Maternal Health Thematic Fund

Annual Report 2012

Cover photos:
Midwives in Uganda: From training to saving lives.
Small photo: Training of midwives with equipment supplied by UNFPA. UNFPA Uganda.
Large photo: Midwife at work in a refugee camp in Northern Uganda. Diego Goldberg, UNFPA.

UNFPA:
Delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.

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ACKNOWLEDGEMENTS

UNFPA wishes to acknowledge its partnerships with national governments and donors, and with other UN agencies, in advancing the UN Secretary-General's Global Strategy for Women's and Children's Health.

We also acknowledge, with gratitude, the multi-donor support generated to strengthen reproductive health. In particular, we thank the governments of Austria, Australia, Autonomous Community of Catalonia (Spain), Canada, Finland, Germany, Iceland, Ireland, Luxembourg, the Netherlands, New Zealand, Norway, Poland, the Republic of Korea, Spain, Sweden, Switzerland and the United Kingdom. We also thank our partners in civil society and in the private sector, including EngenderHealth, European Voice, Friends of UNFPA, Johnson & Johnson, Virgin Unite, Zonta International and the Women's Missionary Society of the African Methodist Episcopal Church, for their generous support. A special thanks goes to our many individual donors and to our UN Trust Funds and Foundations.

We would like to extend our sincere appreciation to UN colleagues around the globe in the World Health Organization, UNICEF, the World Bank and UNAIDS, who are making a stronger and healthier partnership possible, including through the French and Canadian grants promoting maternal, newborn and child health, known as the Muskoka Initiative.

We are also grateful to our development partners for their collaboration and support in championing reproductive health issues and for their technical contributions. These partners include the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, Columbia University's Averting Maternal Death and Disability Program, Johns Hopkins University, Jhpiego, the Guttmacher Institute, the University of Aberdeen, the Woodrow Wilson International Center for Scholars, Women Deliver, EngenderHealth, Family Care International, Integrare, national and regional institutions, and private sector partners, including Intel Corporation.

We look forward to continuing these productive collaborations now and in the future.

ACRONYMS & ABBREVIATIONS

AMDD	Averting Maternal Death and Disability Program (Columbia University)
CDC	United States Centers for Disease Control and Prevention
DFID	Department for International Development (United Kingdom)
EmONC	Emergency Obstetric and Newborn Care (BEmONC = Basic; CEmONC = Comprehensive)
FIGO	International Federation of Gynecology and Obstetrics
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4+	WHO, UNICEF, UNFPA, the World Bank, UN Women and UNAIDS
HPV	Human Papillomavirus
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IESO	Integrated Emergency Obstetrics and Surgery (Master's Program, Ethiopia)
INGO	International Non-governmental Organization
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LDCs	Least Developed Countries
MNH	Maternal and Newborn Health
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MHTF	Maternal Health Thematic Fund
MMR	Maternal Mortality Ratio
MSF	Médecins sans Frontières
NCDs	Non-Communicable Diseases
NGO	Non-governmental Organization
PMC	Population Media Center
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SOWMR	State of the World's Midwifery Report
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIA	Visual Inspection with Acetic Acid (a simple technique to detect pre-cancerous lesions of the cervix to prevent cervical cancer)
WHO	World Health Organization

FOREWORD

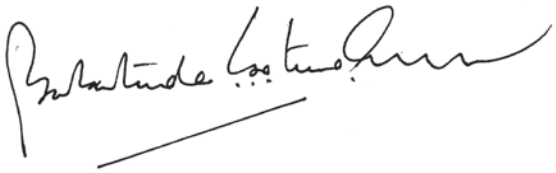
by Dr. Babatunde Osotimehin, Executive Director, UNFPA

Empowering and enabling women to proactively decide whether and when to get pregnant, to act on this decision, and to go through pregnancy and childbirth safely are human rights. They also constitute Millennium Development Goal No. 5. A number of countries still strive to reach the targets of this goal, which are to reduce maternal deaths and to achieve universal access to reproductive health, including family planning.

With the Maternal Health Thematic Fund (MHTF), UNFPA supports 43 high maternal mortality countries to achieve MDG 5 and to accelerate progress in reducing the number of women who die giving life or who suffer from associated morbidity. This report gives evidence to the progress that has been facilitated by the Maternal Health Thematic Fund, including the Midwifery Programme and the Campaign to End Fistula. The report also demonstrates the invaluable benefits brought about through partnerships, as the MHTF collaborates with global, regional and national champions in their respective fields of work.

The Maternal Health Thematic Fund and its twin sister—the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)—constitute important contributions from UNFPA to MDG 5, to the UN Secretary-General's Global Strategy for Women's and Children's Health and to the UN Commission on Life-Saving Commodities for Women and Children. The MHTF and the GPRHCS also contribute to the implementation of the UNFPA Adolescent and Youth strategy and Family Planning strategy.

The many achievements featured in this report are the result of strong political commitment, particularly at the nation level, generous funding and enduring partnerships. I would like to take this opportunity to thank countries, donors, other partner organizations and colleagues for their productive collaboration now and in the future to save women's lives.



Dr. Babatunde Osotimehin
Executive Director, UNFPA

EXECUTIVE SUMMARY

To accelerate improvements in maternal and newborn health and progress towards Millennium Development Goal 5, UNFPA (the United Nations Population Fund) has launched two thematic funds to provide additional support to countries most in need. Funding from these two sources—the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and the Maternal Health Thematic Fund (MHTF)—complements UNFPA core resources and other funding mechanisms, including H4+ funding, and is used to implement and scale up interventions to promote maternal and newborn health.

The MHTF was launched in 2008 and currently includes UNFPA's flagship Midwifery Programme and the Campaign to End Fistula. It supports activities in 43 countries and completed its fourth full year of operations in 2012. The MHTF's business plan, which was grounded in the latest scientific evidence and programme results, identified maternal death and disability as an entry point for programmes to advance universal access to reproductive health.

The MHTF contributions are both strategic and catalytic in nature to achieve high impact and to support the outcome and outputs of the business plan. MHTF activities fall within the five programmatic areas: advocacy and demand-creation for maternal and newborn health; emergency obstetric and newborn care; the midwifery programme; the campaign to end fistula; and maternal death surveillance and response. All are discussed in this report.

HIGHLIGHTS OF 2012

Advocacy and demand-creation for maternal and newborn health

Raising awareness on maternal health has been a focus from global to community levels:

- The MHTF has contributed to advocacy and communications efforts to raise maternal health on the international political agenda, and to promote the vision of eliminating preventable maternal deaths within one generation;

- To foster accountability and to promote an enabling policy and political environment for maternal health, the MHTF has for the last three years been working in support of the United Nations Secretary-General's Global Strategy for Women's and Children's Health and the African Union's Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This was particularly important to help increase involvement and leadership of national authorities in CARMMA countries, and to provide new impetus to reducing preventable maternal death in the

region. By the end of 2012, 38 countries in sub-Saharan Africa had successfully launched CARMMA, including South Africa, which joined the campaign in 2012;

- At country level, MHTF initiatives have served not only to raise political awareness and support but also to create demand at community level for maternal health, family planning and other reproductive health services. Examples of such work include entertainment-education programmes—for instance, radio soap operas and telephone hotlines—community health education programmes and raising awareness about the life-saving skills of midwives.

Emergency obstetric and newborn care

- In 2012, eight countries conducted EmONC needs assessments (Bangladesh, Cameroon, Congo, the Democratic Republic of the Congo, Gambia, Guinea, Mozambique, Togo), and many others finalized their reports and operational plans. UNFPA has been instrumental in advocating for and developing tools and guidelines for standard quality assessments for expanding the level of coverage and use of emergency obstetric and newborn care (EmONC). Since the inception of MHTF, EmONC national needs assessments have been supported in 34 countries (completed or under completion). These provide data for district micro-planning of maternity care, the baselines against which progress will be measured, and for evidence-based advocacy at both domestic and international levels;

- The MHTF has supported the development of costed operational plans for scaling up EmONC services. Regional institutional capacity is being strengthened for sustainability, and support was provided to the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) and National Health Sciences Institute (IRSS) in Burkina Faso. A plan is in place to build capacities of other institutions in sub-Saharan Africa and Asia in 2013;

- A coalition of wills among UNFPA, UNICEF, Jhpiego and AMDD identified the need to develop an implementation guidance document following EmONC needs assessments to foster a structured and systematized response in countries.

The midwifery programme

In 2012, MHTF supported strengthening of midwifery workforce programmes and policies in 30 of the 40 high maternal mortality countries, including:

- Launching an innovative partnership between UNFPA and the technology giant Intel Corporation to strengthen the skills of midwives and other health workers using e-training modules;

- Completing midwifery gap analyses by seven North African and Middle East countries, three African countries and two Asian countries (totalling 31 gap analyses) and four in-depth midwifery workforce assessments under the High Burden Country Initiative by the H4+;

- Improving and expanding midwifery education, including training of over 400 midwifery tutors, establishing new training sites, strengthening over 175 midwifery schools with curriculum and faculty development, training models, equipment and latest books, and establishing a hostel for midwifery students in South Sudan. Model Curriculum Guidelines for midwifery education and the Standard ICM Competency-Based Equipment List for Basic Skills Training in Midwifery Schools by the ICM were also finalized;

- Capacity building of national and regional midwifery advisers to strengthen regulations and to update new tools as well as to share experiences and good practices was organized in Ethiopia;

- Establishing 10 sub-national associations in all 10 states of South Sudan. To date, over 35 national and sub-national midwifery associations have been launched by the programme;

- Implementing an innovative mechanism to deploy 15 midwives as international United Nations Volunteers (in 2011 and 2012) across nine regions in South Sudan.

The Campaign to End Fistula

With UNFPA support to the Campaign to End Fistula:

- 8,400 women and girls with obstetric fistula were treated in 2012;

UNFPA Executive Director, Babatunde Osotimehin, center, and UNFPA Representative in Benin, Diene Keita, right, attend the launch of the CARMMA week in Benin with Maria Antonietta Marchese, left, head of a center for vulnerable young girls.
UNFPA Benin

- 36 high-burden countries developed strategies to prevent, treat and provide reintegration services for women with obstetric fistula to date;
- 35 countries created national coordinating mechanisms for fistula activities to date;
- 33 countries integrated prevention and treatment of fistula in training curricula for health workers to date;
- South-South cooperation among dozens of countries to develop case management and care capacity took place to date.

Maternal death surveillance and response care

In 2012 UNFPA supported:

- The development of technical guidance and tools for Maternal Death Surveillance and Response in partnership with WHO and CDC;
- Orientation workshops in sub-Saharan Africa (22 Francophone and Portuguese-speaking countries, 14 English-speaking countries) to disseminate the WHO Commission on Information and Accountability recommendations and the MDSR tools;
- Increased mandatory notification of maternal deaths in countries, and scale up and institutionalization of Maternal Deaths Review (a central component of the MDSR) in Benin, Burkina Faso, Burundi, Cambodia, Ethiopia, Ghana, Malawi, Mozambique, Namibia and Sierra Leone through CARMMA advocacy and the integration of maternal death in WHO Integrated Disease Surveillance and Response.

RESOURCES

In 2012, around one quarter of the $21 million in expenditures (about $5 million) supported midwifery; around one fifth (about $4 million) supported fistula programming; around 15 per cent (about $3 million) supported Emergency Obstetric and Newborn Care;

and around 30 per cent (about $6 million) strengthened the capacity of priority country and regional offices. The remaining funds went to national capacity building in overall planning, programming and coordination in areas such as maternal death surveillance and quality of care.

EXTERNAL EVALUATIONS

The recent external thematic evaluation of UNFPA support to maternal health and the MHTF mid-term evaluation have shown that the MHTF is contributing in important ways to an enhanced response by UNFPA in supporting countries' progress towards Millennium Development Goal No. 5, to Improve Maternal Health (http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094). The evaluations found that MHTF has rightly supported countries with highest maternal mortality ratios; has provided a catalytic function as intended; has had an appropriate focus on improving midwifery and EmONC (including setting standards and regulations); has been instrumental in policy dialogue to refocus government maternal health priorities and to increase national commitments; and has provided useful technical guidelines. The evaluation also pointed out that UNFPA capacity to deliver impact at country level was affected by inadequate staffing capacity and skill mix of some country offices, annual planning cycles, inadequate definition of the key concept of 'vulnerability,' and insufficient result-monitoring systems and generation of programme-specific evidence.

These challenges are being addressed through a revision of the policy and procedures manual and an update of the MHTF Business Plan in late 2012, to be finalized with input from partners in 2013. UNFPA is strengthening country office capacity with the required skill mix, as well as upgrading skills of existing staff. A position paper on 'vulnerability' is being produced for programmatic guidance.

CHALLENGES

Four major challenges confront maternal health: 1) while there has been significant progress, more is needed in national leadership, governance and management capacity; 2) the issue of human resources for health and the midwifery workforce, in particular, requires major efforts, especially in the 40 high maternal mortality countries; 3) integration of reproductive health services needs more attention; and 4) despite recent increases in the share of national budgets towards health, there is grossly insufficient funding for MDG5, and donor financing in this area is insufficient.

MOVING FORWARD

Given known effective strategies, ending preventable maternal deaths and obstetric fistula within a generation is now within reach. As a focused contribution to UNFPA's 2014-2017 Strategic Plan, and building on the recommendations of the evaluations (including the mid-term review) of UNFPA support to maternal health, the MHTF has a continued role to play in reducing maternal deaths and morbidity and in strengthening health systems with sufficient, sustained funding to 2017 and beyond.

CHAPTER ONE

BACKGROUND AND INTRODUCTION

Balki Garba is a young woman from the village of Angoual Doutchi, located 34 kilometres from Zinder in Niger. Her story exemplifies the raison d'être behind the Maternal Health Thematic Fund. Balki was married to her cousin at age 13 and got pregnant at 15. The pregnancy ended with a stillborn baby. Balki had eight more stillborn babies before her 10th pregnancy finally resulted in a surviving child who is now 3 years old. However, Balki's latest pregnancy also ended with a stillborn and left her with a fistula, a stigmatizing condition that occurs as a result of prolonged labour with no access to emergency obstetric care. Fistula causes leakage of urine and/or feces from the vagina.

"I will never understand what happened to me, I lost interest in life, I told myself that this is a curse, but as a believer, I also said that everything comes from God," said Balki.

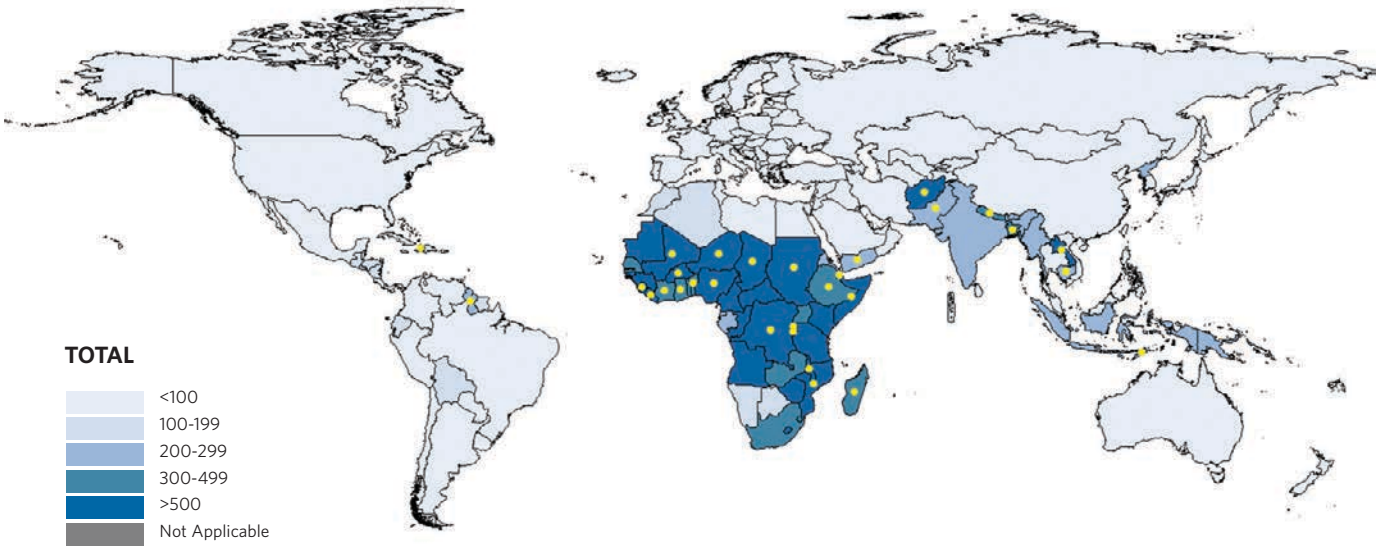
Balki Garba, a Nigerienne who has recovered from fistula and is now a fistula advocate.
UNFPA Niger

Balki's story is not uncommon in countries with high maternal mortality and morbidity rates, triggered by early marriage and early childbirth (which entails increased risk when a girl is not fully developed), lack of an appropriate midwifery workforce and timely access to emergency obstetric and newborn care to alleviate the obstructed labour, and delays in appropriate health seeking behaviours.

Support from UNFPA enabled Balki to receive care at the fistula treatment center in Zinder. She is now a fistula advocate in her community, helping to bring many women living with fistula out of the shadows. Often they have been marginalized by family members and outcast. Balki now wants to have access to contraception to decide if and when she wants to become pregnant again.

FIGURE 1

Geographic focus of the Maternal Health Thematic Fund (yellow dots indicate MHTF-supported countries and shading represents the maternal mortality ratio per 100,000 live births.[1])



MHTF GOAL AND OUTPUTS

To accelerate reductions in maternal mortality and morbidity, UNFPA has launched two thematic funds to provide enhanced support to countries most in need: the Maternal Health Thematic Fund (MHTF) and the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). Funding from these entities complements other funding mechanisms, including UNFPA core resources, H4+ funds and national resources to support implementation and scale up of high-impact, low-cost interventions to promote maternal and newborn health in countries.

