New York, a film crew chronicled fistula survivors' community life, prevention initiatives, the work in health care facilities and social reintegration after surgery. The images from Kenya have been used for media outreach and will be edited for larger distribution in 2011.

Niger used community radio to spread messages about fistula, as did **Guinea-Bissau**, which also produced and distributed leaflets and flyers. UNFPA in **Mali** conducted detailed training and orientation sessions with the media, which resulted in increased coverage of UNFPA's work, including on fistula. Community dialogues spread commitments to reducing maternal mortality. Through Health Surveillance Assistants, communities learn of the causes of fistula, how to prevent it and where they can access treatment. In **Mauritania**, UNFPA sensitized the Parliamentary Group on Population and Development on reproductive health issues, including obstetric fistula and reproductive health commodity security. **Sierra Leone** also received UNFPA support to develop a national communication strategy to promote reproductive health—including obstetric fistula services. In **Zambia**, the Ministry of Health produced two documentaries on fistula during two treatment camps. These were aired on television and used for advocacy during a parliamentarians' workshop, and orientation trainings for midwives and nurses.

Sudan achieved a high level of media coverage of fistula, with journalists intensively reporting about the Campaign, and interviews with health officials airing on radio and TV, and appearing in newspapers. In **Timor-Leste**, high-level advocacy meetings were held with key policy and decision-makers at Dili National Hospital. A community awareness programme was launched in selected districts, and information, education and communication materials were distributed to community members and service providers. In **Yemen**, as part of a national safe motherhood Campaign, television and radio spots on fistula prevention were produced and information materials disseminated. Sensitization workshops took place for different hospitals in four governorates.

BOX 3 Transforming survivors into champions

Fistula survivors can play a valuable role in reaching out to their communities to help prevent and treat fistula, thereby saving other women and girls from suffering the same fate. There is no more powerful voice to speak about fistula than that of a recovered fistula survivor.

Campaign countries are implementing innovative approaches to involve fistula survivors as community educators, mobilizers, advocates or champions. In **Ghana**, women and girls treated for fistula were trained in advocacy, communication and counselling skills, and subsequently sent out to sensitize and educate their peers about the causes, prevention and treatment of fistula. Nineteen survivors galvanized support for reducing fistula in their communities and spread words of hope. UNFPA worked with the advocates on joint work plans establishing clear lines for referrals for fistula patients, and clinic days for fistula at each of the repair centres.

In **Guinea**, women treated for fistula were trained in behavior change communication techniques and function as peer educators. They help break myths and taboos surrounding fistula, and teach their communities about possibilities for treatment.

OUTPUT 2.

Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health (midwifery), emergency obstetric and newborn care, and obstetric fistula.

Indicator: Up-to-date needs assessments for maternal and newborn health as part of the national health plan, which includes emergency obstetric and newborn care, family planning, midwifery and obstetric fistula services.

Since the beginning of the Campaign, twenty-nine countries have conducted needs assessments related to obstetric fistula. UNFPA and other Campaign partners, such as EngenderHealth, have supported these assessments. EngenderHealth has developed a standardized fistula needs assessment tool to aid in carrying out assessments, and to permit standardized data collection and comparable indicators across countries.

OUTPUT 3.

National health plans focusing on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages between reproductive health and HIV to achieve the health MDGs.

Indicator: Existence of national development plan for sexual and reproductive health package (including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care).

National leadership and ownership drive the fight to end fistula, including through the integration of actions to prevent and treat obstetric fistula into national policies and plans. Many Campaign countries have made progress in this area, with over half having included fistula in national sexual and reproductive health policies or plans. Additional countries are revising their existing sexual and reproductive health policies to ensure full integration.

Highlights

In **Sierra Leone**, the Ministry of Health and Sanitation, with support from UNFPA, developed a five-year strategic plan for obstetric fistula prevention, treatment and social reintegration. In **Guinea**, to better

coordinate and implement interventions for fistula-affected women, stakeholders adopted a national framework, and advocacy efforts are underway to develop a national strategic plan.

In **Sudan**, UNFPA assisted the Abbo Fistula Management Center in Khartoum to develop a national protocol for fistula management. **Mozambique** created a draft Strategy and National Plan for Screening and Treatment of Obstetric Fistula that went to a technical group for review. In **Uganda**, UNFPA supported the Ministry of Health to develop an obstetric fistula strategy to guide prevention, treatment and rehabilitation of fistula patients. Key partners came together in **Chad** to validate guidelines for the clinical management of women living with fistula, and to harmonize therapeutic norms and procedures for care. In **Timor-Leste**, the basic emergency obstetric care training for midwives was modified slightly to emphasize obstetric fistula as a result of obstructed labour, linking this to existing teachings on using the partograph for prolonged labour.

Several countries have created National Task Forces for fistula prevention, treatment and reintegration that facilitate coordinated planning and interaction between partners working on fistula. National Task Forces for fistula should ideally comprise the Ministry of Health, international and national NGOs, civil society organizations, social support NGOs, Ministries of Women's Affairs and Family Health, medical providers and UN agencies. **Malawi** has a national taskforce that meets regularly to assess progress in addressing fistula management, and support to repair centres to identify challenges and mentor people on the ground. A programme officer within the Ministry of Health focuses specifically on fistula. In **Kenya**, UNFPA is helping the newly established National Task Force for fistula to implement the national strategy for obstetric fistula advocacy, prevention, treatment and rehabilitation. In **Mozambique**, UNFPA has successfully worked with the government to raise obstetric fistula to a priority level within the Ministry of Health.

In the **Republic of Congo**, the Government officially launched a national campaign to eradicate fistula. **Malawi's** First Lady was named the National Coordinator for Safe Motherhood activities, and launched her Safe Motherhood foundation to mobilize resources from the private sector. She pledged to sustain the Campaign to End Fistula when she closed the UNFPA fistula repair camp in the country in November 2010.

The Campaign on Accelerated Reduction of Maternal Mortality in Africa, launched in 2010 in the Republic of the Congo, attests to the commitment to improve maternal health in the country, including the extension of the fistula programme and other measures. Photo by UNFPA, Republic of the Congo.

OUTPUT 4.

National responses to the human resource crisis in maternal and neonatal health, with a focus on planning, and increasing the number of midwifery and other mid-level services.

Indicator: Number of doctors trained on surgical obstetric fistula repair, and number of health personnel trained on the management of fistula.

The Campaign assisted countries to develop personnel and facilities for quality services. In 2010, UNFPA provided equipment, supplies and renovation services to health facilities, and facilitated the training of health-care personnel in fistula prevention and management in a number of countries (see Table 2).

Some countries, such as the **United Republic of Tanzania**, have established a national association of fistula surgeons. The Association of Obstetric Fistula Surgeons in Tanzania was registered in 2010. Its executive committee members include the Ministry of Health and Social Welfare-Safe Motherhood Initiative, the African Medical and Research Foundation, Women's Dignity, Comprehensive Community Based Rehabilitation in Tanzania, Muhimbili (National Referral Hospital), representatives from district hospitals and UNFPA.

One year into the recovery efforts in Haiti, UNFPA has remained committed to raising awareness about obstetric fistula and improving national capacities through South-South collaboration. Photo by UNFPA, Haiti.

Numerous initiatives helped countries exchange ideas, share experiences and learn from each other through South-South cooperation. **Ghana** and **Nigeria** hosted a team from the Ministry of Health of **Eritrea** and the National Union of Eritrean Women, which learned about rehabilitation. A surgical team from **Zambia** conducted a field visit to Hamlin Fistula Hospital in **Ethiopia** to hear about their fistula model, including the integration of services and coordination of satellite sites. Surgeons from **Ethiopia** trained obstetricians and midwives from Juba and Wau teaching hospitals in southern **Sudan** on fistula repair and management. The Ministry of Health in southern **Sudan** began discussions with Addis Ababa Fistula Hospital in Ethiopia for support and training in fistula repair. UNFPA's **Sudan** country office hosted a **Yemeni** team of health professionals, led by the Ministry of Health. It facilitated field visits to the Abbo Fistula Center in Khartoum and to social rehabilitation/reintegration centres, as well as meetings with key national partners. Two fistula experts from **Bangladesh** visited **Timor-Leste** to treat women suffering from fistula. And **Niger** welcomed a team of doctors and surgeons from **Haiti**, who were trained by Dr. Sanda Ganda in treating complex cases. Thirty-nine patients were operated on during the course of the training.

Table 2: Number of trained doctors and health providers by country (2010)

Country	Number of doctors trained in fistula repair	Number of health professionals trained in fistula management
Afghanistan	13	30
Bangladesh	39	25
Benin	15	10
Burkina Faso	0	0
Burundi	3	10
Cameroon	12	22
Central African Republic	8	17
Chad	—	—
Côte d'Ivoire	17	130
Democratic Republic of the Congo	51	26
Djibouti	1	1
Eritrea	3	18
Ethiopia	15	30
Ghana	—	8
Guinea	10	52
Guinea Bissau	8	35
Haiti	2	2
Kenya	96	264
Lao People's Democratic Republic	—	—
Liberia	6	174
Madagascar	—	5
Malawi	2	32
Mali	3	13
Mauritania	12	130
Mozambique	—	44
Nepal	5	12
Niger	16	21
Nigeria	40	40
Pakistan	3	15
Republic of Congo	3	3
Rwanda	—	—
Senegal	6	30
Sierra Leone	1	20
Somalia	2	20
Sudan (southern)	2	2 teams
Sudan (northern)	2	40
Timor-Leste	—	—
Uganda	7	26
Yemen	2	64
Zambia	2	78

Fistula patients receive personal hygiene kits, blankets, plastic mats and mosquito nets at the Elfasher Fistula Center. Photo by UNFPA, Sudan.

OUTPUT 5.

National equity-driven scale up of family planning and emergency obstetric and newborn care services, maternal and newborn health commodity security, and obstetric fistula services.

Indicators:

- Number and proportion of functioning referral centres for fistula treatment;
- Number and proportion of treatment facilities that offer social reintegration services;
- Number of women surgically treated for obstetric fistula per year; and
- Number and proportion of women treated for obstetric fistula who have been offered social reintegration.

In 2010, UNFPA helped more than 5,000 women and girls in 36 countries receive treatment for fistula. It supported improved services, and surgeon and health worker training, and provided medical supplies and equipment. A number of countries have successfully increased their overall capacity to treat fistula. Table 3 highlights results in 2010 in all countries, while Figure 2 illustrates progress over time in selected countries with established fistula treatment programmes. While increases in services are encouraging, the number of yet-to-be-treated women and girls remains enormous, underscoring the urgent need to further scale up effective prevention, care and treatment services.

Many countries are expanding the availability of services by increasing and decentralizing treatment and referral facilities. In **Malawi**, obstetric fistula repair services are now being offered at 13 hospitals throughout the country. The **Central African Republic** expanded access to treatment by creating three new fistula repair centres, and **Sudan** inaugurated two new fistula management satellite sites. **Côte d'Ivoire** identified and evaluated places to rehabilitate, with a view to extending fistula prevention and care services in the future.

In **Yemen**, a fistula unit was established at a hospital in Sana'a, and medical equipment procured for its functioning. Two medical teams were trained at Abbo Fistula Center in Khartoum, and 60 midwives from three governorates learned to manage and prevent fistula. A national expert was also recruited to ensure that fistula management and prevention are well reflected in updated emergency obstetric care management protocols for doctors and midwives. In an effort to ensure services are accessible to those in need, a letter of understanding was signed with the Ministry of Public Health and Population, Al-Thawra Hospital and UNFPA to ensure free services for fistula patients.

Table 3: Numbers of fistula treatment centres and women and girls treated for fistula by country, 2010

Country	Number of functioning treatment centres	Number of women treated
Afghanistan	1	49
Bangladesh	10	369
Benin	4	120
Burkina Faso	7	238
Burundi	2	2,550*
Cameroon	4	150
Central African Republic	1	104
Chad	6	38
Côte d'Ivoire	5	242
Democratic Republic of the Congo	28	567*
Djibouti	1	—
Eritrea	2	127
Ethiopia	4	1,400*
Ghana	9	79
Guinea	5	62
Guinea Bissau	2	73
Haiti	1	20
Kenya	13	190
Lao People's Democratic Republic	—	1
Liberia	13	191
Madagascar	6	100
Malawi	3	300
Mali	4	1,833*
Mauritania	3	50
Mozambique	4	179
Nepal	3	25
Niger	6	301
Nigeria	14	120
Pakistan	14	462
Republic of Congo	2	38
Rwanda	7	—
Senegal	7	73
Sierra Leone	2	270
Somalia	2	120
Sudan (southern)	1	66
Sudan (northern)	2	400
Timor-Leste	1	6
Uganda	12	1,479*
Yemen	1	2
Zambia	5	378

** Conducted through partners in the country.*

Figure 2: Increase in number of women and girls treated for fistula in selected countries from 2009 to 2010

Social reintegration: Surgical repair and medical care and treatment are not the end of the road on the journey to healing for a fistula survivor. Psychosocial and socioeconomic support are equally crucial. While more evidence and consensus are required regarding what constitutes successful rehabilitation and reintegration, many countries are beginning to attempt such interventions.

In **Burkina Faso**, 53 surgically repaired women were assisted to start income-generating activities. In the **Central African Republic**, women received support in managing micro-projects and were aided in integrating into women's community cooperatives and associations. In **Chad**, 38 fistula survivors benefited from similar interventions, and in the **Republic of Congo**, 28 women received support for socioeconomic reinsertion, representing an intensification of the Campaign in 2010.

In **Eritrea**, a needs assessment for fistula survivors was carried out as the basis of future rehabilitation and reintegration services. In **Ghana**, health and social workers were trained to incorporate reintegration into national programmes, with community involvement. Nineteen surgically repaired women learned skills of their choice to regain dignity and economic empowerment. **Ghana** included fistula survivors in the Livelihood Empowerment Against Poverty Programme.

In **Guinea**, 29 women learned soap-making through a partnership with a local NGO supported by UNFPA. The **Liberia** fistula project provides life skills training for income generation, adult literacy and business management, with specific training in tailoring, soap-making, tie-and-dye, cosmetology and pastry-making. It also provides post-training starter kits. Regular monitoring visits are conducted to follow up on the welfare of rehabilitated and reintegrated survivors. **Madagascar** has an integrated package for fistula repairs and social reintegration for all 100 fistula survivors during 2010. In **Niger**, UNFPA assisted 185 women in reintegrating into their communities by offering health education, training in income-generating activities and small loans. In **Sierra Leone**, UNFPA worked with community-based organizations and Aberdeen Women's Center to sensitize, identify, treat and help reintegrate women. In **Zambia**, 10 former fistula patients identified as fistula ambassadors counseled clients waiting for repair surgery and educate them about family planning.

As shown in Table 4, some countries are beginning to collect data on the number of facilities that offer social reintegration services, and the number of women and girls who receive these. More countries are recognizing the importance of partnering with NGOs and civil society organizations to ensure that women and girls treated for fistula are linked with much-needed social support services.

However there is a long way to go in ensuring that all fistula survivors access essential services to rebuild their lives and escape the cycle of poverty and marginalization that likely contributed to their fistula in the first place. A number of countries have not yet begun such reintegration initiatives, and many woman and girls are "lost to follow up" after their treatment. Countries need to strengthen monitoring and evaluation to track women and girls following treatment, so that they do not fall back into poverty and sickness.

Women at the UNFPA Fistula Rehabilitation Centre in Liberia learn skills to enable them to be financially independent when they return home from the hospital. [2] Photo by Marcus Bleasdale/VII Photo. Liberia.

Table 4: Social reintegration services by country, 2010

Country	Number of women who received social reintegration services	Number of facilities offering social reintegration services
Afghanistan	0	0
Bangladesh	85	1
Benin	27	0
Burkina Faso	53	1
Burundi	0	0
Cameroon	89	0
Central African Republic	104	0
Chad	38	1
Côte d'Ivoire	47	3
Democratic Republic of the Congo	56	2
Djibouti	0	0
Eritrea	0	0

(continued)

2 To read feature stories about the social reintegration of fistula survivors in Liberia and the Democratic Republic of the Congo, go to www.endfistula.org. To see a slide show from Liberia, see www.unfpa.org/public/home/news/pid/7251.