The Maternal Health Thematic Fund was established in 2008. In its Business Plan 2008-11, the Fund's goal was stated: "The MHTF aims to boost support to high maternal mortality countries to reduce maternal mortality and morbidity." To do so, the Fund, in collaboration with governments and key partners, has supported these seven outputs:

1. An enhanced political and social environment for Maternal and Newborn Health (MNH) and Sexual and Reproductive Health (SRH);

2. Up-to-date needs assessments for the SRH package, particularly focused on family planning, human resources for MNH, and Emergency Obstetric and Neonatal Care (EmONC);

3. National health plans focused on SRH, especially family planning and EmONC, with strong RH/HIV linkages to achieve the health MDGs;

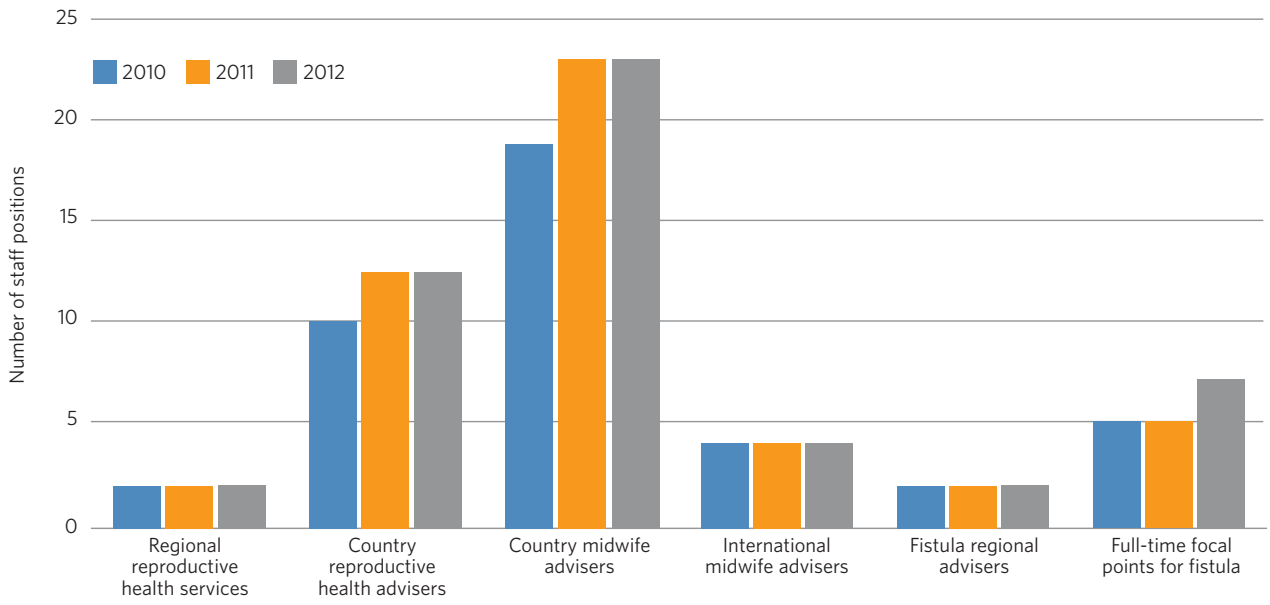
4. National responses to the human resource crisis in MNH, focused on planning and scaling up of midwifery and other mid-level providers;

5. National equity-driven scale up of family planning and EmONC services, and maternal and newborn health commodity security;

[1] Countries currently receiving support from the Maternal Health Thematic Fund: 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, Pakistan, Rwanda, Sierra Leone, South Sudan, Sudan, Timor-Leste, Uganda, Yemen and Zambia. Ten additional countries receive support for obstetric fistula only: Cameroon, Central African Republic, Congo, Eritrea, Guinea, Guinea-Bissau, Kenya, Mauritania, Senegal and Somalia.

FIGURE 2

Number and type of staff positions in UNFPA country and regional offices supported by the MHTF



6. Monitoring and results-based management of national MNH efforts;

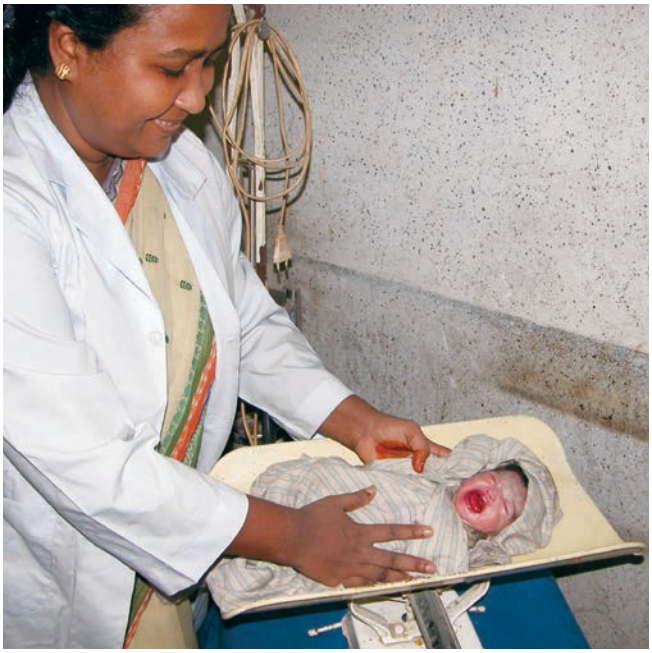
7. Leveraging of additional resources for MDG5 from government and donors.

Since its inception, the Maternal Health Thematic Fund has invested primarily in strengthening health systems while advocating for removal of the root social and cultural causes of poor maternal and newborn health. Moreover, the MHTF has promoted innovative approaches and fostered South-South cooperation among countries with the highest maternal mortality, most of which are in sub-Saharan Africa (Figure 1).

To this end and to provide technical support on maternal and newborn health, it is a key activity of the MHTF to improve the human resource capacity of UNFPA on maternal health at all levels. In 2012, the MHTF maintained its support to staffing at national, regional and headquarters levels (Figure 2).

The MHTF includes UNFPA's Midwifery Programme and the Campaign to End Fistula. To oversee the governance of thematic funds, UNFPA developed reproductive health thematic funds guidelines, which are included in the UNFPA Policy and Procedures Manual.

The MHTF serves as a key UNFPA contribution to the UN Secretary-General's Global Strategy for Women's and Children's Health ('Every Woman Every Child') and supports the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The Maternal Health Thematic Fund ended its fourth full year in 2012.



Midwife with newborn.
UNFPA Bangladesh

TABLE 1. Evolution of support to countries by the Maternal Health Thematic Fund, 2008-2011

	2008: Launch of the MHTF	2009: First full year	2010: Second full year	2011: Third full year	2012: Fourth full year
Countries supported in maternal health overall	11	15	30	33*	33*
Countries supported by the Midwifery Programme		15	22	30	30
Countries supported by the Campaign to End Fistula		25	42	43*	43*
Total number of countries supported by the MHTF	**11**	**25**	**42**	**43***	**43***
Expenditures	**$ 1 million**	**$14 million**	**$21 million**	**$25 million**	**$21 million**

* In 2011, Sudan became two countries, which is reflected in the figures in this table.

SELECTING MHTF COUNTRIES

In 2008-2009, the selection of countries to receive Maternal Health Thematic Fund support was based on recommendations from UNFPA regional offices and these criteria:

- High maternal mortality (> 300 per 100,000 live births)
- Recommendations of the H4+ group
- Commitment of country teams (government and partners)
- Support by the Global Programme to Enhance Reproductive Health Commodity Security to foster synergies between activities supported by the two thematic funds to accelerate impact.

Funding decisions for the MHTF countries are fully agreed upon with governments as part of UNFPA support to the national reproductive health strategy. Table 1 shows the number of countries supported by the Maternal Health Thematic Fund since its launch.

THE 2012 MHTF ANNUAL REPORT

Purpose

The purpose of the annual report of the Maternal Health Thematic Fund is to provide an overview and concrete examples of the 2012 activities of the MHTF, including the Midwifery Programme and the Campaign to End Fistula. This demonstrates the scope of interventions supported by the MHTF, and shows how added value has been created through partnerships and how interventions at global, regional and national levels have all helped save women's lives. It is the hope and intention that these accounts will inspire countries that are involved in the MHTF as well as partners and non-MHTF countries.

Organization of the report

Chapters Two to Six of this annual report 2012 present results that have been achieved in maternal and newborn health at global, regional and national levels. Chapter Two shows results in policy and political environment; Chapter Three, in emergency obstetric and newborn care; Chapter Four, in the midwifery programme; Chapter Five, in the campaign to end fistula; and Chapter Six, in maternal

death surveillance and response. These subjects cover the content of the outputs in the original MHTF Business Plan but do not correspond directly to the individual outputs. Rather, they reflect the development of the MHTF since its inception; for instance, the inclusion of the Campaign to End Fistula.

Chapter Seven of the report provides an overview of the MHTF's resources. Chapter Eight highlights the findings of the evaluations of UNFPA support to maternal health, which came out in 2012; and Chapter Nine discusses challenges and the way forward. Annex 1 lists the partners in the Campaign to End Fistula. Annex 2 contains the results framework towards the MHTF outputs.

It should be noted that while the report's purpose is to give an account of results of the MHTF in 2012, the practical situations in country offices means that resources are sometimes pooled towards specific activities. This can make it difficult to directly link outcomes to funding sources. The report also refers in some places to the cumulative results of MHTF activities over several years, demonstrating progress till now or showing 2012 results built on several years' work.

CHAPTER TWO

ADVOCACY AND DEMAND-CREATION FOR MATERNAL AND NEWBORN HEALTH

As Balki Garba's story showed in Chapter One, maternal and newborn health requires both strengthening health systems and improving wider socio-cultural determinants of sexual and reproductive health and rights. Therefore, it is critical to enhance the political environment to bolster health systems and to address such issues as gender inequalities, child marriage and girls' education. Building on the achievements of recent years and with the aid of strong partnerships, the Maternal Health Thematic Fund made significant progress in 2012 in fostering supportive political environments. At the same time communication initiatives at community level have facilitated demand-creation for reproductive health services.

GLOBAL HIGHLIGHTS

Communicating to advance the maternal health agenda

In 2012, the overall goal of communications initiatives for reproductive health and MDG 5 was to raise awareness and influence the public and political agenda globally and nationally. Initiatives focused on emergency obstetric care, unmet need for reproductive health (including family planning), social determinants of maternal mortality, midwifery and fistula.

The approaches included direct MHTF support to the UN Secretary-General's 'Every Woman Every Child' initiative (www.everywomaneverychild.org), partnering with the H4+, implementing an evidence-informed communications project (see below) and supporting national communications efforts in high maternal mortality countries.

The MHTF fostered news hooks, media events and key stakeholders outreach related to the 45th session of the Commission on Population and Development, the International Day of the Midwife, Mother's Day in various countries, the Rio+20 Summit, World Population Day, the UN General Assembly, the 2012 FIGO World Congress of Gynecology and Obstetrics, the UN Commission on Life-Saving Commodities Ministerial Meeting and international fistula meetings.

In 2012, the MHTF team at UNFPA headquarters continued to partner with communications focal points at national and regional levels. This work included joint video, reportage and photography projects demonstrating innovation, impact and results of UNFPA's work on the ground, thus moving communications beyond description of activities and events. This strategy allowed for a consistent flow of stories, which were used for global advocacy, promoting political commitment at national level and enhancing visibility for the thematic funds and UNFPA.

To make information on key issues easily accessible to media and donors and to promote more cohesive messaging on reproductive health, fact sheets were developed, widely

Margaret is 16 years old and eight months pregnant. Despite the hardship of living in a refugee camp in Northern Uganda, she is fortunate that excellent health services are available in the camp.

Diego Goldberg, UNFPA

shared and added to resource kits, including those available online at www.unfpa.org/public/home/mothers/pid/4390 and www.endfistula.org.

Promoting the elimination of preventable maternal deaths

The MHTF Business Plan 2008-11 ends with the sentence: "We could then envisage, in a not too distant future, a world where maternal mortality has been eliminated." Since then, this vision has been taken even further, resulting in the Resolution of the UN Commission on the Status of Women in 2012 on "eliminating maternal mortality and morbidity through the empowerment of women."

This landmark resolution was drafted and nurtured by the MHTF. Building on the resolution, the MHTF team wrote a piece titled, *'What will it take to eliminate preventable maternal deaths?'* The piece was published by UNFPA senior management with Tedros Adhanom Ghebreyesus, the Minister of Health of Ethiopia at the time, as a Comment in *The Lancet* issue dedicated to the London Family Planning Summit FP2020 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60982-9/fulltext). The Comment noted that with the currently available high-impact interventions, one could envisage ending preventable maternal mortality within a generation. Since the publication of the article, work has been continuing on an elimination strategy, led by WHO in partnership with United States Agency for International Development (USAID).

Building on the successes of controlling infectious diseases, a new key strategy has been added to further accelerate reducing maternal deaths: maternal death surveillance and response. Work in this area is described in Chapter Six.

Contributing to the non-communicable diseases global agenda

The effects and complications of non-communicable diseases (NCDs) are issues of rising importance on the global agenda, and include themes of relevance to maternal and newborn health. The MHTF has therefore contributed to the non-communicable diseases agenda in several ways:

- The MHTF team provided expert advice on the development of the upcoming WHO guideline on tobacco and pregnancy, to be widely disseminated and implemented as part of effective antenatal care;
- The MHTF team provided input to the UNFPA contribution to the NCD Global Action Plan on Tobacco Control adopted at the World Health Assembly in May 2013. UNFPA is now including this as part of its work with adolescents and young people;
- The focus on NCDs has also highlighted the need to address vigorously cervical cancer through a dual approach of 'screen and treat' and HPV vaccination. With the rapid declines in maternal mortality, cervical cancer now kills more women than maternal causes do, with around a quarter of a million deaths per year. As has been demonstrated in many countries, nearly all of these deaths and unnecessary suffering could be averted through these high-impact, low-cost interventions.

REGIONAL HIGHLIGHTS

The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)

Turning from the global to the regional level, it is particularly important to focus on sub-Saharan Africa. While the average annual rate of reduction in MMR between 1990 and 2010 has been -5.7 per cent in eastern Asia and -4.9 per cent in southern and in south-eastern Asia, the progress in sub-Saharan Africa has been half as fast, with an average annual rate of decline of -2.6 per cent. Sub-Saharan Africa represents 56 per cent of all maternal deaths globally, while accounting for only 11 per cent of the world's population.[2]

The Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an African Union Commission (AUC) initiative launched in 2009 and

[2] Trends in Maternal Mortality 1990 to 2010. WHO, UNICEF, UNFPA and World Bank estimates. WHO 2012.

supported by UNFPA to intensify the implementation of the Maputo Plan of Action to lower maternal deaths and to attain MDG 5 in Africa.

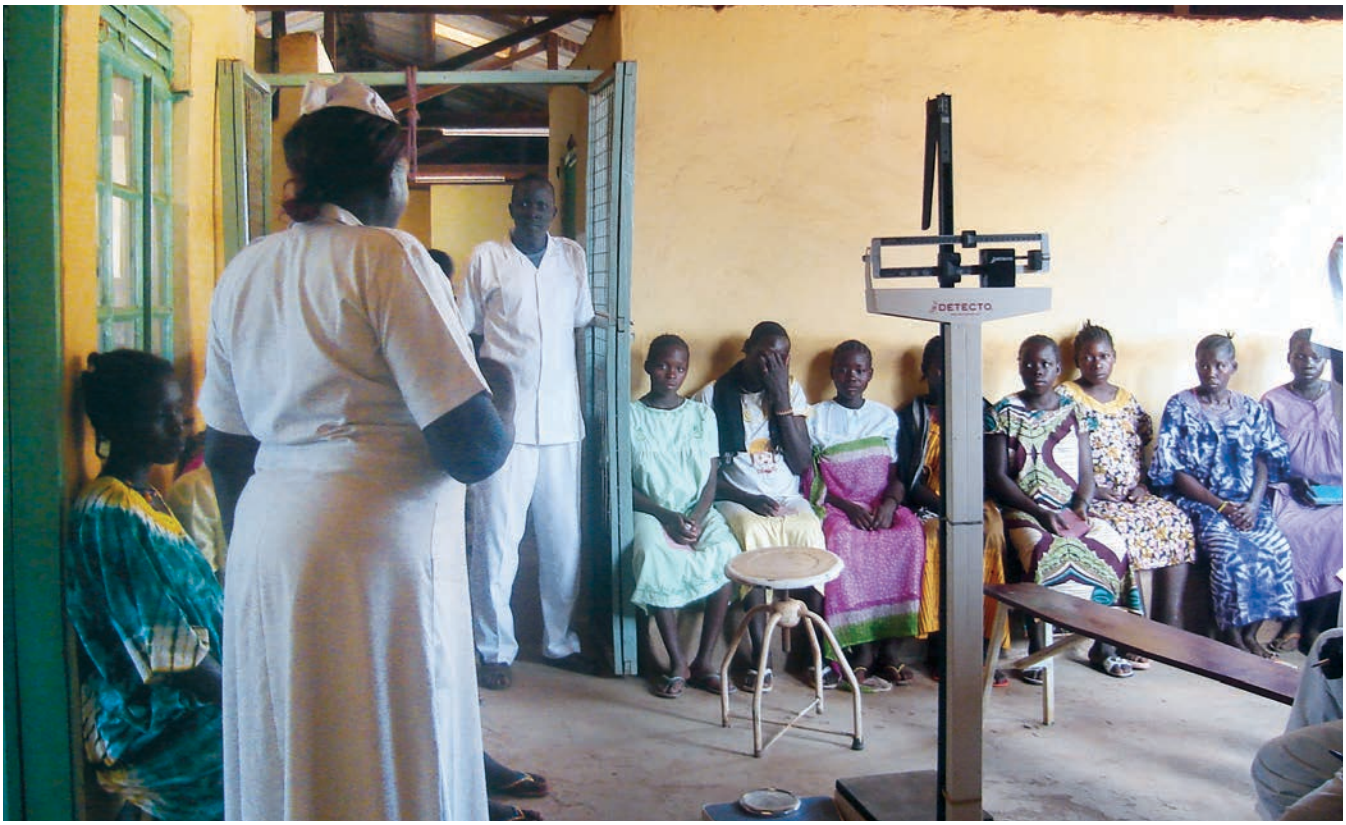
The objectives of CARMMA were to enhance political leadership and commitment at national and regional levels, to identify and work with national champions to mobilize support and participation at national level, to raise and maintain awareness as well as appropriate responses at global, regional and national levels, to build linkages with existing global campaigns, and to promote the recognition of maternal mortality as a key indicator of a well-functioning health system and society.

By the end of 2012, CARMMA was initiated in 38 African countries and has led to strong political commitment for maternal and newborn health, including the adoption by the African Union and other regional entities of several normative frameworks, with maternal and newborn health featured prominently. The MHTF has contributed financial and programmatic support to CARMMA at regional and national levels since its inception.

Evidence-informed communications

An evidence-informed communications project was begun in 2010 with MHTF support. The goal was to demonstrate that regular, systematic and evidence-informed communications can contribute to better results in reproductive health. Led at the regional level, this endeavour started with four English-speaking countries in sub-Saharan Africa: Ethiopia, Malawi, Nigeria and Sierra Leone. It was expanded in 2011 to include five French-speaking countries: Benin, Burkina Faso, Mali, Niger and Senegal; in 2012, it added six countries in West and Central Africa: Chad, Congo, Côte d'Ivoire, Guinea, Mauritania and Togo.