(continued)

Table 4: Social reintegration services by country, 2010

Country	Number of women who received social reintegration services	Number of facilities offering social reintegration services
Ethiopia	140	2
Ghana	19	0
Guinea	29	—
Guinea Bissau	47	—
Haiti	0	1
Kenya	150	3
Lao People's Democratic Republic	—	—
Liberia	44	1
Madagascar	100	6
Malawi	97	1
Mali	677	3
Mauritania	20	2
Mozambique	0	0
Nepal	0	0
Niger	185	5
Nigeria	—	10
Pakistan	—	1
Republic of Congo	21	2
Rwanda	—	7
Senegal	11	2
Sierra Leone	270	2
Somalia	120	2
Sudan (southern)	0	0
Sudan (northern)	—	1
Timor-Leste	5	—
Uganda	813	3
Yemen	—	—
Zambia	0	0

OUTPUT 6.

Monitoring and results-based management of national maternal and newborn health efforts.

Indicator: Monitoring, evaluations and results-based management.

Knowledge generation: To help fill the severe gap in data on the recovery of fistula survivors, Johns Hopkins University, in collaboration with WHO and UNFPA, is conducting a three-year multi-country study to examine post-operative prognosis, improvements in quality of life, social reintegration and rehabilitation of fistula patients after surgical treatment. The study is addressing existing research gaps in linking surgical prognosis and treatment to obstetric fistula patients' long-term health and psychosocial outcomes following surgery. A secondary objective is to use data for developing a prognostic-based classification system for obstetric fistula. In 2010, the study was launched in **Bangladesh**.

Data and research: A number of countries are conducting research to better understand the burden and needs of women and girls suffering from fistula. In **Benin**, a medical student is carrying out a study to assess the psychological aspects of obstetric fistula. Benin also completed data collection for its emergency obstetric and neonatal care assessment and began analysis. To evaluate the quality of obstetric care, draw lessons learned and identify opportunities for improvement, "near miss" audits were conducted on a small sample of women experiencing obstetric fistula. The **Central African Republic** carried out a needs assessment of women who had undergone fistula repair. It is developing tools to follow up with survivors benefiting from reintegration support and to collect lessons learned, as well as to estimate the level of reintegration, identify those still in need of further support, and promote family planning.

In **Eritrea**, a needs assessment of obstetric fistula patients will form the basis for developing rehabilitation and reintegration interventions. An obstetrician/gynecologist resident is researching the health conditions of women who have undergone fistula repair, including the management of complications using an appropriate and locally available diet. In **Guinea-Bissau**, a database for fistula was created and an obstetric fistula module integrated into the MICS. Findings of a fistula study in **Rwanda** were disseminated, causing medical directors of hospitals to commit to raising awareness for prevention and implementing activities from the national fistula plan. In **Nepal**, data on 350 women who had undergone surgery at Patan Hospital is being analysed.

In **Niger**, UNFPA supported a scientific meeting of technical experts working on medical and surgical treatment and care of fistula-affected women and girls. Niger's national network to eradicate obstetric fistula organized the meeting; it collaborates with UNFPA and partners to carry out all fistula-related activities in the country. In **Benin**, the UNFPA country office provided assistance to an international workshop on prevention and early treatment of obstetric fistula in West and Central Africa.

OUTPUT 7.

Leveraging of additional resources for MDG 5 from governments and donors.

Indicator: Leveraging of additional resources for fistula from governments and donors

Using fistula as an entry point to advocate for support and action on broader sexual and reproductive health issues can be an effective way to leverage resources. Such a strategy was implemented in some countries, including **Ghana**, through the Livelihood Empowerment Against Poverty Programme, and **Sierra Leone**, through the launch of the Campaign to Accelerate Maternal Mortality Reduction in Africa.

Countries are increasingly developing and implementing innovative approaches to caring for fistula survivors. Selected examples are highlighted in Table 5.

Table 5: Country examples of innovative approaches to fistula programming

Country	Project	Description
Ghana	The Livelihood Empowerment Against Poverty Programme reaches out to help obstetric fistula survivors reintegrate into their communities and escape the cycle of poverty	This social cash transfer programme provides cash and health insurance to extremely poor households to alleviate short-term poverty and encourage long-term human capital development. It began in 2008, and ensures that beneficiaries have free health insurance through the National Health Insurance Scheme. They are also given regular monetary incentives. Fistula survivors were included following advocacy meetings with the Department of Social Welfare initiated by UNFPA and its partners. They have access to free treatment and care at designated fistula repair centres. This has largely released UNFPA resources, which were initially used to pay for treatment and later health insurance for fistula patients.
United Republic of Tanzania	Harnessing the power of technology to ensure that no woman or girl suffering from obstetric fistula is left behind in Tanzania	UNFPA provides technical support to national stakeholders on fistula. It established a partnership with Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Hospital in 2009 for referring fistula patients via Vodacom's M-PESA mobile-to-mobile banking technology. In 2010, CCBRT began using M-PESA to send money for transport to women suffering with fistula, increasing the number of women accessing fistula surgery by 60 percent. Between September and December 2010, when UNFPA funds were provided to support surgical repairs, 92 women living with fistula were transported to CCBRT for treatment, and 108 women with fistula received life-changing surgery.

Contributions and results at regional and global level

Advocacy

In October 2010, the U.N. Secretary-General's Report "Supporting Efforts to End Obstetric Fistula" was released. It called for increased support for cost-effective interventions to address fistula. It stated that considerable progress has been achieved, and highlighted the links between fistula and poverty, income inequalities, gender disparities, discrimination and poor education. The report called for intensified action to put an end to this health and human rights tragedy. Subsequently, the UN General Assembly adopted the resolution "Supporting Efforts to End Obstetric Fistula." With 172 countries backing it, the resolution called for renewed focus on obstetric fistula through specific programmes and additional resources.

The Campaign to End Fistula was one of the few initiatives featured in MDG Good Practices, a 2010 publication by the United Nations Development Group. The publication emphasized the innovative and comprehensive approach of the Campaign, which combines programmatic, technical, and advocacy and communication interventions.

The work in partnership with Virgin Unite and Campaign ambassador and spokesperson Ms. Natalie Imbruglia continued in 2010, when she had the opportunity to raise awareness and funds for maternal health and obstetric fistula by running the Virgin London Marathon in April. She also continued raising funds to fight fistula in developing countries.

Throughout 2010, the Campaign assisted leading officials to highlight obstetric fistula in speeches and presentations, including the U.S. Secretary of State, Ms. Hillary Clinton; the U.S. Permanent Representative to the United Nations, Ambassador Susan E. Rice; UN Secretary-General Ban Ki-moon and UN Deputy Secretary-General Dr. Asha-Rose Migiro. Ms. Clinton mentioned fistula survivors and advocates such as Caroline Ditina, from the Democratic Republic of the Congo, in her speech marking the 15th anniversary of the International Conference on Population and Development.

UNFPA Goodwill Ambassadors Yuko Arimori, Catarina Furtado and Goedele Liekens, and UNFPA Patron Her Royal Highness Crown Princess Mary of Denmark (photo by Christine Ong, UNFPA) raised their voices in 2010 to end fistula. Photos by UN and Campaign to End Fistula archives.

2010 was a particularly rich year in terms of content made available to a larger audience through institutional platforms and the media. In conjunction with increased media attention to reproductive health issues in general, there was greater coverage of fistula. Special inputs were also provided for media outreach during key events—including the MDG Summit, the UN Commission for Population and Development meeting and the AU Summit—and for donor-related communication.

Technical assistance and knowledge sharing

High-quality treatment and care for women and girls affected by fistula is one of the highest priorities for the Campaign. An integral component is to support and expand the numbers of well-trained, competent and highly qualified medical personnel available to deliver such care. The International Society of Obstetric Fistula Surgeons, founded in 2007, promotes knowledge sharing, professional development and quality assurance among fistula surgeons and other health care providers. It has a defining role in producing the International Federation of Gynecology and Obstetrics-led Competency-Based Training Manual for fistula surgeons.

UNFPA supported over 60 people, including fistula surgeons, from more than 20 countries to participate in the society's third conference in 2010 in Senegal. It brought together a large number of fistula surgeons as well as other fistula health care professionals and organizations to share their experiences in fistula prevention, management, training and research, and to develop partnerships to stop fistula.

Partnership

Now comprising almost 100 members from more than 50 global and regional partner agencies, the International Obstetric Fistula Working Group, with UNFPA serving as the secretariat, is a key body promoting effective, collaborative partnerships to address all aspects of fistula. This global coordination mechanism facilitates partner dialogue and joint projects, with five sub-working groups on prevention and conservative management; advocacy and partnerships; treatment and training; data, indicators and research; and social reintegration.

In December 2010, before the International Society of Obstetric Fistula Surgeons conference, the working group held its annual meeting in Senegal to foster participation from French-speaking countries, and to facilitate working relationships with the international society. Nine new partner organizations

joined the meeting: the Bangladesh Medical Association, Fistula Foundation Nigeria, Health and Development International, Human Rights Watch, Médecins Sans Frontières (Belgium), Obstetrical and Gynecological Society of Bangladesh, the Uganda Childbirth Injury Fund, Women and Health Alliance International, and Women's Hope International. While there was a strong presence of medical and surgical organizations, participants recognized the urgent need for engaging with more advocacy and social reintegration partners in the future. This includes human rights groups, as it was the recognition of fistula as a neglected medical and human rights issue that initially gave rise to the global Campaign.

Findings of the mid-term evaluation and the new three-year vision for the Campaign were shared with working group members. Updates on fistula activities included a session led by EngenderHealth on current fistula research, and the formulation of a list of research recommendations to overcome research gaps and strengthen the evidence base on fistula. The meeting agreed that future actions should include a comprehensive mapping exercise of all fistula centres, experts and actors on a global scale, with much greater emphasis on data, quality and results. The role of the five sub-working groups will be pivotal in this process.

More than 20 journalists from national, regional and international media attended a press conference with fistula experts at the meeting, and followed the stories of fistula survivors as they underwent treatment and returned to their communities. Their reporting helped raise awareness about the importance of expanding treatment.

Lessons learned

- Strong government commitment and involvement are key to success, promoting ownership and sustainability.
- Integrating fistula care into routine hospital care with trained personnel increases the number of patients treated and is a potentially more holistic approach.
- Harmonization and standardization of techniques and procedures for fistula treatment promotes effective care.
- Information sharing at health facilities accredited to repair fistula leads to increased opportunities and access for repairing complex cases.
- Training health care workers, including in primary care, in fistula management can improve the quality of services at all levels.
- A continuum of care model is important in developing fistula programming and services.
- Community involvement in fistula programming fosters increased ownership at the local level.
- Community involvement through NGOs helps reduce stigma and increase demand for and access to sexual and reproductive health services, including fistula treatment.
- Use of obstetric fistula advocates, such as recovered fistula patients, can galvanize support for preventing and reducing fistula, and serves as a strong entry point for advocacy on maternal and newborn health issues.
- It is important to involve NGOs in prevention, treatment and reintegration.
- Partnerships among research, training and government institutions can improve the effectiveness of project implementation.
- Media coverage can increase the use of fistula services, sensitize the public and reduce stigma.
- Training journalists, traditional birth attendants and community leaders can increase service utilization and reduce maternal deaths, complications and morbidity, including fistula.
- Sufficient funding is critical.

- Mobile phone technologies have strong potential to reach, follow up and help support women and girls living with fistula.
- Maternity waiting homes can help bridge the gap in accessing obstetric care.
- More research is necessary to support quality fistula prevention, treatment and social reintegration.

A young fistula survivor who benefited from a project that uses mobile phone technology to transfer funds and enable patients to travel to health facilities. "The fistula ambassador received the money and then he got us the bus tickets to go to the hospital." Photo by Lisa Russell, Tanzania.

Challenges

The mid-term evaluation of the Campaign to End Fistula noted its positive impacts. Significant progress has been achieved since its inception. It faces a number of important challenges, however, which it must address to move forward.

Strengthening national leadership and commitment

- Ensuring government commitment, ownership and leadership, and coordination among all partners, including by advocating with governments to establish National Task Forces on fistula;
- Supporting countries in integrating a holistic approach to obstetric fistula in their national health strategies, and developing dedicated budgets; and
- Effectively implementing national strategies and programmes to end fistula.

Expanding access to care and improving its quality

- Improving primary prevention of fistula;
- Securing substantially more human and financial resources to make quality emergency obstetric and neonatal care services available to all who need them, and to address all aspects of prevention, management and follow-up for fistula survivors;
- Managing recent fistula cases with bladder catheterization in a timely manner to promote spontaneous healing of simple fistulas;

- Preventing the recurrence of fistula during subsequent pregnancies and preserving the life of previously repaired women during their childbearing years;
- Scaling up accessible, high-quality, sustainable treatment services that are integrated into routine health services;
- Ensuring sufficient supply, distribution and retention of well-trained, skilled and competent fistula surgeons;
- Providing sufficient human resources at global, regional, national and sub-national levels;
- Standardizing fistula training and treatment;
- Ensuring continuous availability of high-quality medical and surgical supplies;
- Sensitizing communities and increasing demand for fistula services;
- Coordinating and linking institutions providing fistula care and treatment and those providing social reintegration services;
- Attending to the number of countries seeking the Campaign's assistance;
- Developing and implementing effective communication strategies;
- Preventing iatrogenic fistula caused by an inadvertent medical or obstetric practice; and
- Addressing traumatic fistula resulting from rape or sexual violence.

Team of local surgeons during a fistula repair. Photo by UNFPA, Zambia.

Tackling issues of equity and social determinants of health

- Reducing poverty that hinders women affected by fistula from paying for transport and food, and bars or delays some of them from accessing treatment;
- Improving identification and follow-up of women and girls affected by fistula;
- Helping all fistula survivors to reintegrate socioeconomically into their communities;

- Addressing the broader, underlying social determinants of maternal mortality and morbidity, including obstetric fistula;
- Integrating fistula prevention into gender, human rights and broader development policies; and
- Reaching out to and caring for women and girls living with fistula declared "inoperable."

Improving data and evidence

- Obtaining reliable, comprehensive and high-quality data on fistula; and
- Securing evidence on the impact of various components of fistula care, including those related to the social reintegration of fistula survivors, long-term survival following repair (including in subsequent pregnancies), clinical practice, fistula advocates and maternity waiting homes.

Fistula survivors Rita Soares and Orlanda Babo with Dr. Amita Pradhan Thapaa. The work of midwives is crucial to assist in the prevention and treatment of obstetric fistula.
Photo by Marcus Bleasdale, VII Photo/UNFPA, Timor Leste.

Moving forward

The mid-term evaluation was a valuable, enlightening and motivational exercise. Drawing on its findings and recommendations, UNFPA, as the leader of the Campaign to End Fistula, resolves to move forward to strengthen strategies, broaden reach and improve performance, based on lessons learned and evidence-based practices. A new technical specialist and Campaign coordinator joined UNFPA in 2010, and will help accelerate efforts aimed at achieving significant and sustained progress. All of these will have one purpose: to end the needless, avoidable suffering of women, girls, families and communities affected by fistula.

Key priorities of the Campaign

Guided by the findings and recommendations of the independent evaluation, and field experiences, the Campaign will renew its efforts to advance the fight to end fistula and to improve the lives of those affected by it. The new priorities are:

- Working with National Task Forces for fistula comprising in-country partners and led by the Ministry of Health;
- Promoting a more holistic approach to care for women and girls with fistula by incorporating services into existing health structures and firmly anchoring them in sustainable maternal/newborn health programmes and policies, including by gradually scaling up training and treatment services in response to the number of existing cases, and shifting away from occasional interventions towards more permanent fistula services in selected hospitals;
- Increasing emphasis on prevention, specifically looking at bladder catheterization following obstructed labour and developing strategies for securing maternal survival in subsequent pregnancies, to ensure healthy outcomes for mothers and babies, and to prevent the development of new fistulas;
- Expanding and strengthening successful socioeconomic reintegration of fistula survivors, including through their development as advocates for fistula prevention and maternal/newborn health promotion;
- Strategizing approaches for supporting women and girls with inoperable fistula cases, or with some degree of incontinence following treatment, if they cannot or do not wish to return home;
- Reinforcing human resources at every level, including recruitment of fistula focal points in high burden countries, to enable Campaign partners to adequately meet the tremendous unmet needs of women, girls and communities affected by fistula;
- Increasing emphasis on producing high-quality data and research for monitoring and evaluating the progress and quality of programming; identifying needs, gaps, successes and lessons learned; and improving strategic decision-making and the use of resources;
- Enhancing advocacy and resource mobilization efforts at the country level, involving fistula survivors as community-based advocates for preventing maternal and newborn death and disability;
- Strengthening collaboration among both existing and new partners;
- Improving the internal information flow and communication within the Campaign and among partners;
- Enhancing external global, regional and national communication and advocacy efforts to raise further awareness, garner support and spur action;
- Helping to develop "the big picture" on current activities, needs and gaps through a global mapping exercise of organizations active on fistula, carried out with partners such as Fistula Foundation and Direct Relief International; and
- Continuing to advocate with governments to promote integration of fistula prevention, treatment and care within national health policies, strategies, and budgets.