Multidisciplinary teams are trained and supported to move beyond traditional public relations campaigns (such as distribution of T-shirts) to communicate more about issues and changes (or lack of change) in people's lives. These communications efforts target main stakeholders (national decision makers, development partners, including donors, and influential groups and civil society) and feature storytelling with short videos on issues pertaining to maternal and newborn health, bulletins, fact sheets and more. Some



A health education programme for pregnant women in South Sudan.
UNFPA South Sudan

examples include the following mini-videos from Côte d'Ivoire, produced by country teams during training workshops in 2012:

- Access to Caesarean section: http://www.youtube.com/watch?v=ZiTZosls3sw
- Maternal death: http://www.youtube.com/watch?v=_e7_tA2nKWc
- Family planning: http://www.youtube.com/watch?v=V3cdncVRMzo
- Midwifery: http://www.youtube.com/watch?v=koINKB4HI8Y

COUNTRY HIGHLIGHTS

CARMMA to the people in Benin, Burkina Faso and Central African Republic

In Benin, a CARMMA week was organized for the third consecutive year with support from UNFPA. It was conducted under the leadership of the President of Benin and in the presence of the UNFPA Executive Director. Targeted advocacy activities were organized for parliamentarians, government, locally elected officials and religious and traditional leaders. Five advocacy campaigns were arranged to involve men and youth and locally elected officials and opinion leaders in promoting family planning. Significant outputs of this mobilisation effort include the creation and commitment from the government to maintain a line item in the national budget for purchasing contraceptives, a ministerial decree for institutionalizing maternal death reviews and mandatory notification for maternal deaths.

In Burkina Faso, 2012 saw the expansion of the national CARMMA advocacy campaign in all 13 regions of the country, using maternal health indicators specific to each region (evidence-informed communications). Over 600 community leaders, government officials and other development partners participated in the advocacy and awareness activities. As a result of this decentralized campaign, opinion leaders and heads of health institutions renewed their commitment to increase efforts to reduce maternal mortality and morbidity.

In Central African Republic, the 2013-2016 CARMMA action plan, which was developed in 2012, includes obstetric fistula. On 24 August 2012, the Minister of Health issued a decree making the notification of maternal deaths compulsory. Moreover, a sensitization workshop was organized for all 16 provincial and 40 municipal authorities on maternal mortality and morbidity, child marriage, violence against women and girl's education.

Village committees and radio dramas in Burkina Faso

With support from UNFPA, 462 village-based Emergency Obstetric and Newborn Care (EmONC) management committees were established in 26 health districts to improve timely referral for 247 health facilities, making up 25 per cent of the country's health facilities. Delays in obtaining skilled assistance have been identified as a major cause of many maternal deaths in rural areas. The village management committees were installed to substantially raise awareness on danger signs and the need for skilled assistance during childbirth. The ownership of communities to the agenda is evident in their construction of maternity waiting homes and rehabilitation of roads leading to health facilities.

In Burkina Faso, barriers to using modern contraceptives are largely informational and cultural. Among sexually active, fertile women in union, the top reasons for non-use are the desire for more children (18 per cent); personal, partner or religious opposition (17 per cent); fear of health effects (10 per cent); and not knowing a method or a source (10 per cent). Cost is cited by only 2.5 per cent, and lack of access by only 0.7 per cent. With MHTF support, UNFPA country offices have been instrumental in initiating several entertainment-education programmes with the partner organization, Population Media Center (PMC). The programmes are designed to overcome the information barrier and thus increase demand for reproductive health services. For example, the center developed two (in two local languages) 156-episode radio dramas to promote gender equality, maternal health services and use of family planning—a project also supported by UNICEF.

The programmes started broadcasting in September 2012 and were complemented by grassroots community-based communications activities. These included theatre and film

screenings with discussions on family planning and how to recognize danger signs during pregnancy and childbirth. The activities reached over 180,000 people directly.

Soap operas in Sierra Leone and other priority countries

In Sierra Leone, the Population Media Center is broadcasting a 208-episode radio drama to promote reproductive health, including family planning. The programme also addresses such issues as ending child marriage, preventing or repairing obstetric fistula, ending female genital mutilation/cutting, stopping gender-based violence and preventing HIV infection. Launched in April 2012, the programme, 'Saliwansai' ('Puppet on a String'), was cited by 57 per cent of 1,525 reproductive health clients, interviewed at clinics in the second half of 2012, as influencing their decision to seek services. The need for such programming is clear. Only 7 per cent of married women (15 to 49 years of age) in Sierra Leone use a modern method of contraception. Among non-users of modern contraception, the reasons given for not using are partner opposition (14.4 per cent), fear of side effects or health concerns (14.2 per cent), personal opposition (13.5 per cent), lack of knowledge of methods or sources (12 per cent), wanting as many children as possible (10.8 per cent) and religious opposition (9.3 per cent). Cost was cited by only 1.3 per cent, and lack of access was cited by only 0.3 per cent.

UNFPA supports similar projects by PMC in Burundi, DRC, Nigeria, Papua New Guinea and Rwanda, and has previously supported such initiatives in the Philippines, Senegal and Viet Nam.

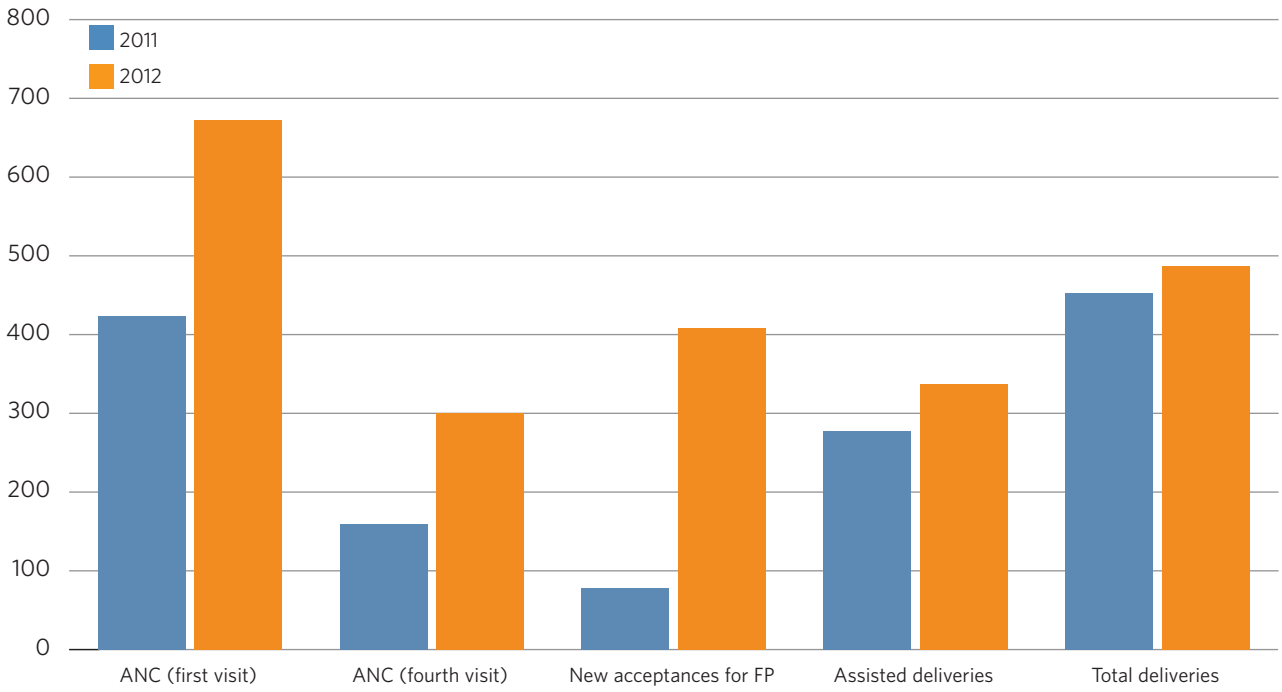
In partnership with UNICEF, a randomized control trial with independent evaluation research is being considered to quantify the effect of radio soap operas on actual behaviours related to child marriage, adolescent pregnancy and family planning in Niger.

Community-based birth preparedness in Liberia

In Liberia, some of the main challenges to reducing maternal and newborn deaths are cultural barriers to

FIGURE 3

Progress in health indicators (Antenatal Care (ANC) visits, new acceptances for Family Planning and assisted deliveries as compared to total deliveries) from 2011 to 2012 after the introduction of the community's husbands' school initiative in Toumodi Health District, Côte d'Ivoire



Midwives carrying banners with messages on safe motherhood ready to start a procession into the town of Aroma to celebrate the International Day of Midwives.
UNFPA Sudan

health-seeking behaviours. With UNFPA support, a community-based awareness and birth-preparedness programme has been developed to target the most disadvantaged counties. In Sinoe county, 20 community health educators were trained to help promote use of health facilities, disseminate messages on HIV/AIDS, family planning, teenage pregnancy, antenatal care, skilled delivery services at health facilities, pregnancy complications, labour, delivery, post-partum care and birth preparedness.

Husbands' schools in Côte d'Ivoire

To improve use of health services at community level, UNFPA in Côte d'Ivoire decided to roll out the good practice of 'husbands' schools,' developed and implemented in Niger, starting in Toumodi health district. The goal was to increase community-based distribution of contraceptives and the use of family planning, develop an innovative communications strategy and engage men as agents of change to raise the utilization of reproductive health services.

The husbands' school is a space for discussions, awareness, decision making and action based on a voluntary, participatory approach to improve reproductive health outcomes. Community ownership and participation is fostered with men as catalysts for community mobilization. Weekly meetings are organized in each village covered by the initiative, with facilitators who are trained on the content and on how to lead discussions. An action plan is developed to address access to and use of reproductive health services (such as antenatal care, institutional delivery, immunizations, family planning, referrals for emergency obstetric and newborn care) and other development-related issues. The graph below illustrates changes observed in Toumodi since the start of the initiative.

Community insurance scheme for maternal health in Djibouti

In 2012, the UNFPA country office in Djibouti invested in strengthening the technical, logistics and managerial capacity of mobile district health teams, building on progress made since the launch of community health insurance for 75 women's groups in rural areas. Monitoring tools and training have been offered to the groups on antenatal care, institutional delivery, immunizations, post-partum care and

family planning to document advances and the effectiveness of the initiative.

Celebrating the 2012 International Day of the Midwife in 30 countries

The theme of the 2012 International Day of the Midwife was 'Midwives Save Lives.' Many events were organized by countries around the world to draw the attention of policy makers towards contributions made by midwives in promoting health in communities and saving the lives of women and their newborns. The celebrations included poster competitions, organized walks, radio and TV talk shows, seminars and debates, and highlighting the need for investments in the midwifery workforce now more than ever to improve sexual and reproductive health. To mark the day, some 30 countries organized events ranging from workshops in life-saving skills for midwives; community mobilization programmes; and free camps on family planning, antenatal care, and breast cancer, cervical cancer and STD screenings. The organization of events was led by national midwifery associations with support from International Confederation of Midwives (ICM) and UNFPA and high-level participation of policy makers from Ministries of Health.

Increasing national commitments towards midwifery

By the end of 2012, some 35 governments had pledged additional investments in midwifery and skilled attendance at all births. These commitments were a result of enhanced advocacy done by UNFPA, ICM and several partners in response to the UN Secretary-General's 'Every Woman Every Child' initiative. The evidence generated by the *State of the World's Midwifery Report* (SOWMR), which was launched globally in 2011 by UNFPA, ICM and 30 global partners, played a major role in achieving the pledges. The SOWMR received vast media coverage throughout 2011 and 2012 and also saw 20 national high-profile launches in Asia, Africa, Latin America and Arab States. Drawing on the example of the SOWMR, the UNFPA Latin America and Caribbean Regional Office completed updated national midwifery profiles for Ecuador, Guyana, Paraguay, Peru, Trinidad and Tobago and Uruguay. The profile for Bolivia, included in the report, was also updated. These profiles are now being used as public advocacy tools to enhance investments in midwifery.

"Urgent action is needed to achieve the Millennium Development Goals 4 and 5 on child and maternal health before the target year of 2015, and investing in human resources for health, especially midwifery, is one of the soundest investments a country can make to accelerate progress. Midwives are the unsung heroes of women's and children's health, and their work must be supported every step of the way."

Extracts from Joint Statement of UNFPA Executive Director, Dr. Babatunde Osotimehin, and ICM Secretary General, Agneta S. Bridges on International Day of the Midwife

CHAPTER THREE

EMERGENCY OBSTETRIC AND NEWBORN CARE

Countries with high maternal mortality typically have the weakest health information and health systems, which do not have the capacity to deal with the major causes of such deaths. These causes include haemorrhage, obstructed labour, eclampsia, sepsis, ruptured uterus and retained products of conception. The availability—and use—of emergency obstetric and newborn care (EmONC) services are essential for the survival of mothers and their newborns.

In 2012, the Maternal Health Thematic Fund strategically supported catalytic interventions to improve access and uptake of EmONC services, such as: planning and conducting quality assurance of EmONC need assessments and costed operational plans in each district (district micro-planning); revising or updating national norms and protocols for EmONC; monitoring of the scale up of EmONC services; revising curricula in training schools (medical faculties, nurse and midwifery schools) to ensure standards and competencies for basic and comprehensive EmONC are mainstreamed in pre-service training; providing in-service EmONC training; providing life-saving commodities (delivery kits, essential medicines, anatomic models, portable devices, etc.), particularly in humanitarian settings; communicating for maternal health to improve access and reduce delays (leaflets, social mobilization, birth preparedness focusing on EmONC needs); and fostering the development of innovative referrals for EmONC in countries.

GLOBAL HIGHLIGHTS

Technical partnerships

In support of national EmONC needs assessments, the MHTF has developed and nurtured a global technical partnership (the Alliance of UNICEF, UNFPA and AMDD), tools, norms and guidance documents. It also directly supports priority countries with technical assistance and funding. A national EmONC needs assessment is a survey of health facilities that serve three main functions:

- Establish a programme baseline in every district;
- Serve as an advocacy tool to promote maternal and newborn health and to improve the coverage and quality of services;
- Help set priorities based on need and available human and financial resources, thereby guiding the scaling up of maternal health services, district by district (district micro-planning).

Guidance document on scale-up of quality EmONC

In 2012, UNFPA and partners agreed to do a companion document to the EmONC monitoring handbook[3] to

[3] Monitoring emergency obstetric care. A handbook. WHO, UNFPA, UNICEF, Columbia University. WHO 2008. http://www.who.int/reproductivehealth/publications/monitoring/9789241547734/en

◀ Long distances to emergency obstetric and newborn care services can put women's lives at risk.

Diego Goldberg, UNFPA

Training on emergency and obstetric newborn care, Ethiopia.
Photo by UNFPA Ethiopia

improve the translation of evidence into policy and practice. The guidance document will build on relevant existing tools and technical guidance as well as on experiences and practices in scaling up EmONC in different countries and settings, including humanitarian situations.

Improving access to life-saving commodities

UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), a sister thematic fund to the MHTF, leads UNFPA's work in life-saving commodities. The MHTF team has collaborated closely with the GPRHCS team, WHO and UNICEF in updating the H4+ list of life-saving commodities and in supporting the work of the UN Commission on Life-Saving Commodities for Women and Children and its follow-up.

REGIONAL HIGHLIGHTS

Capacity building for EmONC needs assessments

The UNFPA alliance with Columbia University's Averting Maternal Death and Disability Program and UNICEF has developed the capacity of regional institutions over the years. This has increased sustainability and the pool of technical experts who can assist countries to conduct EmONC needs assessments, develop operational plans and monitor scale up of EmONC facilities. One example is the Health Sciences Research Institute (IRSS, based in Burkina Faso), which supported the assessments in Burkina Faso, Guinea and Togo. Similarly, the capacity of the icddr,b (International Centre for Diarrhoeal Disease Research in Bangladesh) has been strengthened to support South-East Asian countries. So far, it has supported the needs assessment in Bangladesh and Laos and will soon provide assistance to Nepal. Plans are under way to improve and expand this regional capacity building in sub-Saharan Africa to other institutions, such as the Schools of Public Health of the Obafemi Awolowo University (Nigeria); University of Ghana; University of Pretoria (South Africa); and Cheik Anta Diop University (Senegal). In Asia, this support is planned for the University of the Philippines. These institutions will be convened at a capacity strengthening workshop in 2013.

COUNTRY HIGHLIGHTS

EmONC need assessments in four countries in 2012

By the end of 2011, 24 countries had completed or were engaged in developing an EmONC needs assessment. Ten more countries have planned the assessment in 2012, of which seven (Bangladesh, Congo, Cameroon, Mozambique, Gambia, Guinea, Togo) have been completed (Figure 4).

To illustrate the work in countries on national EmONC needs assessments, Figure 4 and Table 2 present some results of recently finalized EmONC needs assessments in four countries (Chad, DRC, Gambia, Lao People's Democratic Republic). The indicators point to low

FIGURE 4

Cumulative number of MHTF-supported countries with needs assessments for emergency obstetric and newborn care

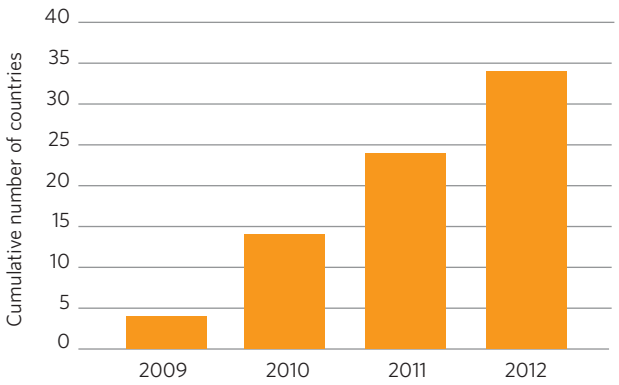


TABLE 2. Sample indicators for emergency obstetric and newborn care in MHTF-supported countries

EmONC indicators	Chad	**DRC** (3 provinces: Bas-congo, Bandundu, Kinshasa)	Gambia	Lao People's Democratic Republic
Total number of facilities assessed*	141	266	92	51
Availability of basic EmONC facilities**	3 facilities (Minimum acceptable level: 84)	5 facilities (Minimum acceptable level: 123)	2 facilities (Minimum acceptable level: 14)	5 facilities (Minimum acceptable level: 18)
Availability of comprehensive EmONC facilities	20 facilities (Minimum acceptable level: 23)	4 facilities (Minimum acceptable level: 31)	7 facilities (Minimum acceptable level: 4)	9 facilities (Minimum acceptable level: 5)
Geographic distribution: Proportion of subnational areas with the required number of EmONC facilities (minimum acceptable level, according to international standards, is five, including one comprehensive facility for every 500,000 population)	None of the 22 regions has an adequate number of EmONC facilities	0 out of 3 provinces meet the recommended minimum	0 out of 7 districts meet the recommended minimum	4 out of 12 districts meet the recommended minimum
Proportion of all births in EmONC facilities	4.6%	0.8%	62%	24.9%
Met need for EmONC†	4.3%	0.01%	56%	16.54%
Direct obstetric case fatality rate: The case fatality rate among women with direct obstetric complications in emergency obstetric care facilities (should not exceed 1%)	18.8%	0.5%	2%	0.16%
Intrapartum and very early neonatal death rate	41.5 per 1,000 live births	13.7 per 1,000 live births	27 per 1,000 live births	26 per 1,000 live births
Caesarean sections as a proportion of all births	0.5% (normal range 5%–15%)	1.3% (normal range 5%–15%)	3% (normal range 5%–15%)	2.6% (normal range 5%–15%)

* Partially functioning facilities are not included. Figures are based on signal function performance in the preceding three months (signal functions are key medical interventions used to treat the direct obstetric complications that cause the vast majority of maternal deaths around the globe).