CHAPTER FOUR

FINANCE

The work of the Maternal Health Thematic Fund is supported by two multi-donor thematic trust funds: The Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula.

Thematic Trust Fund for Maternal Health

Table 1 shows total contributions received during the year amounting to $22,676,243. This includes contributions from three major donors received in the fourth quarter of 2010 totaling $18,067,898, which will be allocated for 2011 programme activities.

Table 1: Total contributions received in 2010 *(in United States dollars)*

Donor	Amount
Austria	530,504
Luxembourg	1,538,462
Netherlands	2,426,470
Norway*	2,530,364
Private contributions*	112,909
Spain*	8,232,932
Sweden*	7,304,602
Total 2010	**22,676,243**

* *Contributions received in the fourth quarter of 2010*

Funding allocations from the MHTF are based on peer-reviewed and approved annual work plans and an operating budget available for the year.

Table 2 indicates the 2010 operating budget for maternal health programme activities. It consists of carry-over balances from 2009 and contributions received in 2010 (excluding contributions received in the fourth quarter). Carry-over balances include contributions received from major donors in the fourth quarter of 2009 ($295,858 from Austria, $2,425,000 from the Netherlands and $6,903,353 from Spain), which were to be used in 2010, as well as unused allocations.

Contributions received for the MHTF through the third quarter of 2010 totaled $4,495,436. Carry-over funds were $17,833,437, bringing total funds available for 2010 programming to $22,328,873 (see Table 2).

Table 2: Operating budget for 2010 *(in United States dollars)*

Donor	Amount
Carry over from 2009	17,833,437
Austria	530,504
Luxembourg	1,538,462
Netherlands	2,426,470
Total 2010	**22,328,873**

Total expenditures in 2010 were $16,609,630 (84 percent of approved allocations). Approximately thirty-three percent went to midwifery activities and 21 percent to emergency obstetric and newborn care needs assessments. Strengthening country and regional office capacities (emergency obstetric and newborn care, fistula, midwifery, etc.) absorbed 18 percent of remaining expenditures. The balance primarily went toward emergency obstetric and newborn care upgrades and scale up, family planning (community mobilization and demand generation activities), communication, and monitoring and evaluation.

Approximately 86 percent of expenditures were spent at country and regional levels (including expenses by global implementing partners/international NGOs totaling $2,962,857) and 14 percent at the global level.

Table 3: Approved allocations and expenditures for 2010 *(in United States dollars)*

Regional Offices, Country Offices, Global Technical Support, Partners	Approved allocation	Expenses	Percentage
Sub-Sahara Africa Region			
Africa Regional Office	300,000	302,048	101
Benin	862,819	870,912	101
Burkina Faso	600,000	498,496	83
Burundi*	600,000	262,895	44
Chad	400,000	432,813	108
Côte d'Ivoire	375,000	376,516	100
Ethiopia	2,000,000	1,970,716	99
Ghana*	300,000	273,043	91
Guinea	34,773	30,863	89
Liberia	400,000	356,372	89
Madagascar	500,000	499,616	100
Malawi	700,000	742,705	106
Mali*	300,000	14,117	5
Mozambique*	200,000	67,616	34
Namibia	64,200	67,395	105
Niger	150,000	127,852	85
Nigeria*	300,000	37,171	12
Rwanda*	100,000	58,691	59
Sierra Leone	200,000	185,234	93
Uganda	125,000	111,256	89
Democratic Republic of the Congo*	1,114,000	677,916	61
Zambia	100,000	101,365	101
Sub-total	**9,725,792**	**8,065,610**	**83**

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Regional Offices, Country Offices, Global Technical Support, Partners	Approved allocation	Expenses	Percentage
Arab States Region			
Djibouti*	600,000	365,886	61
Yemen*	100,000	72,379	72
Southern Sudan	400,000	376,452	94
Northern Sudan	200,000	210,260	105
Subtotal	**1,300,000**	**1,024,978**	**79**
Asia and Pacific Region			
Asia and Pacific Regional Office*	200,000	20,324	10
Bangladesh	200,000	154,066	77
Cambodia	337,419	301,558	89
Lao People's Democratic Republic	200,000	196,093	98
Nepal*	200,000	37,493	19
Sub-total	**1,137,419**	**709,534**	**62**
Latin America and Caribbean Region			
Latin America/ Caribbean Regional Office	110,000	110,256	100
Haiti	1,353,500	1,049,113	78
Guyana	400,000	406,099	102
Sub-total	**1,863,500**	**1,565,468**	**84**
Global Technical Support			
Global Technical Support, including Implementing Partners	5,416,942	5,054,647	93
Information and External Relations Division	30,000	15,063	50
Media and Communications Branch	234,790	174,330	74
Sub-total	**5,681,732**	**5,244,041**	**92**
Grand Total	**19,708,443**	**16,609,630**	**84**

** Lower than expected implementation resulted from staffing transitions, unforeseen challenges at the country level, and the addition of bilateral funding that offset the need for MHTF support.*

As UNFPA's 2010 financial closure is still in process, all financial figures in this report are provisional until actual expenditures are reflected in the certified financial report.

Thematic Fund for Obstetric Fistula

Table 4 indicates total contributions received during the year, which amounted to $1,660,851. This includes a contribution of $669,344 from Spain that was received in the fourth quarter of 2010. It will be allocated for 2011 programme activities.

Table 4: Total contributions received in 2010 *(in United States dollars)*

Donor	Amount
Americans for UNFPA*	38,132
Iceland	100,000
Canada***	167,538
Luxembourg	674,764
Private contributions***	11,073
Spain**	669,344
Total 2010	**1,660,851**

** Contributions received from individuals in the United States.*
*** Contributions received in the fourth quarter of 2010.*
**** Individuals made these private contributions directly to UNFPA.*

Funding allocations for the global Campaign to End Fistula are based on peer-reviewed and approved annual work plans and operating budgets.

Table 5 presents the Campaign's 2010 operating budget. It consists of carry-over balances from 2009 and contributions received in 2010 (excluding contributions received in the fourth quarter). Carry-over balances include contributions from major donors in the fourth quarter of 2009 ($500,000 from Korea, $1,683,431 from Norway and $3,451,677 from Spain), which were to be implemented in 2010, as well as unused allocations.

Total contributions received through the third quarter of 2010 reached $823,969. Carry-over funds amounted to $7,095,883, bringing total funds available for 2010 programming to $7,919,852.

Table 5: Operating budget for 2010 *(in United States dollars)*

Donor	Amount
Carry-over from 2009	7,095,883
Americans for UNFPA	38,132
Iceland	100,000
Luxembourg	674,764
Private contributions	11,073
Total 2010	**7,919,852**

Several private sector donors also provided earmarked funds outside of the thematic pooled funds to support fistula programmesin UNFPA country offices. Johnson & Johnson gave $160,000 ($70,000 for Côte d'Ivoire, $70,000 for Liberia and $20,000 for Eritrea), Zonta International gave $100,000 ($450,000 awarded in total over three years for Liberia), Virgin Unite gave $588,500 ($1,032,550 awarded in total over three years for Nigeria), and Women's Missionary Society–African Methodist Episcopal Church gave $25,000 (for Ghana, received in the fourth quarter of 2009 for 2010 programming).

Total expenditures in 2010 were $4,340,881 (72 percent of approved allocations), of which approximately 81 percent was spent at country and regional levels, and 19 percent at the global level.

Table 6: Approved allocations and expenditures for 2010 *(in United States dollars)*

Regional Offices, Country Offices, Global Technical Support, Partners	Approved allocation	Expenses	Percentage
Sub-Sahara Africa Region			
Africa Regional Office*	428,000	7,806	2
Benin	307,190	228,772	74
Burkina Faso	50,000	46,701	93
Burundi*	50,000	28,864	58
Cameroon	75,000	53,609	71
Central African Republic	100,000	98,915	99
Chad	125,000	129,109	103
Republic of Congo*	182,000	96,560	53
Côte d'Ivoire	200,000	173,890	87
Eritrea	125,000	103,942	83
Ghana*	100,000	36,071	36
Guinea*	100,000	67,281	67
Guinea-Bissau	75,000	74,862	100
Kenya*	150,000	157,565	105
Liberia*	200,000	119,919	60
Madagascar	175,000	165,902	95
Malawi	75,000	73,917	99
Mali	100,000	77,104	77
Mauritania	100,000	105,578	106
Niger	150,000	135,318	90
Nigeria*	208,025	10,368	5
Senegal	100,000	96,597	97
Uganda	100,000	99,508	100
Democratic Republic of the Congo	543,380	455,937	84
Zambia	100,000	90,220	90
Sub-total	**3,918,595**	**2,734,316**	**70**

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Regional Offices, Country Offices, Global Technical Support, Partners	Approved allocation	Expenses	Percentage
Arab States Region			
Yemen*	50,000	32,689	65
Somalia*	75,000	46,706	62
Southern Sudan	150,000	57,212	38
Northern Sudan	100,000	72,175	72
Sub-total	**375,000**	**208,783**	**56**
Asia and Pacific Region			
Asia and Pacific Regional Office*	100,000	37,742	38
Afghanistan	300,000	244,862	82
Bangladesh*	150,000	88,560	59
Timor-Leste	60,000	47,817	80
Nepal*	50,000	25,711	51
Pakistan*	200,000	114,916	57
Sub-total	**860,000**	**559,607**	**65**
Global Technical Support			
Global Technical Support, including Implementing Partners	672,275	660,521	98
Information and External Relations Division	162,757	177,654	109
Sub-total	**835,032**	**838,175**	**100**
Grand Total	**5,988,627**	**4,340,881**	**72**

** Lower than expected implementation resulted from staffing transitions, unforeseen challenges at the country level, and the addition of bilateral funding that offset the need for MHTF support.*

As UNFPA's 2010 financial closure is still in process, all financial figures in this report are provisional until actual expenditures are reflected in the certified financial report.

CHALLENGES AND WAYS FORWARD

Elanie Jacques holds her three day old granddaughter, born to her daughter, Katiana Bourdeaux, 18.
Photo by Lynsey Addario, VII Photo/UNFPA. Haiti.

Main Challenges

In 2010, the main challenges that the MHTF encountered related to:

- Socio-political contexts of countries with conflict, post-conflict or emergency situations (**Côte d'Ivoire**, **Haiti**, **Madagascar**, **Sierra Leone**, **and Sudan**);
- National technical and managerial capacity of countries;
- Capacities in some UNFPA country offices;
- Technical assistance modalities and operations; and
- A funding base to expand support to a greater number of priority countries.

In 2011, the MHTF will focus on the following priorities:

Policy and financing

- National commitments to MDG 5, and financial commitments contributing to the work of the UN Secretary-General's Strategy for Women and Children's Health;
- Enhanced accountability mechanisms at country level;
- Support for countries in leveraging additional resources through quality information, and evidence-based needs assessments and plans;
- Enhanced communication and media outreach to raise awareness, increase funding and spur action, particularly at the country level; and
- Expansion of the donor base for the MHTF towards better support for the priority countries of the UN Secretary-General's Strategy on Women's and Children's Health.

Service delivery

- Strengthened evidence base for national maternal and newborn health plans, and for their implementation (implementation science);
- Improved access to and uptake of basic and comprehensive emergency obstetric and newborn care, approached through equity and rights lenses, district-by-district; and
- Strengthened family planning efforts through supporting policy development and service delivery, and stimulating greater public demand.

Midwifery

- Close work with midwifery schools, midwifery trainers and governments to put in place recommended curricula for midwifery; UNFPA will also focus on expanding enrolment in midwifery schools, recruiting graduates to serve where they are most needed and motivating midwives.

Obstetric fistula

- Mainstreaming of fistula programming into national plans, better coordination of fistula interventions at country level with the establishment of national task forces for fistula, fostering of sustainable service

delivery in national hospitals, prevention of recurrence, scaling up of national workforce for fistula repairs, enhanced social reintegration, and encouragement of fistula champions and advocates for effective advocacy.

Maternal and newborn health commodities

- Strengthening of commodities procurement and supply chain management, and with GPRHCS, the resource base for life-saving commodities.

Managing for results

- Capacity strengthening of countries, and UNFPA country and regional offices;
- Work with countries to ensure real-time and mandatory notification of maternal deaths with feedback loops to officials, key decision-makers, civil society advocates and the public;
- Continued strengthening of management for results, especially through national health management information systems and monitoring, in line with national standards, H4+ guidelines and the MHTF results framework;
- Further improvements in implementation rates, particularly for fistula; and
- Expanded use of innovation, including mobile health initiatives to improve service delivery and monitoring.

Conclusion

Overall, 2010 was a successful year for maternal health, with the global community more than ever committed to aligning its efforts to secure additional financing and political commitment for women's and children's health. After this second year of full MHTF operations, key results have laid the groundwork for accelerated progress in expanding the coverage of proven, highly cost-effective interventions that will reduce maternal mortality and morbidity. With the support of donors, and in close collaboration with national governments and partners, the MHTF and UNFPA will continue striving to improve the lives of women and girls, and prevent maternal deaths and morbidities.

ANNEX:
CONSOLIDATED RESULTS FRAMEWORKS OF ALL MHTF COUNTRIES

Countries with MHTF support started in 2009 (M) and (F) indicate midwifery/fistula programming	MDG 5a and MDG 5b indicators					
	a) Maternal mortality ratio	**a)** Skilled attendance at birth, %	**b)** Adolescent birth rate (per 1,00 women)	**b)** Antenatal care coverage, % (at least one/ at least four visits)	**b)** Unmet need for family planning, %, total	**b)** Contraceptive prevalence rate, %, any method
Benin (M, F)	410	74	114	84.1/60.5	29.9	17
Burkina Faso (M, F)	560	53.5	131	85/17.6	28.8	17.4
Burundi (M, F)	970	33.6	30	92.4	29	9.1
Cambodia (M)	290	43.8	52.3	69.3/27	25.1	40
Côte d'Ivoire (M, F)	470	56.8	111.1	84.8/45.3	27.7	12.9
Djibouti (M, F)	300	60.6	27	92.3/7.1	—	17.8
Ethiopia (M, F)	470	5.7	109.1	27.6/12.2	33.8	14.7
Ghana (M, F)	350	57.1	70	90.1/78.2	35.3	23.5
Guyana (M)	270	83	90	81.4	—	34.2
Haiti (M, F)	300	26.1	68.6	84.5/53.8	37.5	32
Madagascar (M, F)	440	51.3	148	79.9/49.3	23.6	39.9
Malawi (M, F)	510	53.6	177	91.9/57.1	27.6	41
Sudan (M, F)	750	49.2	72	63.7	26	7.6
Sudan (South)	750	49.2	72	63.7	26	7.6
Uganda (M, F)	430	41.9	159	93.5/47.2	40.6	23.7
Zambia (M, F)	470	46.5	151	93.7/60.3	26.5	40.8

MHTF output 1 country indicators		MHTF output 2 country indicators	MHTF output 3 country indicators		MHTF output 4 country indicators	
National comprehensive communication and advocacy strategy developed for sexual and reproductive health	Reproductive health coordination team in place, led by the Ministry of Health, and involving UNFPA and other partners	Up-to-date needs assessments for maternal and newborn health as part of national health plan including emergency obstetric and newborn care, family planning, midwifery, and obstetric fistula services	Existence of a national development plan for essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care is costed	Midwifery included in strategic national policies/plans as being essential for maternal mortality reduction	Number of midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies
✓	—	✓	✓	✓	—	0
✓	✓	✓	✓	—	—	3 (100%)
✓	—	✓	✓	—	—	5
✓	✓	✓	✓	✓	✓	5 (100%)
✓	✓	✓	✓	✓	—	4 (100%)
✓	✓	✓	✓	—	—	1
✓	✓	✓	✓	✓	✓	23
✓	✓	✓	✓	✓	—	16 (100%)
✓	✓	✓	✓	✓	✓	3
Partial	✓	✓	—	—	✓	20
✓	✓	✓	✓	✓	✓	0
✓	✓	✓	✓	✓	—	14
✓	✓	✓	✓	✓	—	6 out of 28
—	Partial	—	—	—	—	—
—	—	—	—	—	—	4 out of 23
✓	✓	✓	✓	✓	—	10