** Minimum acceptable level of basic EmONC facilities includes only basic facilities.

† 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.

coverage of Basic EmONC services and important issues related to quality of maternity care, as for instance low proportions of Caesarean sections to all births. The situation is better regarding the number of comprehensive emergency obstetric care facilities, which exceeded the minimum required in Gambia and Lao People's Democratic Republic. However, issues of quality of care, anaesthesia, safety of the blood bank and response time for Caesarean sections need to be addressed urgently in such Comprehensive EmONC facilities.

It is not surprising that Chad has one of the world's highest maternal mortality ratios, given that none of its regions meets the required coverage in basic and comprehensive EmONC. Chad probably has the worst direct obstetric case fatality rate in the world, at almost 19 per cent. The direct obstetric case fatality rates (defined as the proportion of women with major direct obstetric complications who die in an emergency obstetric and newborn care facility) should not exceed 1 per cent. However, as Figure 5 shows, all the countries have quality of care issues, which explain their high maternal deaths.

Similarly, Caesarean sections as a proportion of all births remain extremely low in all the countries. Caesarean section is used as a proxy for all surgical emergencies as a result of obstructed labour. It is expected to range between 5 per cent and 15 per cent of all births, but the rates in all four countries are still far below 5 per cent. This points to the need for task-shifting in the short and medium term whilst investing in long-term capacity for all referral hospitals.

FIGURE 5
Direct obstetric case fatality rate for four priority countries

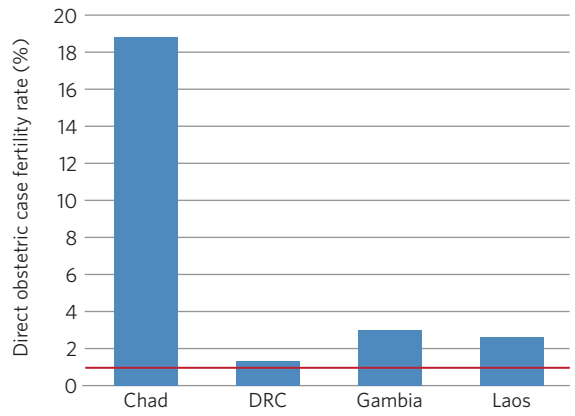


FIGURE 6
Per cent Caesarean sections in four priority countries

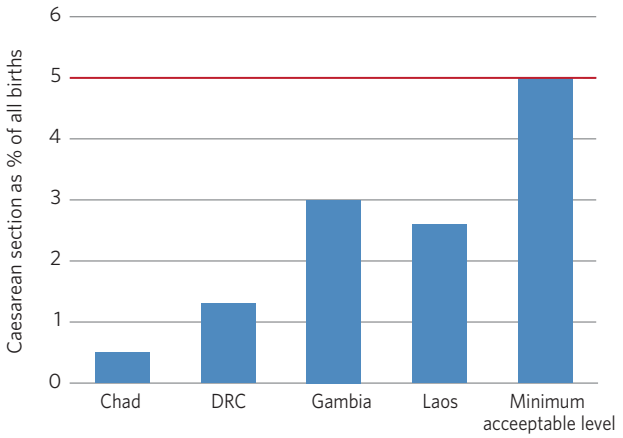
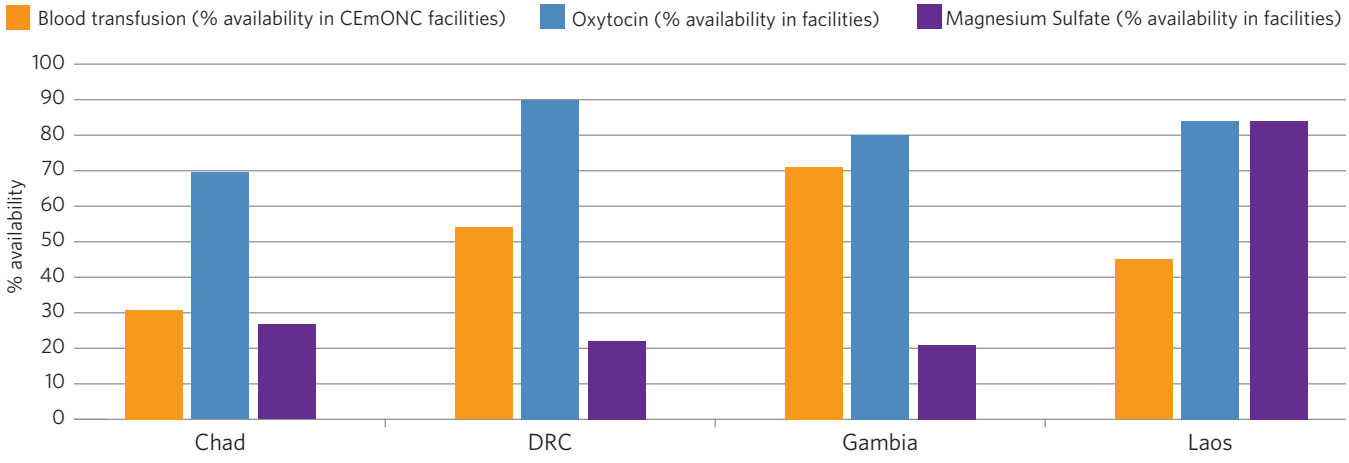


FIGURE 7
Availability of blood transfusion and life-saving maternal medicines



Cutting maternal and newborn deaths cannot be achieved without life-saving medicines and blood transfusions (for management of the first killer of mothers, haemorrhage). Figure 7 (left) indicates a low availability of magnesium sulfate (an inexpensive, life-saving medicine used to manage eclampsia and pre-eclampsia) in Chad, DRC and Gambia and a low availability of blood transfusions. This low coverage is aggravated by frequent stock-outs, such as in DRC, where 12 per cent of all facilities (and 18 per cent of maternities) have experienced a stock-out of oxytocin.

The wealth of evidence provided by such needs assessments on the coverage and use of basic and comprehensive emergency obstetric and newborn care provide a basis for reviewing norms and protocols, national plans and strategies, upgrading and scaling up services, and developing innovative strategies to address demand and referrals. Here are highlights of interventions, following an EmONC need assessment.

Task-shifting in Ethiopia

In response to the 2008 EmONC needs assessment, which depicted very low coverage and use of emergency obstetric and newborn care, the Government of Ethiopia developed several initiatives to improve the coverage and quality of services. These plans include a midwifery programme (production, recruitment and deployment of midwives) and a three-year Master of Science (Msc.) training programme in Integrated Emergency Obstetrics and Surgery (IESO) for Non-Physician Clinicians. UNFPA has supported the IESO programme through advocacy and partnership, capacity building (training of university staffs and equipping hospitals), curriculum development, and review and monitoring of progress.

Graduation of Integrated Emergency Obstetrics and Surgery (IESO) from Jimma University Ethiopia, June 2012.
UNFPA Ethiopia

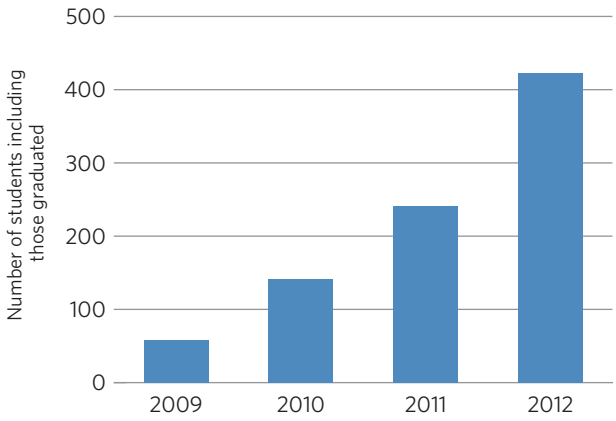
As a result, 422 students have been enrolled, of which 43 were graduated and deployed in 2012. Furthermore, the capacity of affiliated teaching hospitals has strengthened the quality of their services. UNFPA also leveraged partnership and resources (through the Centers for Disease Control and Prevention), which helped to scale up the programme in six additional universities and health science colleges.

Regular follow-up and review mechanisms by all partners helped to monitor progress. Lessons learned were used in a curriculum review to enhance training. In addition, 10 anaesthesia training institutions have been strengthened through teaching and learning materials. Moreover, 63 anaesthesia tutors were trained in teaching skills, anaesthesia drugs management and cardiac support and mechanical ventilation.

Establishing clinical excellence centres and scaling up of EmONC services in Cambodia

With support from UNFPA, three regional clinical EmONC training sites were established in Battambang, Kampong Cham and Takeo Referral Hospitals. Fifteen trainers from the three regions, including six physicians and nine midwife trainers, took part in a five-day training course to provide cascade trainings in their own

FIGURE 8
Number of Master of Science Students in the Integrated Emergency Obstetrics and Surgery programme in Ethiopia



regions. As a result, 15 secondary midwives were trained on post-partum haemorrhage (PPH); three physicians and seven secondary midwives were trained on manual vacuum extraction (MVE); and 20 secondary midwives were trained on magnesium sulfate (MgSo4). This programme is part of an ongoing process to develop life-saving skills in staff of designated EmONC facilities in line with national plans.

The practice of delivering training at regional clinical training sites and offering training on signal functions in a modular fashion has been developed to ensure that key staff can balance learning new skills with their clinical commitments, since past experience has shown that amid limited available human resources, it is not practical for such key staff to spend long periods of learning at central levels, away from the health facilities where they are posted. In addition to the EmONC training-excellence centres, UNFPA has supported the monitoring of scaling up of EmONC facilities by developing tools for data collection and conducting on-site assessment visits twice a year.

Evidence-based improvement of EmONC coverage in Lao People's Democratic Republic

Following the results of the national EmONC needs assessment, it was recognized that action was urgently required to develop a National Action Plan to strengthen EmONC facilities. UNFPA, whilst fostering the development of a national costed operational plan, provided support to the most disadvantaged provinces with essential equipment and life-saving medicines and a refresher competency-based training in basic and comprehensive EmONC for mid- and senior-level providers.

A newborn is delivered at a 'Maternity Smile' facility in Haiti.
UNFPA Haiti

Strengthened EmONC service delivery in Timor-Leste

With support from UNFPA, 300 midwives and 37 general-practioner doctors have been trained on EmONC; of these, 180 were certified as basic EmONC (BEmONC) providers. Twenty-eight health facilities have been equipped with materials and life-saving medicines to improve BEmONC, and a joint ministry of health/UNFPA supportive supervision system has been put in place and helped identify stock-outs of life-saving commodities (magnesium sulfate, oxytocin and sutures) in 4 district hospitals and 29 health facilities. The main bottleneck was a weak logistic-management system at national and subnational levels. Plans for improved procurement and logistics management are being set up.

EmONC services in humanitarian settings in Haiti

After the earthquake in Haiti in 2010, most of the health system was destroyed, and a challenging rebuilding process left women and adolescent girls with tremendous reproductive health challenges. To respond to this situation, UNFPA fostered the concept of 'Maternity Smile' ('Maternité Sourire' in French). The objectives were to:

- Provide 70,000 women and girls with quality services and information on reproductive health issues, including family planning (applying gender and cultural sensitivity);
- Equip maternity hospitals to ensure the seven signal functions for approximately 10,000 pregnant women with an anticipated 1,500 obstetric complications;
- Offer services that include family planning, medical care for victims of violence against women and girls, prevention of mother-to-child transmission of HIV, prevention and management of sexually transmitted infections, immunizations, and screening for cervical cancers;
- Organize an effective referral system.

'*Maternité sourire*' ('Maternity Smile') of Petite Place Cazeau, Haiti.
UNFPA Haiti

The first four '*maternité sourire*' were opened in 2012, with three supported by UNFPA. The facilities were built using anti-seismic standards, were properly equipped, had senior nurses-midwives posted and offered youth friendly services. The facilities will be used as models for scaling up of Basic-EmONC by the Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population) and development partners.

In December 2012, a national workshop was organized by the Ministry of Public Health and Population with UNFPA and USAID support and facilitated by the MHTF team. The purpose was to develop, with partners, a national multi-year scale-up plan for family planning and maternal health. As the broad strokes of the plan were written jointly, there was strong ownership by key stakeholders and the Minister, who led the proceedings. Subject to funding availability, the plan calls for meeting the minimum EmONC needs within a five-year period and to go a long way towards meeting the unmet need for family planning. The plan is available from the UNFPA Haiti Country Office.

CHAPTER FOUR

THE MIDWIFERY PROGRAMME

The Midwifery Programme was launched in 2008 and completed its fifth year of implementation in 2012. This partnership of UNFPA with the International Confederation of Midwives (ICM) aims to improve skilled attendance at all births in low-resource countries by developing the foundations of a sustainable midwifery workforce. To achieve this goal, the programme supports and guides national efforts by:

- Building capacities in ICM/WHO competency-based midwifery training and education;
- Developing strong regulatory mechanisms to promote the quality of midwifery services;
- Strengthening and establishing midwifery associations;
- Conducting proactive advocacy with governments and stakeholders to encourage investment in quality midwifery services to save the lives of women and their newborns.

Thirty countries received support from the Maternal Health Thematic Fund in 2012 to strengthen midwifery training and comprehensive workforce policies. Twenty-two midwifery advisers were placed at country level, four ICM advisors at regional level and a coordinating team at UNFPA headquarters. In addition, more than 20 countries used regular resources to strengthen midwifery education and comprehensive midwifery workforce policies in 2012 in Latin America, Arab States and Central European countries.

Figure 9 shows progress in select indicators related to midwifery education, regulation and associations in 30 countries[4] that received MHTF support for midwifery from 2010 to 2012. The data is self-reported from countries. A consolidation of results in 2011 through 2012 can be observed regarding national curricula after the release of WHO and ICM competencies; and regulations authorizing midwifery practice and national midwifery associations.

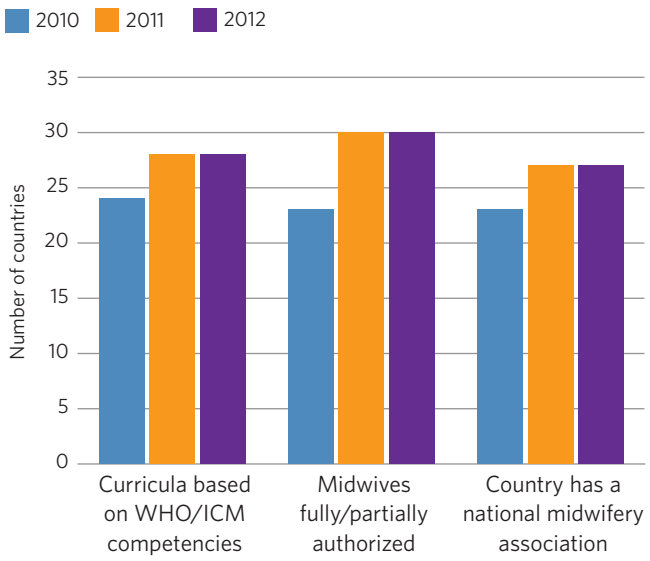
[4] Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Ethiopia, Ghana, Guyana, Haiti, India, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone, Uganda, South Sudan, Sudan, Timor-Leste and Zambia.

A midwife with a newborn. The photo was submitted to a photo contest in connection with UNFPA's first State of Midwifery Report.

UNFPA Cape Verde

FIGURE 9

Progress towards midwifery education, regulation and associations in 30 MHTF-supported countries



GLOBAL HIGHLIGHTS

Strengthening midwifery in revised UNFPA Strategic Plan 2012-2013

The significance of strengthened midwifery in achieving MDG 5 was recognised by the Executive Board of UNFPA when it adopted the revised strategic plan 2012-2013 with a new key output on midwifery: "To strengthen national capacity to implement comprehensive midwifery programmes" under Outcome 2: "Increased access to and utilization of quality maternal and newborn health services."

UNFPA and Intel partnership

In January 2012 at the World Economic Forum in Davos, Intel, a global technology giant, and UNFPA signed a memorandum of understanding to enter into a formal partnership on using e-training modules to strengthen the skills of midwives and other health workers. The modules are developed in collaboration with Jhpiego and WHO.

The programme relies on Intel SKOOOL™ health education software, which enables teaching to take place anytime and anywhere, using low-cost laptops/netbooks that health workers can be trained to use. UNFPA is the project lead in helping secure and develop the right content for the trainings in collaboration with partners, national stakeholders and governments, and in obtaining the accreditation and approvals for using the e-learning courses in countries. Intel will provide a no-charge license to use the SKOOOL™ platform and educate governments on improving access to broadband and connectivity solutions. In addition, Intel will assist in training the healthcare workforce on information and communications technology (ICT) skills, digital curriculum development and providing technology solutions.

To ensure global quality standards, a Technical Advisory Group (TAG), comprising ICM, International Council of Nurses (ICN) and International Federation of Obstetrics and Gynecologists (FIGO), reviews and vets each module.

The drafts of two training modules for pre- and in-service education of frontline health workers on pre-eclampsia/eclampsia and post-partum haemorrhage were completed in 2012 and are undergoing review by TAG. Two additional modules on prolonged and obstructed labour and post-abortion care are being developed. The plans are to produce multimedia e-learning modules on the entire WHO Basic emergency life-saving functions for midwives and other frontline healthcare workers by 2013.

Two pilots with partnerships in Ghana and Bangladesh were in the initial stages of planning and operation in 2012. In Ghana, the initiative on e-learning has already been adopted to improve capacities of midwives through technology driven pre- and in-service training in the MDG 5 Accelerated Framework Country Operational Plan (MAF COP). Consequently, e-learning for midwives has been included in the regional and district plans as part of the interventions for the next three years. In Bangladesh, a memorandum of understanding has been signed with the Ministry of Health and a detailed proposal titled '*ICT4RH*' has been developed. Additionally, operating plans were being formulated.

The partnership with Intel has received high visibility since its launch and was highlighted at United Nations General Assembly week at the Accountability Commission breakfast, the UN Innovation Working Group luncheon and the WHO Partnership for Maternal, Newborn and Child Health public-private partnership report, among others.

New Midwifery Tools Launched

The International Confederation of Midwives finalized and published '*ICM Standard Equipment List for Competency-Based Skills Training in Midwifery Schools*' to provide a reference document for countries to upgrade and/or equip laboratories in midwifery schools.

The newest tool produced by ICM and adopted in 2012 is the '*Model Curriculum Outline for Professional Midwifery Education.*' This features four resource packets based on the updated competencies and global education standards:

Packet #1: Background and the Curriculum Development Process

Packet #2: Model Midwifery Curriculum Outlines

Packet #3: Key Resources Available for Midwifery Education

Packet #4: Teaching and Learning in a Competency-based Curriculum

(For more information, go to http://www.internationalmidwives.org)

REGIONAL HIGHLIGHTS

- In Asia, efforts are under way to establish a Regional Resource Centre, which is expected to be a technical hub for midwifery education, regulation and association. Several technical meetings in the region were held to conceptualize its formation and establishment;

- Throughout 2012, efforts were made to widely disseminate and train midwives on the new ICM global education and regulation standards. In Uganda, ICM and White Ribbon Alliance (WRA) hosted a two-day standards and tools dissemination meeting, which was attended by over 35 participants from countries in sub-Saharan Africa. Dissemination of standards was also done at the Middle East and North African States meeting held in the United Arab Emirates in November 2012; and UNFPA and ICM hosted a panel at the International Federation of Gynecology and Obstetrics (FIGO) conference in Rome. The panel showcased the successes under the joint UNFPA/ICM programme active in 30 countries, mostly in Africa and Asia, and highlighted efforts towards ensuring competency-based midwifery education programmes while simultaneously strengthening midwifery regulations and associations;

- ICM provided assistance to the West Africa College of Nursing (WACN) secretariat in finalizing its diploma curricula for the subregion under the leadership of the West Africa Health Organization (WAHO). The regional curriculum reflects ICM standards and competencies;

- The draft outline document on preceptorship guidelines for quality midwifery education has been developed among ICM, Jhpiego and the American College of Nurse-Midwives (ACNM);

- The ICM and the White Ribbon Alliance partnered to share best practices in advocacy for midwives and midwifery services and to support country teams to develop advocacy plans for addressing select challenges in midwifery in 10 African countries;

- In July, a Train-the-Trainer (TOT) workshop was held in Lima (Peru) with representatives from that country and Bolivia, Ecuador, Guatemala and Paraguay. The workshop successfully achieved the objective of strengthening professional midwifery in the Latin America and the Caribbean (LAC) region by introducing new ICM competencies and global standards and developing leadership and advocacy skills to use in participants' respective political environments.

- More than 450 participants from 37 countries worldwide participated in the ICM Asia Pacific Regional Conference in Hanoi (Viet Nam). The conference was hosted by the Vietnamese Association of Midwives (VAM) with the theme '*For the health of women and children — Let's take action.*' The conference generated a lot of experiential sharing and networking among midwives in the region.

Capacity-Building Workshop of Country Midwife Advisers (CMAs)

To ensure the programme's success, it is important that the skills of country midwife advisers be updated and kept well informed of new global and regional progress and have opportunities to share experiences and knowledge and learn from one another.

The mid-year review and capacity-building workshop of CMAs is an annual programme feature. In September 2012, CMAs and programme staff from 25 countries participated in a workshop in Ethiopia. Besides knowledge sharing and programme review, the capacity-building efforts focused on training CMAs on a step-by-step approach to establish and strengthen regulatory councils and develop regulatory guidelines at country level. Regulations surrounding midwifery is the weakest component of the programme yet one of the most crucial elements, since they provide an enabling environment that midwives need to practice their profession and also protect the public. In addition, hands-on induction training was provided on the recent training package developed by Jhpiego and American College of Nurse Midwives (ACNM) on newborn resuscitation (Helping Babies Breathe) and postpartum haemorrhage (Helping Mothers Survive). These efforts used the latest innovative training models produced by Laerdal Global Health.

COUNTRY HIGHLIGHTS

As a result of the new output on midwifery in the revised UNFPA Strategic Plan 2012-13, programming for midwifery services was boosted in ongoing and upcoming country programmes of UNFPA.

National Needs Assessments Completed

In 2012, the joint UNFPA/ICM programme helped support the completion of gap analyses in an additional three African countries (Liberia, Malawi and Democratic Republic of the Congo) and two Asian countries (Timor-Leste and Viet Nam). Through this endeavour, the programme has helped support 31 gap analyses and needs assessments, of which 12 countries did both a needs assessment and a gap analysis. Using this example, midwifery gap analyses were also completed in seven North African and Middle East countries under the leadership of ICM and the UNFPA Arab States Regional Office.

South Sudan has the world's highest maternal mortality ratio (estimated around 2,000 per 100,000 live births). Yet it has fewer than 10 fully trained midwives and 150 community midwives. UNFPA, in collaboration with the Ministry of Health and the support of USAID, has deployed 15 international United Nations Volunteer (IUNVs) midwives in the healthcare system across nine states. In 2011 and 2012, the IUNV midwives have served more than 100,000 women in antenatal clinics across the country; supervised over 37,000 safe deliveries in hospitals and facilities; provided over 7,000 babies with newborn care; offered emergency obstetric care services to over 5,000 women; and given family planning services to more than 3,000 women.

The High-Burden Country Initiative

In 2012, in-depth national midwifery workforce assessments were conducted in eight countries: Afghanistan, Bangladesh, DRC, Ethiopia, Mozambique, Tanzania, India and Nigeria. These countries represent nearly 60 per cent of global maternal and newborn deaths.

This initiative came as a result of a 2011 meeting among Ministers of Health, leaders of UN agencies and the MDG Advocates Group as well as representatives from civil society, the private sector, partner governments and health professionals. The meeting elaborated priorities for H4+ (UNFPA, UNICEF, World Bank, WHO, UN Women and UNAIDS) support. Attendees recommended that H4+ should initiate, with government and development partners, national assessments of the midwifery workforce (all cadres, including doctors, nurses, obstetricians and community health workers) in all eight countries. The activities fell within the scope of the UN Secretary-General's Global Strategy for Women's and Children's Health.

Four national assessments have been completed in Afghanistan, Bangladesh, Ethiopia and Tanzania and are undergoing validation. Preliminary findings were presented at the 'Every Woman Every Child' summit in New York in September 2012.

The 2012 national assessments have compiled new and existing data on the quality of and access to midwifery services at the community level. The assessments provide modeled projections of midwifery service demands and workforce supply informing costed scenarios and policy options.

The Diploma Midwifery Curriculum in South Sudan has been approved by the Ministry of Health; over 200 students have been enrolled and are pursuing studies in midwifery and nursing at national health training institutes in Uganda and South Sudan. Nine national tutors graduated recently from Arusha (Tanzania) with diplomas in Health Professional Education and have been deployed at national health institutions across South Sudan. The midwifery in-service training programme and manual has also been finalized. UNFPA, in collaboration with the Ministry of Health and the UNDP Global Fund Programme, built a hostel in 2012 to accommodate 120 students at the Juba College of Nursing and Midwifery.

In **Bangladesh**, 350 midwives graduated from the six-month post-basic midwifery programme in October 2012, from 20 training sites. Bangladesh now has 525 trained midwives. A new three-year direct midwifery programme also began in November 2012 with 525 enrolled students. Since 2010, 138 midwifery teachers have been trained under the programme.

In **Burkina Faso**, skills and competencies of midwifery students were strengthened through the deployment of 49 senior midwives and 12 obstetrician/gynaecologists for clinical mentorship of students. This has contributed to an increased success rate of students in final exams.

In **Sudan**, UNFPA supported the recruitment of four professional midwifery tutors to serve in the Academy of Health Sciences to educate future midwives using ICM education standards.

In **Liberia**, two midwifery schools graduated their first classes of approximately 46 students with diplomas in midwifery in 2012. The BSc. (degree) midwifery programme has also begun at one of the universities.

In **Lao People's Democratic Republic**, June 2012 was designated by the Ministries of Health as the 'Month of Midwives' to celebrate the second cohort of community midwives being awarded their national accreditation license to practice. Additionally, 44 teachers from training institutions upgraded their midwifery and teaching skills, and 14 national midwifery examiners were trained in the new accreditation and licensing examination.

To further build capacities in midwifery skills, **Côte D'Ivoire** organized three workshops that trained 65 trainers from 22 clinical training sites in emergency obstetric care skills (Active Management of the Third Stage of Labor/AMTSL). The trainers will now coach 600 students every year.

All 29 midwifery schools in **Ghana** now have a curriculum based on ICM essential competencies. In collaboration with the Northern Regional Directorate of the Ghana Health Service and the Ghana Registered Midwives Association, 45 practicing midwives serving in remote areas of the north were identified for capacity building in obstetric and neonatal emergencies. They have since undergone intensive two-week life-saving skills training in both theory and clinical practice. The training is expected to empower the midwives with enhanced skills to detect and manage complications of pregnancy and childbirth.

In **Nepal**, efforts are under way to start a bachelor's degree in midwifery programme for which first-year teaching and training materials have been developed. UNFPA has conducted a feasibility study and found five potential universities that are ready to introduce midwifery with global standards. Skill labs have been established in three of the five universities.

In **Djibouti**, an innovative micro-planning tool has been launched by a team of four midwives and supervised by a

Leveraging Canadian support for a Midwifery Services Programme in South Sudan

UNFPA South Sudan successfully mobilized over $19 million (Canadian dollars) from the Canadian International Development Agency for a comprehensive midwifery services programme. This five-year project was signed in April 2012 and focuses on expanding and strengthening work already started on midwifery education, regulations, associations and advocacy. The project will also contribute to strengthening comprehensive emergency obstetric and newborn care (CEmONC) services in South Sudan by establishing and implementing a task-shifting programme to train non-physician clinicians in CEmONC, including Caesarean sections.

gynaecologist to improve the quality of reproductive health services in maternity units. The tool relies on a system of self- and peer-assessments that midwives can use to measure their performance, identify problems and find solutions to dysfunctions in healthcare facilities.

Midwifery Regulation

Burkina Faso's National Midwifery Council: In 2012, the country adopted a law on the creation and functioning of the Midwifery Council. With this law, the Council is empowered to enforce compliance with the core values of midwifery in Burkina Faso. An improved quality of care and professional ethics training was organized for 52 reproductive health managers and executive members of midwives organizations. This training has enhanced midwives' and other birth attendants' knowledge on the basics and practical aspects of the legislation and reproductive health rights, as a step towards patient-centred care.

Cambodian Midwifery Council (CMC) received technical and financial support from UNFPA to strengthen core competencies of midwives, internal regulations for midwives and development of a code of ethics for midwives. To ensure effective monitoring, the CMC committee informed midwives to register as CMC members. The number of registered midwives increased from 2,160 in 2011 to 2,870 in 2012 (representing 62 per cent of midwives in Cambodia). More efforts are needed to increase the proportion of midwives formally registered with the CMC. The Code of Ethics for Midwives was finalized, submitted to the Office of the Council of Ministers and endorsed; it is pending final approval by the Prime Minister, expected to occur in early 2013. The CMC also developed the Essential Competencies for Basic Midwifery Practice with technical inputs from high-level officials of the Ministry of Health and Health Development Partners, ensuring that it complies with best practice.

In **Afghanistan**, the Act for Nursing and Midwifery Council was passed through the Ministry of Health and was followed up during its vetting process in the Ministry of Justice. This is a key step in regulating midwifery services in Afghanistan.

In **Benin**, a law for the creation of a midwifery council was developed in 2012 and is pending a National Assembly vote.

Midwifery Associations

South Sudan has established State Nurses and Midwives Associations in all 10 states. This step follows the major launch of the national association in 2011. These associations provide a useful opportunity to engage key state officials, including the State Ministers of Health, in discussions on strengthening midwifery and maternal health services in all the states.

In April, **Afghan Midwives Association** (AMA) held its eighth annual congress to celebrate its resolute

The Accelerated Midwifery Training Programme in Ethiopia

In Ethiopia, the Ministry of Health has established an Accelerated Midwifery Training Programme to achieve a minimum standard of midwife-to-population ratio and increase skilled birth attendance. Approximately 1,600 midwives graduated in 2012, surpassing the annual target of 1,000 midwives. This increase contributed to more available midwives, from 1,275 in 2008 to 4,700 in 2012. The progress is considered on track in achieving the national Human Resources for Health Strategy target of training 8,635 midwives by 2015.

Midwives have been deployed to health centres and are now providing delivery and Basic Emergency Obstetric and Newborn Care (EmONC) services. Thirty-one midwifery training institutions were equipped with teaching and learning materials, including books, training models, monitors and computers. Furthermore, there has been an increased capacity of 124 midwifery tutors through training in effective teaching skills, family planning and basic emergency obstetric care.

The newly released ICM Midwifery competencies and standard training modules were distributed to 25 teaching heads and tutors of Midwifery Departments from all universities and representatives from Federal Ministry of Health. The Country Office supported the Federal Ministry of Health to train 12 officers in curriculum development and to develop a National In-service Training Guideline.

commitment to improving maternal and newborn health. Approximately 800 people attended, including midwives and students from 33 of the country's 34 provinces.

Midwifery associations in many countries continued to increase their membership. For example, the **Midwifery Society of Bangladesh** registered 260 new members.

In **Timor-Leste**, the midwifery association finalized registration with the government authority and participated in a study tour to Indonesia to learn more about the work of midwifery associations.

In **Ethiopia**, the Midwives Association, with support from UNFPA, conducted a census by registering all midwife professionals and students enrolled in public and private institutions. A total of 4,332 midwives and 7,037 midwife students, with their background information and place of assignment, have been registered. UNFPA supported the Ethiopia Midwifery Association (EMA) to establish a database to be updated every quarter by the EMA. The database has proved effective in ensuring fair distribution of graduates among regions; meeting the standard number of midwives at various levels; monitoring attrition rates; and assessing the correlation between number of midwives and skilled birth attendance. The database provides complete background information, practices and place of assignment of 4,725 midwives and 7,037 students.

In **Zambia**, a three-day leadership skills workshop for 19 nurse/midwife leaders was conducted and mentoring and supportive supervision was provided for six health facilities.

In **Guyana**, the midwifery association is in the forefront in its continuing education of midwives across eight regions of the country. Midwives have also enhanced their knowledge and skills in providing family planning services. This work has contributed to significantly improving uptake of family planning across Guyana.

The five-year strategic plan and monitoring tool for the **Ghana** Registered Midwives Association has been finished and will help streamline activities of the association.

Uganda increases midwifery coverage in remote areas

In Uganda, UNFPA, in partnership with the Ministries of Health, Education and Sports, Women Achievers and the White Ribbon Alliance of Uganda, implemented a Midwifery Career Promotion project targeting schools in the Karamoja region to encourage students to make midwifery a career. Karamoja is a hard-to-reach region, with a harsh environment, and lack of social amenities like schools and poor roads. Health personnel do not want to work there because of insufficient medical supplies and work overload.

Consequently, Karamoja has the least number of midwives in Uganda, with 91 per cent unfilled midwives' positions at Health Centre (HC) I level and up to 70 per cent unfilled positions at HC II level.

A bursary fund was established for midwifery training for underserved districts like the ones in Karamoja. The beneficiaries are bonded to work in the targeted districts for at least two years following their training. However, few students from Karamoja districts applied for midwifery training.

A midwifery career promotion in the senior year of secondary school was therefore introduced to inspire young people to apply for midwifery training and benefit from the bursary scheme. They would in turn serve in their districts to meet the challenge of midwifery understaffing. Through the project, students in Karamoja have been encouraged to consider a midwifery career with activities such as guided facility visits, essay competitions on midwifery and student-led advocacy of midwifery at the district level. The media have also been tapped to promote careers in midwifery.

The project has led to over 100 per cent increase in the number of students applying and enrolling in midwifery studies. Of these, 22 completed training by September 2012 and 8 were recruited at health centres in their birth districts. The other 14 were in the process of being recruited. Furthermore, facility-based deliveries in health centres with a midwife have witnessed a remarkable increase.

CHAPTER FIVE

THE CAMPAIGN TO END FISTULA

Obstetric fistula is a severe morbidity that is caused by prolonged obstructed labour without timely access to emergency obstetric care, typically a Caesarean section. The sustained pressure of the baby's head on the mother's pelvic bone damages her soft tissues, creating a hole—or fistula—between the vagina and the bladder and/or rectum. In most cases, the baby is stillborn or dies within the first week of life, while the fistula renders the woman incontinent. With skilled attendance at birth and timely access to emergency obstetric care, these injuries can be prevented.

Besides the physical condition, fistula leaves women ashamed, ostracized and alone. Many women and girls who suffer from fistula are excluded from daily community life and abandoned by their husbands and families, isolating them socially and emotionally. This makes it difficult to maintain a source of income or support, thus deepening the poverty and suffering of the women.

It is estimated that two to three million women and girls are living with obstetric fistula[5] and more than 50,000 new cases[6] develop each year. Yet, obstetric fistula is preventable and, in most cases, treatable.

Taking the lead in global efforts to eliminate obstetric fistula, UNFPA and partners launched the Campaign to End Fistula in 2003, with the goal of making fistula as rare in developing countries as it is in the industrialized world. Through its three-pronged strategy of prevention, treatment and social reintegration, the Campaign has helped women and girls rebuild their lives after suffering from fistula.

Recognizing that "only through concerted efforts to work in partnership will we realize our mutual goal to eliminate preventable maternal mortality and morbidity, in line with human rights obligations,"[7] the campaign harnesses the power of partnerships as well as coordinated, concerted efforts to tackle this neglected health and human rights issue. The campaign operates in 55 countries in Africa, Asia, the Arab States and Latin America (Figure 10), bringing together over 80 partner agencies at global level plus many others at national and community levels. UNFPA serves as the secretariat for the International Obstetric Fistula Working Group, the main decision-making body of the Campaign to End Fistula. The working group promotes effective, collaborative partnerships to address all aspects of

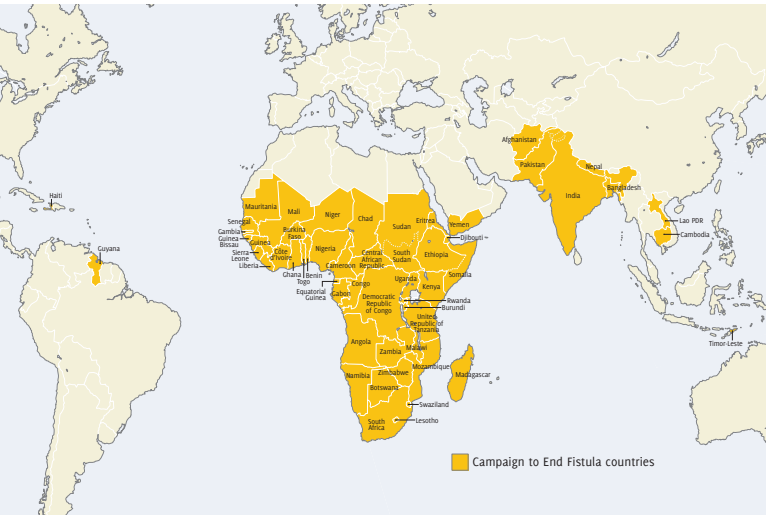
[5] http://www.who.int/features/factfiles/obstetric_fistula/en/
[6] van Beekhuizen, Heleen J et al., "Complications of obstructed labour: pressure necrosis of neonatal scalp and vesico-vaginal fistula," *Lancet*, vol. 368, issue 9542. (September 2006).
[7] Pillay, N. Maternal mortality and morbidity: a human rights imperative. *Lancet*, Vol. 381. (April 2013).