Countries with MHTF support started in 2009 (M) and (F) indicate midwifery/fistula programming	MHTF output 4 country indicators					
	Annual number of midwifery graduates from national midwifery training institutions	Midwives authorized to administer core life-saving interventions (the 7 basic emergency obstetric and newborn care functions)	Midwives benefiting from systems for compulsory supportive supervision	Midwives benefiting from systems for continued professional education	Country has a national midwifery council or board (standalone or included in nursing)	Number of doctors trained in surgical obstetric fistula repair
Benin (M, F)	—	✓	✓	✓	✓	15
Burkina Faso (M, F)	237	✓	✓	✓	✓	0
Burundi (M, F)	20	No	—	—	✓	3
Cambodia (M)	370	Partial	Partial	Partial	✓	—
Côte d'Ivoire (M, F)	327	✓	✓	✓	—	17
Djibouti (M, F)	40	Partial	✓	✓	✓	1
Ethiopia (M, F)	3,900	✓	—	—	—	15
Ghana (M, F)	400	✓	✓	✓	✓	2
Guyana (M)	100	Partial	—	—	—	—
Haiti (M, F)	35	✓	—	—	—	2
Madagascar (M, F)	140	✓	✓	✓	✓	—
Malawi (M, F)	160	✓	—	✓	✓	2
Sudan (M, F)	1,100	Partial (village midwives)	✓	✓	—	2
Sudan (South)	—	—	—	—	—	2
Uganda (M, F)	372	✓	—	✓	✓	7
Zambia (M, F)	385	✓	✓	✓	✓	6

MHTF output 4 country indicators	MHTF output 5 country indicators				UN emergency obstetric and newborn care indicators (part of output 5 indicators)	
Number of health personnel trained in the management of fistula cases	Number of functioning treatment centres for fistula repairs	Number of treatment facilities that offer social reintegration services	Number of women surgically treated for obstetric fistula per year	Number of women treated for obstetric fistula who have been offered social reintegration	Availability of basic emergency obstetric and newborn care: national number of facilities	Availability of comprehensive emergency obstetric and newborn care: national number of facilities
10	4	0	120	27	—	—
0	7	1	53	238	—	—
10	2	0	250	0	—	—
—	—	—	—	—	20 (out of 347 assessed)	27 (out of 347 assessed)
130	5	3	242	47	—	—
1	1	0	—	0	—	—
30	4	2	1,400	140	25 (out of 797 assessed)	58 (out of 797 assessed)
4	9	—	79	30	—	—
—	—	—	—	—	5	0
2	1	1	20	0	41 (out of 61 assessed)	12
5	6	6	100	100	3 (out of 294)	19 (out of 294)
32	3	1	300	97	5 (out of 299)	42 (out of 299)
40	2	1	400	—	—	—
2 teams	1	0	66	0	—	—
26	12	3	1,479	813	—	—
158	5	0	378	0	—	—

Countries with MHTF support started in 2009 (M) and (F) indicate midwifery/fistula programming	UN emergency obstetric and newborn care indicators (part of output 5 indicators)					
	Geographic distribution: proportion of sub-national areas with the required number of emergency obstetric and newborn care facilities	Proportion of all births in emergency obstetric and newborn care facilities, %	Met need for emergency obstetric and newborn care, %	Direct obstetric case fatality rate, %	Neonatal mortality (intrapartum and very early neonatal deaths)/ 1,000 deliveries	Proportion of births with caesarean sections as a proportion of all births, %
Benin (M, F)	—	—	20	87	29	1.10
Burkina Faso (M, F)	—	—	—	—	—	—
Burundi (M, F)	—	—	—	—	—	—
Cambodia (M)	1 out of 24	11.40	12.70	0.80	1.24	1.30
Côte d'Ivoire (M, F)	—	—	—	—	—	—
Djibouti (M, F)	—	—	—	—	—	—
Ethiopia (M, F)	1 out of 11 regions	3	3	1.10	62	0.60
Ghana (M, F)	—	—	—	—	—	—
Guyana (M)	5 out of 10 regions	87	41	< 1	23	13
Haiti (M, F)	—	6.50	6	2.30	40	3.30
Madagascar (M, F)	17 (out of 111)	4.10	9.60	2.20	121	1.50
Malawi (M, F)	2 (out of 28)	22	22	2	37.1	3.60
Sudan (M, F)	—	19 (5 states)	—	—	—	5 (5 states)
Sudan (South)	—	—	—	—	—	—
Uganda (M, F)	—	—	—	—	—	—
Zambia (M, F)	—	—	—	—	—	—

MHTF output 6 country indicators				MHTF output 7 country indicators	
Internationally agreed maternal and newborn care indicators integrated in national health management information system	Mandatory notification and surveillance of maternal deaths	Routine practice of maternal death audits/reviews	Confidential enquiries system for maternal deaths in place	Share of government expenditures for health, %, as per annual government figures	National budget for maternal and newborn health overall and per capita (including all flows, domestic and external), as measured through national health accounts where they exist, %/US$
No	No	No	No	7.23 in 2008	—
✓	—	✓	—	—	—
✓	✓	—	—	4.7	—
✓	✓	—	—	—	—
—	—	—	—	—	—
✓	—	—	—	15	—
✓	—	Partial	Pilot	16	15/$12
✓	✓	—	—	—	—
✓	✓	✓	✓	—	—
Partial	✓	Partial	Partial	—	—
✓	—	—	✓	—	—
✓	✓	✓	✓	—	—
Partial	✓	✓	Maternal Death Reviews	4	1
—	—	—	—	—	—
—	—	—	—	—	—
✓	✓	—	—	—	—

Countries with MHTF support started in 2010 (M) and (F) indicate midwifery/fistula programming	MDG 5a and MDG 5b indicators					
	a) Maternal mortality ratio	**a)** Skilled attendance at birth, %	**b)** Adolescent birth rate (per 1,00 women)	**b)** Antenatal care coverage, % (at least one/ at least four visits)	**b)** Unmet need for family planning, %, total	**b)** Contraceptive prevalence rate, %, any method
Afghanistan (M, F)	1400	14.3	151	16.1	—	15.5
Bangladesh (M, F)	340	18	133	51.2/20.6	17.1	55.8
Cameroon (F)	600	63	141	82/60.4	—	29.2
Central African Republic (F)	850	53.4	132.9	69.3/39.7	16.2	19
Chad (M, F)	1200	14.4	—	—	—	—
Republic of Congo (F)	580	86.1	131.5	85.8/74.7	16.2	44.3
Democratic Republic of the Congo (F)	670	74	127	85.3/46.7	24.4	20.6
Eritrea (F)	280	28.3	85	70.3/40.9	27	8
Guinea (F)	680	46.1	153	88.4/50.3	21.2	9.1
Guinea-Bissau (F)	1000	38.8	170	77.9	—	10.3
Kenya (F)	530	41.6	103	91.5/52.3	24.5	45.5
Lao People's Democratic Republic	580	20.3	110	35.1	39.5	32.2
Liberia (F)	990	46.3	177	79.3/66	35.6	11.4
Mali (M, F)	830	49	190	70.4/35.4	31.2	8.2
Mauritania (F)	550	60.9	88	75.4/16.4	31.6	9.3
Mozambique (F)	550	55.3	185	89.1/53.1	18.4	16.5
Namibia	180	81.4	74	94.6/70.4	6.7	55.1
Nepal (M, F)	380	18.7	106.3	43.7/29.4	24.6	48
Niger (F)	820	32.9	198.9	46.4/14.9	15.8	11.2
Nigeria (F)	840	38.9	123	57.7/44.8	20.2	14.6
Pakistan (M, F)	260	38.8	20.3	60.9/28.4	24.9	27
Rwanda	540	52.1	43	95.8/23.9	37.9	36.4
Senegal (F)	410	51.9	96	87.4/39.8	31.6	11.8
Sierra Leone (M, F)	970	42.4	143	86.9/56.1	27.6	8.2
Somalia (F)	1200	33	123	26.1/6.3		14.6
Timor Leste	370	18.4	59.2	60.5/29.6	3.8	10
Yemen (F)	210	35.7	80	47/11.4	38.6	27.7

MHTF output 1 country indicators		MHTF output 2 country indicators	MHTF output 3 country indicators		MHTF output 4 country indicators	
National comprehensive communication and advocacy strategy developed for sexual and reproductive health	Reproductive health coordination team in place, led by the Ministry of Health, and involving UNFPA and other partners	Up-to-date needs assessments for maternal and newborn health as part of national health plan including emergency obstetric and newborn care, family planning, midwifery, and obstetric fistula services	Existence of a national development plan for essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care is costed	Midwifery included in strategic national policies/plans as being essential for maternal mortality reduction	Number of midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies
✓	✓	Partial (only for emergency obstetric and newborn care)	✓	✓	✓	34
✓	✓	✓	✓	✓	✓	3
No	—	✓	—	—	—	—
—	—	—	—	—	—	—
—	—	—	✓	✓	—	—
No	✓	—	✓	✓	✓	0
No	✓	✓	✓	✓	✓	6
—	—	—	✓	✓	—	—
—	—	—	—	—	—	—
—	—	—	—	—	—	—
✓	✓	✓	✓	No	✓	—
No	—	—	—	—	✓	8
—	—	✓	—	—	—	—
✓	✓	No	✓	✓	—	—
—	—	—	✓	—	✓	2
✓	—	✓	✓	✓	—	—
No	—	—	✓	✓	—	1
✓	✓	—	✓	✓	✓	—
✓	✓	✓	✓	✓	—	17
✓	✓	—	✓	✓	—	—
—	—	—	—	—	—	—
No	✓	✓	✓	✓	—	5
✓	✓	✓	✓	✓	—	100%
✓	✓	✓	✓	✓	✓	2
✓	Partial	—	—	—	—	2
—	—	—	—	—	—	—
No	✓	✓	✓	✓	✓	0

Countries with MHTF support started in 2010 (M) and (F) indicate midwifery/fistula programming	MHTF output 4 country indicators					
	Annual number of midwifery graduates from national midwifery training institutions	Midwives authorized to administer core life-saving interventions (the 7 basic emergency obstetric and newborn care functions)	Midwives benefiting from systems for compulsory supportive supervision	Midwives benefiting from systems for continued professional education	Country has a national midwifery council or board (standalone or included in nursing)	Number of doctors trained in surgical obstetric fistula repair
Afghanistan (M, F)	800	Partial	—	—	No	13
Bangladesh (M, F)	60 (in training)	No	No	—	✓	39
Cameroon (F)	—	—	—	—	✓	12
Central African Republic (F)	—	—	—	—	—	8
Chad (M, F)	—	✓	No	✓	No	—
Republic of Congo (F)	—	✓	—	—	✓	3
Democratic Republic of the Congo (F)	—	✓	—	—	✓	51
Eritrea (F)	—	—	—	—	—	3
Guinea (F)	—	—	—	—	—	10
Guinea-Bissau (F)	—	—	—	—	—	8
Kenya (F)	3,000	✓	—	✓	✓	96
Lao People's Democratic Republic	160	Partial	—	—	No	0
Liberia (F)	—	—	—	—	—	6
Mali (M, F)	—	—	✓	✓	✓	3
Mauritania (F)	50	✓	—	—	No	12
Mozambique (F)	—	—	—	—	—	—
Namibia	1,669	—	—	—	✓	—
Nepal (M, F)	—	✓	—	—	✓	5
Niger (F)	300	✓	✓	✓	No	16
Nigeria (F)	—	✓	✓	✓	✓	40
Pakistan (M, F)	—	—	—	—	—	3
Rwanda	300	✓	✓	✓	✓	—
Senegal (F)	536	✓	✓	✓	✓	6
Sierra Leone (M, F)	45	✓	—	✓	✓	1
Somalia (F)	40	✓	—	—	No	2
Timor Leste	—	—	—	—	—	—
Yemen (F)	600	✓	—	—	No	2

MHTF output 4 country indicators	MHTF output 5 country indicators				UN emergency obstetric and newborn care indicators (part of output 5 indicators)	
Number of health personnel trained in the management of fistula cases	Number of functioning treatment centres for fistula repairs	Number of treatment facilities that offer social reintegration services	Number of women surgically treated for obstetric fistula per year	Number of women treated for obstetric fistula who have been offered social reintegration	Availability of basic emergency obstetric and newborn care: national number of facilities	Availability of comprehensive emergency obstetric and newborn care: national number of facilities
30	1	0	49	0	—	—
25	10	1	369	85	—	—
22	4	0	150	89	22 (out of 584 assessed)	32 (out of 123 assessed)
17	1	0	104	104	—	—
—	6	1	38	38	—	—
3	2	2	38	21	—	—
26	28	2	567	56	—	—
18	2	0	127	0	—	—
52	5	0	62	29	—	—
35	2	1	73	47	—	—
264	13	3	190	150	—	—
0	—	—	—	—	—	—
174	13	1	191	44	—	—
13	4	3	1.833	677	86	60
130	3	2	50	20	—	—
44	4	0	179	—	45	33
—	—	—	—	—	—	—
12	3	0	25	0	—	—
21	6	5	301	85	44 (out of 150)	29
40	14	10	—	—	—	—
15	14	1	462	—	—	—
—	7	7	654	—	—	
30	7	2	73	11	39	3
20	2	2	270	270	0	14
20	2	2	120	120	—	—
—	1	—	6	—	—	—
64	1	—	2	—	—	520

	UN emergency obstetric and newborn care indicators (part of output 5 indicators)					
Countries with MHTF support started in 2010 (M) and (F) indicate midwifery/fistula programming	Geographic distribution: proportion of sub-national areas with the required number of emergency obstetric and newborn care facilities	Proportion of all births in emergency obstetric and newborn care facilities, %	Met need for emergency obstetric and newborn care, %	Direct obstetric case fatality rate, %	Neonatal mortality (intrapartum and very early neonatal deaths)/ 1,000 deliveries	Proportion of births with caesarean sections as a proportion of all births, %
Afghanistan (M, F)	—	—	—	—	—	—
Bangladesh (M, F)	—	—	—	—	—	—
Cameroon (F)	No area meets the minimum	19.36	5.97	2.20	2.30	1.28
Central African Republic (F)	—	—	—	—	—	—
Chad (M, F)	—	—	—	—	—	—
Republic of Congo (F)	—	—	—	—	—	—
Democratic Republic of the Congo (F)	—	—	—	—	—	—
Eritrea (F)	—	—	—	—	—	—
Guinea (F)	—	—	—	—	—	—
Guinea-Bissau (F)	—	—	—	—	—	—
Kenya (F)	—	—	—	—	—	—
Lao People's Democratic Republic	—	—	—	—	—	—
Liberia (F)	—	—	—	—	—	—
Mali (M, F)	—	56	17.36	3.83	—	—
Mauritania (F)	—	—	—	—	—	—
Mozambique (F)	—	17	11	5.20	1.0	2
Namibia	—	—	—	—	—	—
Nepal (M, F)	—	—	—	—	—	—
Niger (F)	—	28.30	74	755 (number of cases)	21	1.3
Nigeria (F)	—	—	—	—	—	—
Pakistan (M, F)	—	—	—	—	—	—
Rwanda						
Senegal (F)	1 (out of 14)	—	—	—	3	2.80
Sierra Leone (M, F)	1.2	2	7	7	36	0.9
Somalia (F)	—	—	—	—	—	—
Timor Leste	—	—	—	—	—	—
Yemen (F)	67	—	—	—	—	—

MHTF output 6 country indicators				MHTF output 7 country indicators	
Internationally agreed maternal and newborn care indicators integrated in national health management information system	Mandatory notification and surveillance of maternal deaths	Routine practice of maternal death audits/reviews	Confidential enquiries system for maternal deaths in place	Share of government expenditures for health, %, as per annual government figures	National budget for maternal and newborn health overall and per capita (including all flows, domestic and external), as measured through national health accounts where they exist, %/US$
—	—	—	—	—	—
✓	No	No	No	6.50	—
Partial	No	Partial	No	—	—
—	—	—	—	—	—
✓	✓	—	—	—	—
✓	✓	—	—	—	—
No	No	No	No	—	—
—	—	—	—	—	—
—	—	—	—	—	—
—	—	—	—	—	—
—	No	✓	✓	7	—
—	—	—	—	—	—
—	—	—	—	—	—
✓	✓	✓	✓	7.87	✓
✓	—	No	No	—	—
—	—	—	—	—	—
Partial	✓	✓	✓	—	—
✓	✓	✓	✓	5.3	—
✓	✓	Partial	No	7.85	—
✓	Selected states	Selected states	Selected states	4	—
—	—	—	—	—	—
✓	✓	✓	✓	8.04	—
—	—	No	In progress	8.20	—
—	—	—	—	—	—
—	—	—	—	—	—
2	No	No	No	—	—

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