Rabecca Alberto, 19, is now the proud mother of a healthy daughter. Rabecca lived with a fistula from the time she was 12 years old, when her first pregnancy resulted in a stillborn baby, after she suffered from a prolonged, obstructed labour for five days. Her fistula was surgically repaired four years later.

Gloria Santos

FIGURE 10

Campaign to End Fistula Countries



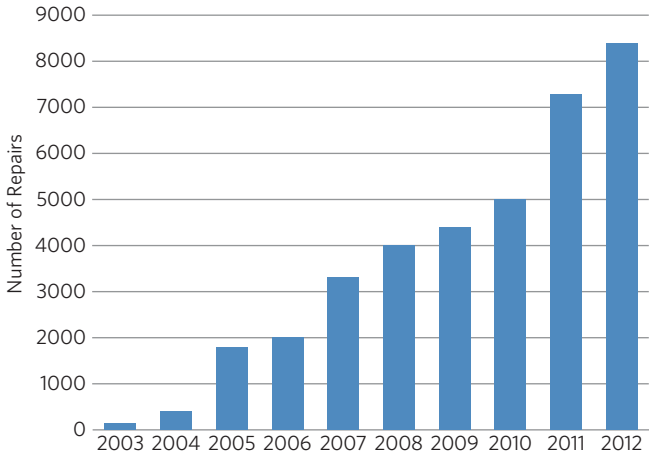
fistula. As a global coordination mechanism, it facilitates partner dialogue and joint projects with five sub-working groups on prevention and conservative management; advocacy and partnerships; treatment and training; data indicators and research; and social reintegration.

Key results in 2012 for the Campaign to End Fistula's first decade

In 2012, 8,400 fistula repairs were performed through direct support from UNFPA, continuing the steady trend of reaching more women and moving us closer to the UNFPA Strategic Plan target of 10,000 in 2013 (Figure 11).

FIGURE 11

UNFPA-supported fistula repair surgeries, 2003–2012



In the decade since the campaign began (2003-2012), UNFPA has directly supported over 35,000 women and girls to access fistula surgery/treatment and care. Furthermore:

- In 2012 alone, 8,400 women and girls in 55 countries were supported by UNFPA to receive fistula treatment;
- 36 high-burden countries have developed strategies to prevent, treat and provide reintegration services for obstetric fistula;
- A national coordinating mechanism for fistula activities is in place in 35 fistula-affected countries;
- 33 countries now have integrated prevention, management and treatment of fistula into their training curricula for healthcare workers;
- Routine data collection mechanisms include indicators on obstetric fistula in 25 countries;
- UNFPA fostered South-South cooperation among dozens of countries.

While this report focuses on UNFPA's role, partnerships continued to be the cornerstone of the campaign, and many have contributed significantly to advancing the cause, including:

- EngenderHealth has supported almost 30,000 fistula repair surgeries since 2001 through the Fistula Care project;
- Health Poverty Action pioneered a 'comb-through approach' to identifying 'invisible' fistula sufferers in the hardest to reach, most deprived communities in Sierra Leone;
- The community-based non-governmental organization, The Association for Re-orientation and Rehabilitation of Women for Development (TERREWODE), mobilized grassroots women's groups to engage partners to prioritize fistula, maternal and child health promotion in Uganda;
- Numerous new partners worldwide joined forces with the global Campaign to End Fistula, including:

Dr. Abbo's National Fistula and Urogynaecology Center (Sudan), Aden Hospital and Sana'a Hospital (Yemen), Cure Hospital (Afghanistan), Hope Against Fistula Support Organization (Uganda), International Nepal Fellowship and World Vision, among others.

GLOBAL HIGHLIGHTS

United Nations Secretary-General: Urgent action on fistula

Noting that over the past several years, considerable progress has been made in focusing attention on maternal deaths and disabilities, including obstetric fistula, the United Nations Secretary General's report '*Supporting Efforts to End Obstetric Fistula*,' (2012) called for intensified political commitment and financial mobilization to accelerate progress towards ending fistula. The Secretary-General noted that despite positive developments, many serious challenges remain. The report recommended that special attention be paid to countries with the highest maternal mortality and morbidity rates, especially those struggling to make sufficient progress toward MDG 5.

Global resolution on ending fistula passed by UN General Assembly

The United Nations General Assembly adopted by consensus the UNFPA-backed resolution on 'Supporting Efforts to End Obstetric Fistula,' calling for renewed focus and urgent additional resources for fistula. The resolution emphasized the importance of securing reproductive rights as well as urgently accelerating efforts to address child marriage. It also designated 23 May as the International Day to End Obstetric Fistula, to be observed annually beginning in 2013 to significantly raise awareness and intensify actions towards ending fistula. In addition, the resolution reaffirms the Programme of Action of the ICPD and the Beijing Declaration and Platform for Action.

Innovative fistula repair kits launched

Innovative partnerships helped to launch new and improved obstetric fistula repair kits to support UNFPA programmes and partners working on fistula globally. To overcome past problems of poor quality equipment and lack of accessible specialized materials for fistula surgery, UNFPA lead a multi-disciplinary team effort to develop new and innovative fistula kits. UNFPA's Procurement Services Branch (PSB) joined forces with the Technical Division and expert members of the International Society of Obstetric Fistula Surgeons (ISOFS) to create fistula repair kits to bridge the longstanding service gap in fistula care and to help improve surgical outcomes in the future. For the first time, there are now two complementary kits to undertake fistula surgery.

These kits are designed to provide the high-quality materials that are needed for performing surgical repairs.

- **Kit 1** is comprised of all necessary fistula repair instruments to do one fistula repair;
- **Kit 2** is comprised of supplementary special materials (often not readily available to many experts in the field) to provide 20 fistula surgical repairs and their post-operative care.

Since introducing the kits at the end of 2012, demand has increased significantly. Over 300 orders were received for Kit 1 and 425 for Kit 2 from 16 countries. Requests are expected to increase in 2013.

Taking a look: Fistula surgeons inspect the new kits on display at the 2012 International Obstetric Fistula Working Group meeting 2012 in Dhaka, Bangladesh.
Photo credit

Global fistula map

Launched in early 2012 by Direct Relief International, together with UNFPA and the Fistula Foundation, the pioneering Global Fistula Care Map (Figure 12 / www.globalfistulamap.org) provides a 'snapshot' of the state of fistula treatment capacity around the world, highlighting over 150 health facilities providing fistula repair surgeries in 40 countries. The map also shows the reality that only approximately 15,000 cases receive treatment each year compared to the estimated 50,000 to 100,000 new cases annually.[8,9] The map also illustrates that the largest gaps are found in countries with the highest levels of maternal deaths and obstetric fistula, such as Burundi, Chad, Central African Republic, Somalia and South Sudan.

The map is a dynamic data tool that will be continuously updated and expanded based on input from fistula experts and practitioners from around the globe.

Film on innovative mobile technology scheme in Tanzania

Harnessing technology to empower and improve the lives of the poorest, most vulnerable and often the hardest to reach populations is a key strategy for eliminating maternal mortality and fistula. One such initiative is the partnership between Vodafone/M-PESA and the Comprehensive Community Based Rehabilitation (CCBRT) Hospital in Tanzania, using Vodafone's mobile banking system, *M-PESA*. The hospital sends money by SMS to community ambassadors, who retrieve the money from a local Vodafone M-PESA agent to buy bus fares for the patients who need treatment but could not afford to access it. After launching this initiative, the number of patients seeking fistula treatment at the Tanzania hospital increased substantially, from about 150 a year in 2009 to over 500 a year in 2012.

At the request of UNFPA, Emmy Award winning filmmaker Lisa Russell documented this initiative. The film premiered at the historic Zanzibar International Film Festival—ZIFF, East Africa's largest film and music gathering, in July 2012. The film aims to share information with practitioners around the world so that they can be inspired to replicate this good practice and develop new ideas about mobile phone use to reach women and girls with fistula and to improve maternal health.

Giving voice to the voiceless: Fistula survivors at annual global meeting

In 2012, for the second time in the history of the Campaign to End Fistula, fistula survivors participated in the International Obstetric Fistula Working Group (IOFWG) annual meeting of technical experts in Dhaka, Bangladesh. This was not only a symbol of the international recognition of their valuable advocacy work with the Bangladesh Women's Health Coalition, but more important it was a key contribution to programmatic and strategic efforts at

FIGURE 12
Screenshot of the global fistula care map website

[8] van Beekhuizen, Heleen J et al., "Complications of obstructed labour: pressure necrosis of neonatal scalp and vesico-vaginal fistula", *Lancet*, vol. 368, issue 9542 (September 2006).
[9] www.globalfistulamap.org.

the global level. Fistula survivors/advocates are increasingly employed to reach women and girls living with fistula, and advocate for prevention, women's empowerment, men's engagement and political commitment to end fistula.

Ground-breaking research on fistula

To contribute to the global knowledge base on obstetric fistula, a landmark international fistula study is being conducted in three countries (Bangladesh, Ethiopia and Niger). The study, carried out with the Johns Hopkins University Bloomberg School of Public Health, icddr,b and other partners, is examining post-operative prognosis, improvement in the quality of life, social reintegration and the rehabilitation of fistula patients after surgical repair in treatment centres. Given the MacArthur Foundation's work on maternal health in Nigeria, UNFPA and colleagues at Johns Hopkins University worked with the foundation to develop the research programme with Nigerian national institutions, making this a four-country cohort follow-up study of women with fistula.

The International Society of Obstetric Fistula Surgeons meeting

With the theme '*Fistula: An Injustice to Women; Let Us Work Together to Bring Justice*,' the congress of the International Society of Obstetric Fistula Surgeons (ISOFS) attracted hundreds of leading surgeons, scholars and practitioners from all over the world. Held in Dhaka (Bangladesh) from 15-17 November 2012, the congress enabled participants to meet and share their experiences on fistula issues and discuss and deliberate on prevention, treatment, rehabilitation and research.

For the first time, a one day post-congress live surgical workshop, featuring world-renowned fistula surgeons, was held on the management of both complicated and uncomplicated fistula. The first set of ISOFS standards and guidelines was unveiled, and a new president, Dr. Tom Raassen, was elected, with other key leadership posts.

REGIONAL HIGHLIGHTS

Increasing South-South cooperation

South-South collaboration is a key strategy of the Campaign to End Fistula. UNFPA and partners continued to support sharing of knowledge, skills and resources among many countries. For example, global fistula expert Dr. Ambaye Wolde Michael Geda of WAHA/Ethiopia, who with Dr. Mulu Muleta is one of the world's best African female fistula surgeons, travelled to Mozambique to help increase capacity there. And another renowned fistula surgeon, Dr. Andrew Browning of Selian Fistula Project/Tanzania, supported Sierra Leone to strengthen its fistula program. The campaign partner Mercy Ships visited both Guinea and Togo to help address the unmet needs of fistula patients. In addition, UNFPA/Yemen Country Office supported a study tour for national partners to the renowned Hamlin Fistula Hospital in Ethiopia.

Reviewing sub-Saharan conditions

In the two UNFPA sub-Saharan Regional Offices, UNFPA's two technical consultants for fistula conducted analytical reviews of the situation in the countries within their respective regions. These assessments resulted in country-specific as well as overall regional recommendations to improve fistula policies and programming within sub-Saharan Africa, which is the worst-affected region of the world regarding fistula. These reports will serve as a foundation to build up and strengthen UNFPA and national partners' efforts to end fistula within their own countries.

COUNTRY HIGHLIGHTS

Enhancing national leadership on fistula

Thirty-six high-burden countries now have policies to prevent, treat and provide reintegration services for fistula. Progress has been made on integrating obstetric fistula into countries' national health policies and plans, including in Bangladesh, Burkina Faso, Ghana, Guinea, Guinea-Bissau, Madagascar, Mali, Mozambique, Sierra Leone, Sudan and Uganda. In Afghanistan, the revised reproductive health policy and strategy focused on male involvement, emergency obstetric care, fistula and gender-based violence.

To facilitate coordinated planning and interaction between partners working on all aspects of obstetric fistula, 35 high maternal mortality and morbidity countries have created a National Task Force for Fistula (or equivalent national coordination mechanism for fistula activities). These task

forces are typically led by Ministries of Health, and consist of civil society organizations, medical providers and United Nations agencies. Uganda's task force is a role model, meeting regularly to enhance dialogue and coordination of fistula activities.

Supporting fistula survivors to "get their lives back"

In 2012, about 19 countries, including Afghanistan, Cameroon, Guinea-Bissau and Nepal, reported on women who received reintegration/rehabilitation services, a key component of the continuum-of-care, reflecting increased commitment to this aspect. However, in most countries, only a fraction of fistula patients are offered reintegration services, despite their significant needs.

National leadership takes ownership in Chad

In a country with high maternal deaths and a low number of maternal health professionals, over 60 health officials and practitioners gathered for training and development in Chad's capital, N'Djamena, in May 2012 to discuss the challenges in overcoming fistula. Following that workshop, UNFPA supported the National Reproductive Health and Fistula Treatment Center in N'Djamena to be fully equipped to treat the condition and train health professionals in fistula surgery and in social reintegration of survivors in Chad. The government's commitment is reflected by the direct involvement of President Idriss Déby Itno and the first lady in maternal health and fistula initiatives.

Cambodia: Women come out of the shadows

In Cambodia, fistula repairs have become available just recently. With support from UNFPA, the Children's Surgical Center (CSC) started a project to address obstetric fistula and help women in remote locations obtain treatment in facilities with international professional standards. Poorer women living in rural areas can now receive free surgical repair through the joint initiative.

Somalia: Reaching the 'invisibles'

The Ministry of Health of Somalia has launched a campaign to end fistula in the country in partnership with UNFPA and WAHA International, an international NGO. The campaign's objective was to reduce the backlog of fistula cases, create awareness of the disability among the general population and advocate for more recognition and funding from governments and donors to fight the problem in the country. During the campaign, all fistula patients are provided with free comprehensive services, including surgery, counselling, food and accommodation, as well as money for transportation, clothes and hygiene products. UNFPA provides on-the-job fistula repair training to Somali health workers and raises community awareness about the availability of free fistula repair services.

South Sudan: Understanding causes of fistula

A recent report highlighting the results of the fistula campaign was launched in South Sudan. The report outlines the findings of an assessment by the London School of Hygiene and Tropical Medicine and UNFPA to help determine the effectiveness of the maternal health infrastructure in the country and understand the underlying causes and factors linked to obstetric fistula. The report can be a starting point for rebuilding the health system.

Recovering after 30 years with fistula

The story of Sam Ean typifies a Cambodian woman's experience with fistula. She developed the condition during her first pregnancy in the early 1970s, when she gave birth to a stillborn child during the country's civil war. At the time, she was unaware of other women with the same problem and did not know how to manage the situation. For years, she tried local healers suggested by friends, relatives and neighbours but found no relief. They all believed that her condition could not be healed. She ended up thinking she would have to live with the problem forever. Unable to consult with experts, she endured the life-shattering consequences of fistula for over 30 years. Happily, she was finally cured in 2012.

Sam Ean and her grandson at home in Paur village, 75 kilometres south of Phnom Penh, after a successful fistula surgery in July 2012. UNFPA Cambodia

Addressing nutritional needs in Guinea

Recognizing the key role of nutrition in the healing process for women and girls when facing and recovering from fistula surgery, UNFPA joined with the World Food Program (WFP) in Guinea to address women's nutritional needs. About 165 women treated for fistula were provided with food during their hospital stay. After being released, they were given a food ration to cover the nutritional needs of a family for five months. Recognizing the need to break the cycle of poverty and vulnerability that renders women and girls susceptible to fistula, the UNFPA/Guinea-WFP collaboration also addresses women's economic empowerment and social reintegration. In 2012, 150 fistula survivors were trained in soap-making and production of a local cassava-based food called gari.

Yemen focuses on national fistula awareness and programming

In Yemen, where awareness of fistula is just beginning to take hold, UNFPA contributed to developing the national fistula strategy to build the capacity of the management teams of fistula units in Sana'a and Aden and to the EmONC assessments in the governorates of Ibb and Hodeida. A number of fistula patients, including some from refugee and internally displaced persons camps (thanks to collaboration with MSF and UNHCR), underwent fistula repair surgery in May and June, with support from UNFPA.

UNFPA also made important strides in monitoring and evaluation (M&E) for fistula, including integrating questions on fistula into the national Demographic and Health Survey (DHS) and implementing an innovative approach to M&E by applying anthropological data collection techniques. This anthropological approach served to: 1) assess the project from the obstetric fistula patients' perspective rather than only from the trainees' perspective and 2) explore the 'lived experience' of fistula from Yemeni women's perspectives and the root causes of obstetric fistula in Yemen. The methodology enabled interviewers to delve into the qualitative dimensions of fistula, which are often difficult to capture.

Promoting a holistic healing model in Nigeria

The Fistula Foundation Nigeria (FFN) is a UNFPA-supported partnership that aims to raise awareness about

Fistula patients ready to be discharged.
Musa Isa, Fistula Foundation, Nigeria

fistula at community level; to develop positive attitudes towards patients to counter stigma; and to promote safe motherhood practices. The foundation offers a mix of counselling, advocacy and service delivery, with periodic surgery pool efforts to reduce the backlog of fistula patients. Following treatment, patients receive intensive professional training to assist them to reintegrate into their communities. This enables them to support themselves, which is crucial to helping them regain their autonomy and dignity. In acknowledging its outstanding service, the foundation was recognized by the Nigerian Institute of Public Health as a model of excellence in promoting safe motherhood and implementing effective fistula management practices. It also received the Excellence Award from the Obafemi Awolowo University in Ile-Ife, Nigeria.

Gauging prevalence through demographic and health surveys

Several countries have incorporated questions related to obstetric fistula in their national demographic and health surveys (DHS). These are supported by national governments, USAID, UNFPA and other development partners and provide invaluable population-based data every few years. Estimates of national prevalence of fistula are now increasingly available through these surveys. Eventually, every woman with fistula should be recorded and receive follow-up to prevent recurrences, take preventive actions to avoid new cases and have actual prevalence figures and not just estimates.


2018

CHAPTER SIX

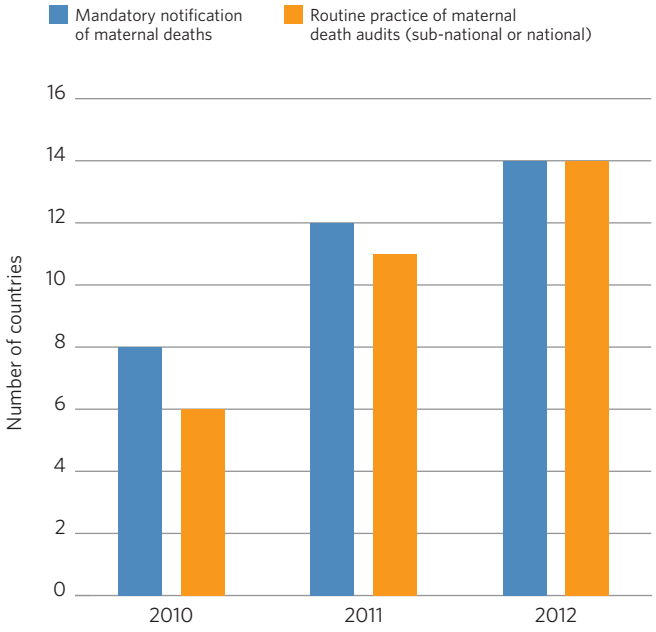
MATERNAL DEATH SURVEILLANCE AND RESPONSE

Current methods for estimating maternal mortality lack precision and are not suitable for monitoring progress in the short run. Without routine information on where the greatest burden of mortality lies within each country, who is concerned, what are the causes and sub-national variations, the accountability of governments, development partners and civil society cannot be assured. The objectives of the Maternal Death Surveillance and Response (MDSR) system are to provide information that effectively guides actions to eliminate preventable maternal deaths at health facilities and in the community. The goals are also to count every maternal death to assess the true magnitude of maternal mortality and to gauge reduction effects by the health system at each level.

In 2012, there has been an increased call for accountability, which has resulted in significant changes in countries in carrying out mandatory and real-time notification of maternal deaths, along with analysis of circumstances surrounding the deaths (maternal death reviews)—see Figure 13.

FIGURE 13

Number of countries reporting mandatory notification of maternal deaths and institutionalization of maternal death reviews, in the first 15 countries[10] that received support from the MHTF



[10] Now 16 countries, including South Sudan.

When pregnancies go wrong: a woman suffering from a fistula. For each maternal death, at least 20 other women suffer from maternal morbidity.

Benedicte Desrus, UNFPA

GLOBAL HIGHLIGHTS

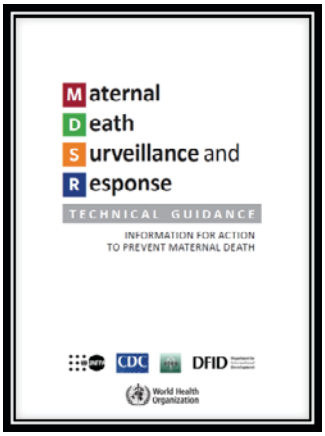
Developing guidance and tools

An inter-agency publication of the MDSR implementation guidance has been finalized with contributions for the MHTF team for UNFPA, with WHO, the Centers for Disease Control and partners. This guidance and the integrated disease surveillance and response manual, with the WHO '*Beyond the Numbers,*' will guide implementation in countries.

In addition to the previously mentioned Comment in *The Lancet* (see Chapter Two), a seminal article was published[11] to position elimination of preventable maternal mortality in the post-2015 agenda; describe the maternal death surveillance and response system; build on lessons from communicable disease surveillance; and consider the pre-requisites for implementation and universal national adoption.

REGIONAL HIGHLIGHTS

Supporting countries' roll-out of MDSR



With support from UNFPA, two regional orientation workshops on Maternal Death Surveillance and Response were organized in Tanzania in partnership with WHO and UNICEF in 2012 for 10 English-speaking countries (Ethiopia, Ghana, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe) and organized 19 Francophone and Portuguese-speaking African countries in Burkina Faso (Angola, Benin, Burkina Faso, Burundi, Cameroon, Chad, Comoros, Congo, Côte d'Ivoire, DRC, Gabon, Guinea, Madagascar, Mauritania, Niger, Central African Republic, Sao Tome and Principe, Senegal and Togo). These workshops also revitalized maternal death reviews and related methodologies ('*Beyond the Numbers*'—WHO, 2004) as integral components of MDSR.

COUNTRY HIGHLIGHTS

Burundi starts verbal autopsies

Building on the institutionalization of maternal death reviews in 2011, Burundi started in 2012 to use verbal autopsy as a tool to ascertain causes of maternal mortality at community level. This process began in two of the five districts supported by UNFPA (Rusizi and Rubavu). A training on verbal autopsy tools and practice was conducted for 92 health providers in charge of community health. This has improved the culture of the mandatory notification of maternal, neonatal and infant deaths occurring at community level within 24 hours of death and review of circumstances surrounding deaths. Preventable causes of mortality are increasingly being identified in the districts covered and appropriate responses are being identified. This experience will gradually be extended to other districts in the country.

Benin begins maternal death reviews

With support from UNFPA, Benin revitalized the maternal death reviews with a center of excellence in the capital and taught trainers for 22 of the country's 34 health zones. Follow-up joint missions (Ministry of Health, UNFPA and WHO) were carried out to monitor the maternal and newborn death reviews in eight randomly selected health zones, where it was observed that the maternal death reviews were not done in three of the zones. So far, 338 maternal deaths have been reviewed, which has helped identify bottlenecks and led to corrective measures being proposed. In addition, 280 deliveries and 56 maternal deaths (43 occurring at home) were recorded by community health workers, improving the completion of notification of cases.

Côte d'Ivoire scales up quality reproductive health services

A critical element of the MDSR framework—in particular of the 'Response' aspect—is quality of care. Building on a holistic approach developed in 2011 to address the quality of

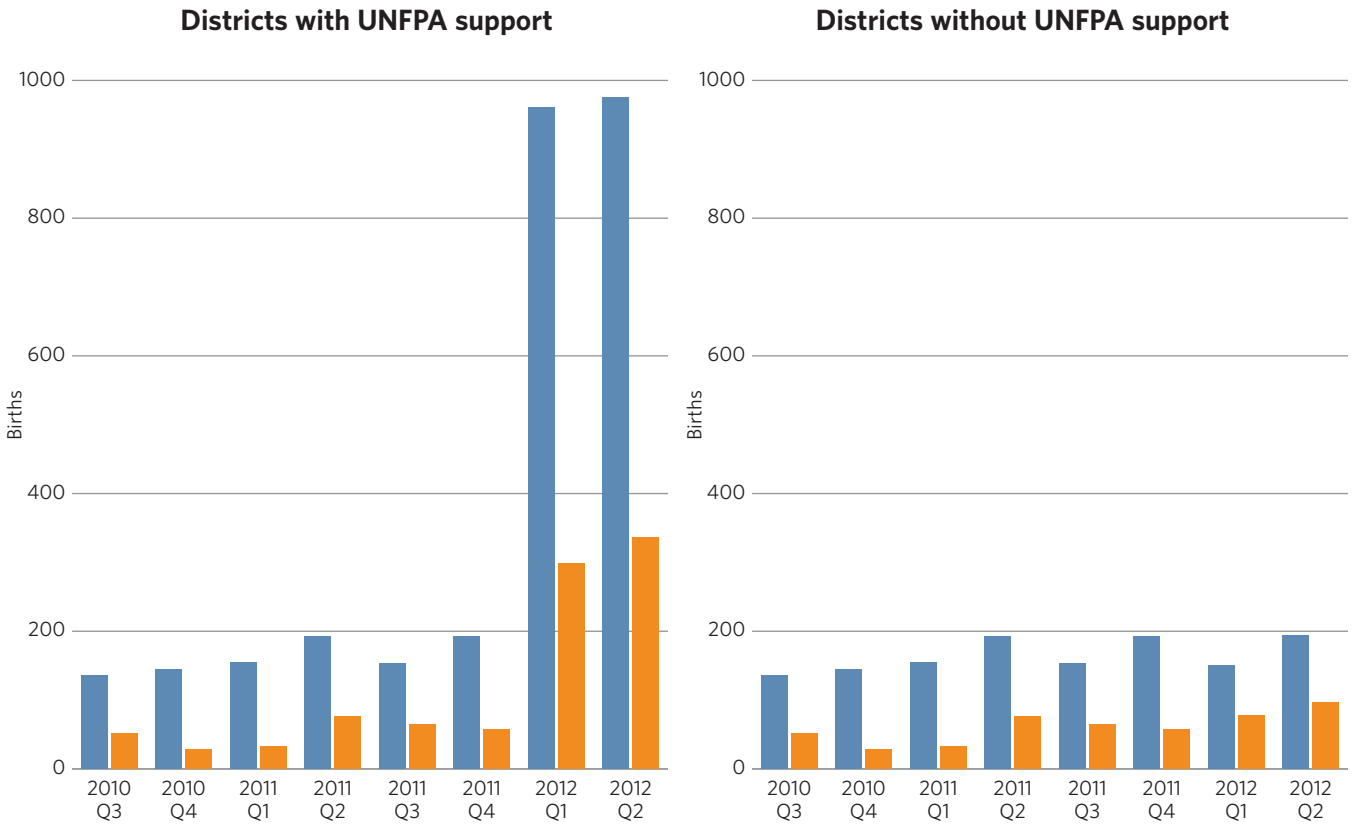
[11] Hounton S et al. "Towards elimination of pregnancy-related deaths: maternal deaths surveillance and response," Reproductive Health. 2013;10(1):1

reproductive health services following the country's political crisis, UNFPA supported integrating reproductive health services in the geographic areas covered by the UNFPA-funded quality improvement project of health services. In 2012, support was provided to 14 health districts with equipment, life-saving medicines and other reproductive health commodities, which contributed to the following outputs:

- Reorganization of reproductive health services implemented in 86 health facilities with 1,149 personnel trained in managing health centres and reproductive health norms, standards and procedures and community mobilization. This has resulted in a 12 per cent increase in the rate of contraceptive use in areas involved in this approach;
- Integration of cervical cancer screening in family planning and maternal and neonatal programmes; equipment to 13 screening sites; training 58 service delivery providers on Visual Inspection with Acetic Acid (VIA)/Cryotherapy for screening and treatment of precancerous stages of cervical cancer; and actual screening of 3,150 women with 95 positive VIA (86 of whom were offered immediate cryotherapy);
- Integration of prevention and care of HIV into reproductive health services in 39 health centres;
- Capacity building of country teams on EmONC good clinical practices;
- Rehabilitation and equipment of 15 health facilities (13 maternity wards and 2 operating theaters) to increase the availability of basic and comprehensive EmONC (For trends in use, see Figure 14).

FIGURE 14

Trends of institutional (blue) and home deliveries (red) in health districts supported by the UNFPA-funded revamping of reproductive health services project versus unsupported health districts in Côte d'Ivoire (2010 Q3 to 2012 Q2)



Burkina Faso's maternal deaths surveillance and response

Case study: Towards eliminating preventable maternal deaths in Burkina Faso

2012 evaluation meeting of the maternal death surveilance programme, chaired by the Director Geneal of Health andattended by both Regional Directors of Health and donors.
UNFPA Burkina Faso

BACKGROUND AND OBJECTIVES

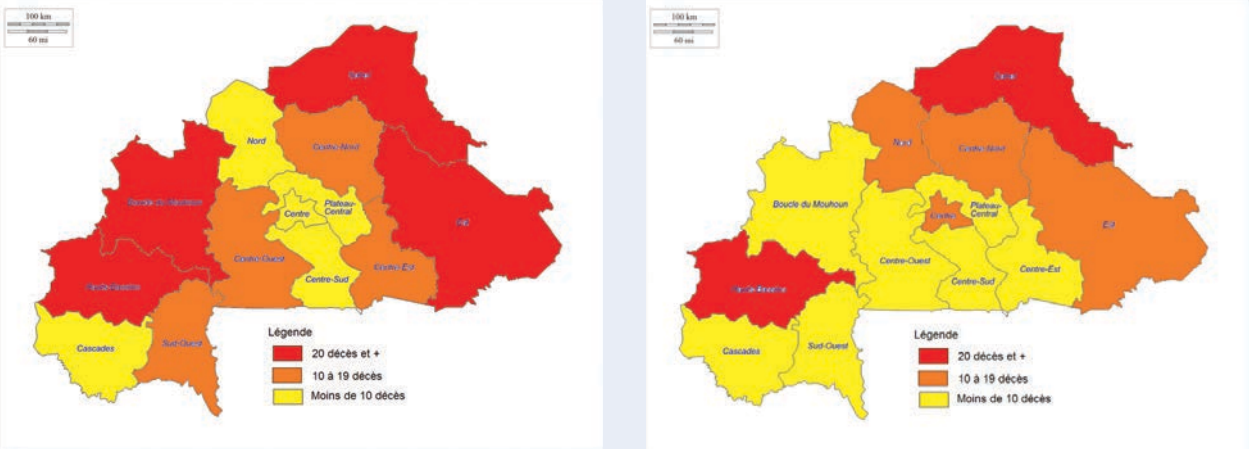
Burkina Faso has made insufficient progress on MDGs 4 and 5, with 341 maternal deaths per 100,000 live births and 28 neonatal deaths per 1,000 births (DHS 2010). Direct causes of maternal deaths represent 80 per cent of all maternal deaths. The majority of maternal and newborn deaths occur in the 24 hours following delivery. Potentially a significant reduction could be achieved through an effective response. Burkina Faso has experienced a recurrent stock-out of contraceptives at central and peripheral levels due to lack of unified procurement, and lack of routine and real-time tracking systems of stock-outs at service delivery points. The Ministry of Health with support from UNFPA started in early January 2012 a Maternal Death Surveillance and Response (routine identification, notification and the determination of causes and possible preventions of maternal deaths, and the use of this information to respond with actions to prevent future deaths) and monitoring of contraceptives and life-saving medicines. The objectives were to generate quality weekly data on maternal and newborn deaths and availability of contraceptives and life-saving medicines; track the evolution of maternal deaths over time; and develop the response and monitoring policy.

PROCESSES

The Government of Burkina Faso, with technical and financial support from UNFPA, introduced maternal deaths monitoring at institutional level, and RH commodity inventory monitoring in service delivery points in existing Integrated Disease Surveillance and Response (IDSR). The Ministry of Health uses the standard WHO case definitions of maternal deaths. Data are analysed by District Maternal Deaths Reviews committees. The Directorate of Maternal and Child Health, with its technical and financial partners (UNFPA, WHO and UNICEF), review biannually the data as well as the response and supervision strategies and activities.

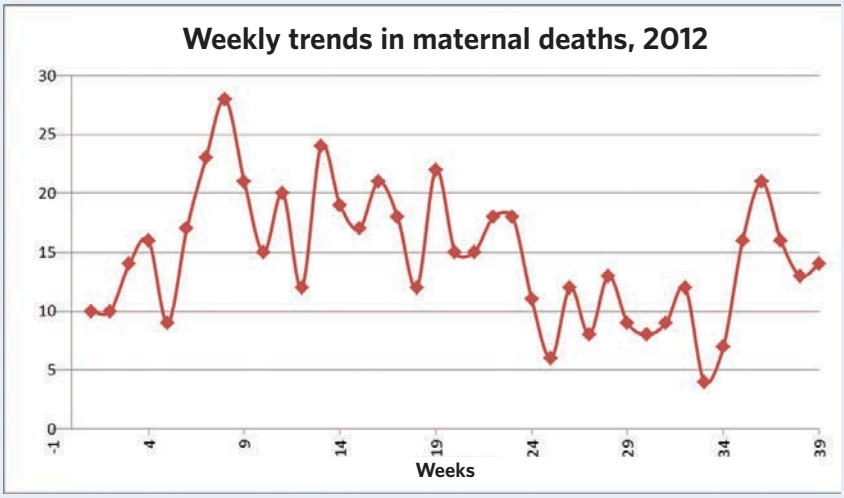
RESULTS

The early results are very encouraging with weekly monitoring of maternal and newborn cases; quarterly mapping of institutional cases of maternal and newborn deaths per health districts and health regions and monthly trends of stock-outs of contraceptives by health districts and regions; and specific, reactive evidence-based interventions. The response to the quarterly reviews, funded by UNFPA, include maternal death reviews and in-service emergency obstetric and newborn care trainings (EmONC) in facilities with high case fatality rates; special procurement of magnesium sulfate (a life-saving medicine) and ad-hoc procurement of contraceptives; equipment of some health facilities lacking appropriate EmONC surgical equipment; training surgical teams for fistula repair; adherence to the international contraceptives alert system; and better redistribution of contraceptives to alleviate stock-outs.



Quarterly mapping of institutional maternal deaths by health regions (Quarters 1 and 3, 2012), Burkina Faso

Weekly notification of institutional maternal deaths (weeks 1-39, 2012), Burkina Faso



CHALLENGES AND RESPONSE

The main difficulties faced in the system so far are linked to data completeness and timeliness in data transmission. To address these and further improve the system, several measures have been considered, namely, revising the *National Integrated Disease Surveillance and Response Guidebook* to include maternal and newborn deaths monitoring, advocacy with key stakeholders, and strengthening the coordination mechanisms that underlie such monitoring. Actions also include developing a communications plan to share efforts of government and technical and financial partners in improving maternal health in Burkina Faso.

CHAPTER SEVEN

RESOURCES AND MANAGEMENT

The work of the Maternal Health Thematic Fund is supported largely by two multi-donor funds: the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula. Since the programmatic integration of the Campaign to End Fistula into the MHTF in September 2009, the bulk of donor funding for obstetric fistula is now provided under the broader maternal health umbrella (ZZT06).

THEMATIC TRUST FUND FOR MATERNAL HEALTH (ZZT06)

Contributions

As indicated in Table 3, total contributions for maternal health received during 2012 totalled $15.9 million, compared to $11.3 million in 2011. The increase is partly attributed to the continuous commitment of generous donors and the receipt in 2012 of contributions for 2013.

Out of $15.9 million, $5.0 million was received during the fourth quarter of 2012; those funds will therefore be used for the implementation of programmes in 2013.

Operating budget

The effective working budget for maternal health in 2012 was $28.0 million (Table 4), an increase of 3.18 per cent over the 2011 budget of $27.2 million. The 2012 operating budget represents contributions received in the fourth quarter of the previous year ($9.5 million), rollover funds from 2011 ($7.6 million) and contributions received during the first three quarters of 2012 ($10.9 million). The contributions received around the fourth quarter of 2011

TABLE 3. Total contributions for maternal health received in 2012

Donors	Contributions (US$)
Sweden	7,277,295
Norway	6,600,660
Luxembourg	1,513,944
Canada	374,473
Austria	114,367
Private contributions	1,852
TOTAL 2012	**15,882,591**

TABLE 4. Operating budget for maternal health activities in 2012

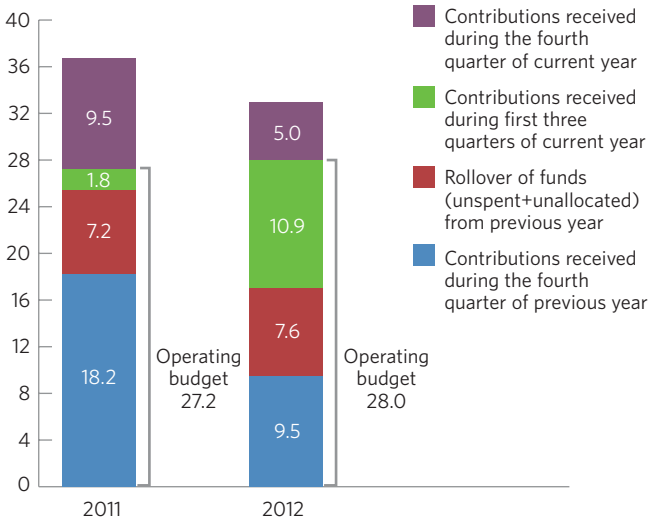
Donors	Contributions (US$)
Carry-over from 2011	17,103,880
Norway	6,600,660
Sweden	2,770,083
Luxembourg	1,513,944
Austria	42,938
Private contributions	1,852
TOTAL 2012	**28,033,357**

Trainee midwives demonstrating the childbirth process using the advanced child birth simulator anatomical model procured by UNFPA.

UNFPA Uganda

FIGURE 15

Operating budgets for maternal health in 2011 and 2012 (US$ millions)



include donations from the governments of Sweden ($2.9 million) and Ireland ($1.3 million) received in December 2011; from the government of Netherlands ($2.4 million) received in October 2011; and from the government of Norway ($2.8 million) received in September 2011. In addition, a small percentage of the 2011 operating budget was withheld by the MHTF to meet financial contingencies in 2012.

Figure 15 explains how the operating budget for each year is established. It clearly indicates that the MHTF continues to rely heavily on contributions received in the fourth quarter of each year for the following year's planning process.

Expenditures

Total expenditures for maternal health in 2012 amounted to $19.33 million, compared to $19.92 million in 2011. During 2012, country and regional programmes, including spending by international NGOs (INGOs) and institutions supporting country-level programme activities, accounted for 88 per cent ($16.98 million) of the total; the remaining 12 per cent ($2.35 million) represents spending on global programmes. This compares with 85 per cent ($16.85 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level, in 2011, and 15 per cent ($3.07 million) for global programmes. Figures 16 and 17 show the percentage of funds spent regionally and globally, including by implementing partners, in 2011 and 2012.

As mentioned above, $19.33 million was spent in 2012 to achieve expected results in maternal health, against a total allocation of $21.17 million. This translates into a financial implementation rate of 91 per cent, compared to 88 per cent in 2011, and shows a rising trend of implementation—a welcome and encouraging sign for the thematic fund, despite its having to work in challenging countries with suboptimal governance or difficult humanitarian situations. Figure 18 shows the operating budgets, allocations and expenditures for maternal health in 2011 and 2012.

FIGURE 16

Share of expenditures for maternal health by region and globally, including implementing partners, in 2011 (per cent)

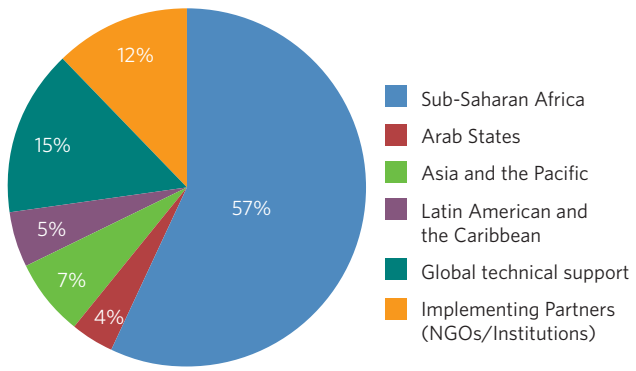


FIGURE 17

Share of expenditures for maternal health by region and globally, including implementing partners, in 2012 (per cent)

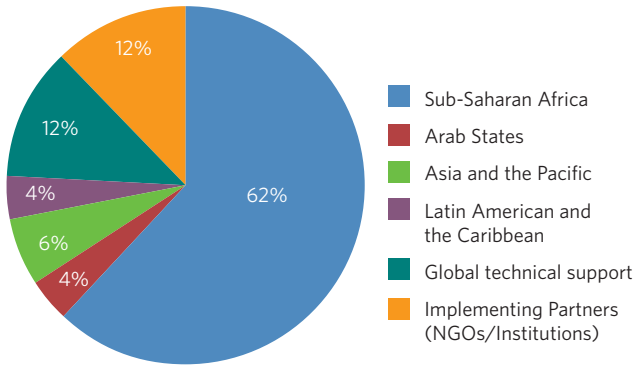
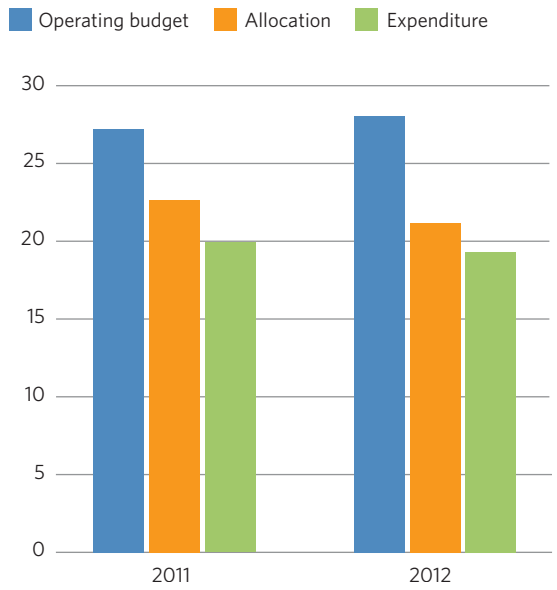


FIGURE 18

Operating budgets, allocations and expenditures for maternal health in 2011 and 2012 (US$ millions)



Support to country, regional and global programmes

In 2012, funds totalling $21.17 million were allocated to country, regional and global programmes in maternal health, compared to $22.66 million for 2011. Of the 2012 total, 88 per cent ($18.65 million) went to regional and country programmes, including INGOs and institutions supporting programme activities at the country level, compared to 82 per cent ($18.67 million) in 2011. Twelve per cent ($2.52 million) was allocated to global programmes, compared to 18 per cent ($3.99 million) in 2011. In terms of regions, the greatest share of resources for maternal health—61 per cent ($12.82 million)—went to sub-Saharan Africa; Asia and the Pacific received 7 per cent ($1.53 million), Latin America and the Caribbean received 5 per cent ($1.04 million), and the Arab States received 3 per cent ($0.74 million). Table 5 shows approved allocations of maternal health funds, expenditures and the financial implementation rate by region, country and globally in 2012 and 2011.

TABLE 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2011 and 2012 ***(continued on next page)***

	2011			2012		
Regional office/country office/ global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**
Sub-Saharan Africa						
Africa Regional Office	328,000	205,655	63	-	-	-
Subregional Office/Johannesburg	-	-	-	303,000	278,905	92
Subregional Office/Dakar	-	-	-	250,000	246,207	99
Benin	800,000	783,498	98	600,000	637,962	106
Burkina Faso	750,000	679,791	91	500,000	497,677	100
Burundi	500,000	484,600	97	550,000	526,458	96
Cameroon	-	-	-	50,000	47,101	94
Central African Republic	-	-	-	50,000	47,241	94
Chad	800,000	793,375	99	1,151,180	1,004,445	87
Congo	-	-	-	50,000	41,893	84
Côte D'Ivoire	1,000,000	995,189	100	725,000	662,885	91
Democratic Republic of the Congo	1,200,000	1,145,932	95	1,500,000	1,505,550	100
Eritrea	-	-	-	43,000	16,326	38
Ethiopia	2,000,000	1,924,213	96	1,500,000	1,427,329	95
Ghana	498,000	437,593	88	465,000	456,154	98
Guinea	-	-	-	65,000	52,079	80
Guinea-Bissau	-	-	-	50,000	48,400	97
Kenya	-	-	-	25,000	23,998	96
Liberia	232,190	227,787	98	300,000	304,046	101

(continued)

TABLE 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2011 and 2012 *(continued on next page)*

Regional office/country office/ global technical support/ partners	2011			2012		
	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)
Sub-Saharan Africa (continued)						
Madagascar	875,000	878,257	100	725,000	556,494	77
Malawi	700,000	658,679	94	600,000	478,243	80
Mali	100,000	93,383	93	178,773	101,455	57
Mauritania	-	-	-	38,500	6,755	18
Mozambique	200,000	190,580	95	200,000	198,210	99
Namibia	65,000	61,552	95	43,200	38,954	90
Niger	200,000	179,456	90	400,000	392,985	98
Nigeria	370,000	332,095	90	400,000	389,523	97
Rwanda	100,000	62,581	63	150,000	144,697	96
Senegal	-	-	-	92,373	75,040	81
Sierra Leone	500,000	419,607	84	500,000	469,148	94
South Sudan	400,000	428,668	107	630,000	596,982	95
Uganda	129,000	128,072	99	330,000	325,398	99
Zambia	300,000	247,543	83	350,000	311,613	89
Sub-Saharan Africa total	**12,047,190**	**11,358,108**	**94**	**12,815,026**	**11,910,156**	**93**
Arab States						
Djibouti	400,000	319,979	80	160,000	150,623	94
Yemen	400,000	374,295	94	75,000	56,306	75
Sudan	67,000	62,791	94	500,000	475,199	95
Arab States total	**867,000**	**757,065**	**87**	**735,000**	**682,127**	**93**
Asia and the Pacific						
Asia and the Pacific Regional Office	18,750	9,026	48	-	-	-
Afghanistan	750,000	516,387	69	481,480	317,291	66
Bangladesh	100,000	93,519	94	189,300	189,828	100
Cambodia	300,000	251,346	84	250,000	198,819	80
Timor-Leste	100,000	102,212	102	106,000	60,717	57
Lao People's Democratic Republic	300,000	286,749	96	200,000	181,535	91
Nepal	100,000	88,828	89	128,827	108,396	84
Pakistan	65,000	38,834	60	175,000	174,586	100
Asia and the Pacific total	**1,733,750**	**1,386,901**	**80**	**1,530,607**	**1,231,172**	**80**
Latin America and the Caribbean						
Latin America and the Caribbean Regional Office	25,000	25,680	103	75,000	71,105	95
Haiti	750,000	576,188	77	661,235	527,707	80
Guyana	400,000	357,196	89	300,000	273,456	91
Latin America and the Caribbean total	**1,175,000**	**959,064**	**82**	**1,036,235**	**872,268**	**84**

(continued)

TABLE 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2011 and 2012 (continued)

Regional office/country office/ global technical support/ partners	2011 Approved allocation (US$)	2011 Expenditure (US$)	2011 Implementation rate (%)	2012 Approved allocation (US$)	2012 Expenditure (US$)	2012 Implementation rate (%)
Global technical support						
Global technical support, including implementing partners	6,705,251	5,337,131	80	4,809,650	4,403,712	92
Information and External Relations Division	-	-	-	151,689	144,807	95
Media and Communications Branch	131,250	119,063	91	94,160	87,576	93
Global technical support total	**6,836,501**	**5,456,194**	**80**	**5,055,499**	**4,636,095**	**92**
GRAND TOTAL	**22,659,441**	**19,917,333**	**88**	**21,172,367**	**19,331,818**	**91**

As UNFPA's 2012 financial closure is still in process, all financial figures in this report are provisional until actual expenditure is reflected in the certified financial report.

THEMATIC TRUST FUND FOR OBSTETRIC FISTULA (ZZT03)

Contributions

Contributions received during 2012 for obstetric fistula totalled $2,334,936. Through the MHTF, $0.73 million was received, compared to $0.86 million in 2011 (Table 6). These relatively modest amounts reflect the fact that most donors are now providing funding for obstetric fistula through the broader maternal health umbrella (Thematic Fund for Maternal Health) rather than to the specific funding for fistula, and private sector donors provide direct support to UNFPA country offices instead of through the MHTF.

This programmatic area remains attractive for both private sector partners and members of the general public, who can immediately equate the value of their donation with a human impact—a donation for a fistula surgery to change a women's life.

TABLE 6. Total contributions to the Thematic Fund for Obstetric Fistula received in 2012

Donor	Amount in US$
Luxembourg	664,010.62
Zonta International*	525,000.00
Korea, Republic*	500,000.00
Johnson & Johnson*	320,500.00
Virgin Unite*	212,355.00
Noble Energy*	50,772.00
Poland	42,726.00
Private contributions	19,572.42
TOTAL 2012	**2,334,936.04**

* Contributions are not channelled through MHTF, but as direct co-financing to different UNFPA country office obstetric fistula programmes in Africa

Operating budget

The effective working budget for the Thematic Fund for Obstetric Fistula in 2012 was $1.82 million, a decline of 70 per cent from the 2011 operating budget of $6.14 million (Table 7), largely reflecting the trend that donors

TABLE 7. Operating budget from the Thematic Fund for Obstetric Fistula (ZZT03) for 2012

Donor	Amount in US$
Carry-over from 2011	1,145,051
Luxembourg	664,011
Private contributions*	12,063
Total 2012	**1,821,125**

* Includes private contributions through Friends of UNFPA

are providing funding for obstetric fistula through the Thematic Fund for Maternal Health (ZZT06). As noted in Chapter Five, the Campaign to End Fistula has seen an increase in programmatic activities during 2012 compared to 2011 and previous years.

The budget for 2012 reflects contributions received during the fourth quarter of 2011 ($0.04 million), rollover funds ($1.11 million) and contributions received during the first three quarters of 2012 ($0.68 million). Rollover funds ($1.1 million) include unspent balances from 2011 allocations to regions and countries (the financial implementation rate for 2011 was 85 per cent), along with unspent balances from prior years from other projects pooled for the fistula programme in 2012. These funds are treated as adjustments and are not considered contributions received during the year.

Figure 19 shows how the operating budgets for 2011 and 2012 have been established. These budgets are the basis upon which the fistula programme is planned and implemented.

Expenditures

Total expenditures from the Thematic Fund for Obstetric Fistula in 2012 amounted to $1.34 million, compared to $5.07 million in 2011. During 2012, country and regional programmes, including spending by INGOs and institutions supporting country-level programme activities, accounted for 65 per cent ($0.88 million) of the total; global programmes accounted for 35 per cent ($0.46 million) of the total. This compares with 87 per cent ($4.40 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level in 2011, and 13 per cent ($0.66 million) for global programmes. Figures 20 and 21 show the percentage of funds spent by region and globally, including implementing partners, in 2011 and 2012.

As mentioned above, $1.34 million was spent to achieve planned results for the obstetric fistula programme in 2012, against a total allocation of $1.61 million. This translates into a financial implementation rate of 83 per cent, a slight decline compared to 2011, which had an implementation rate of 85 per cent. Figure 22 shows operating budgets, allocations and expenditures for obstetric fistula in 2011 and 2012.

Support to country, regional and global programmes

In 2012, allocations to country, regional and global programmes for obstetric fistula totalled $1.61 million, compared to 5.98 million in 2011. Regional and country programmes, including INGOs and institutions

FIGURE 19

Operating budgets for obstetric fistula in 2011 and 2012 (US$ millions)

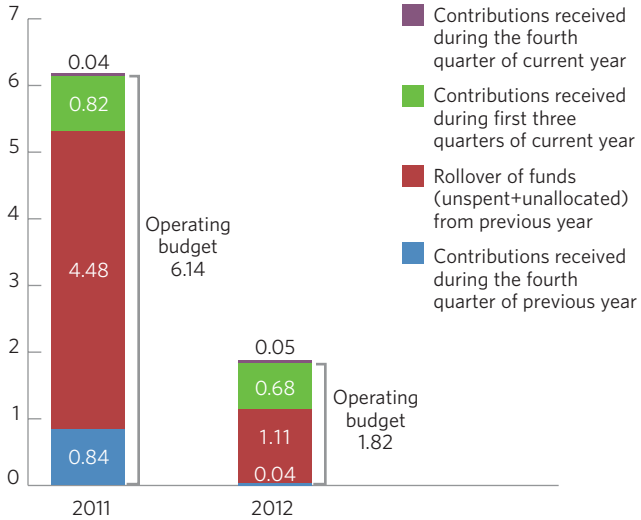


FIGURE 20

Share of expenditures for obstetric fistula by region and globally, including implementing partners, in 2011 (per cent)

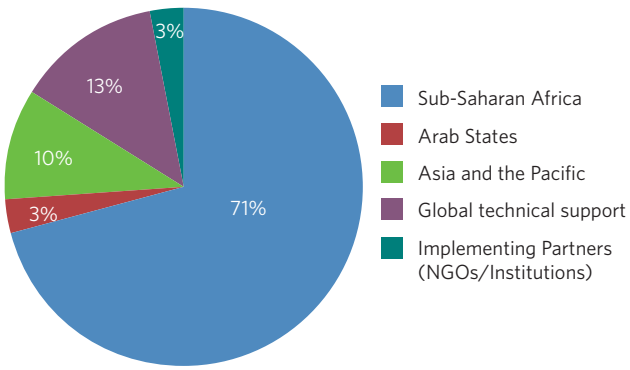


FIGURE 21

Share of expenditures for obstetric fistula by region and globally, including implementing partners, in 2012 (per cent)

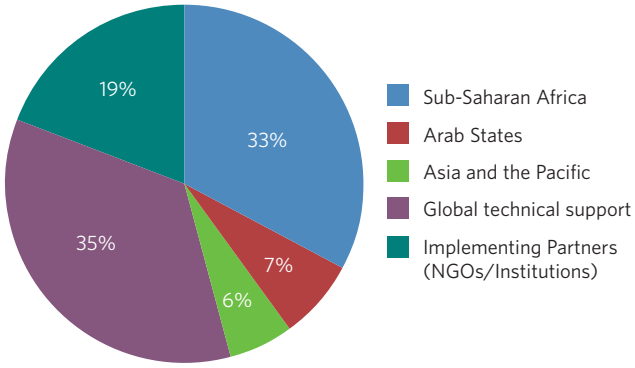
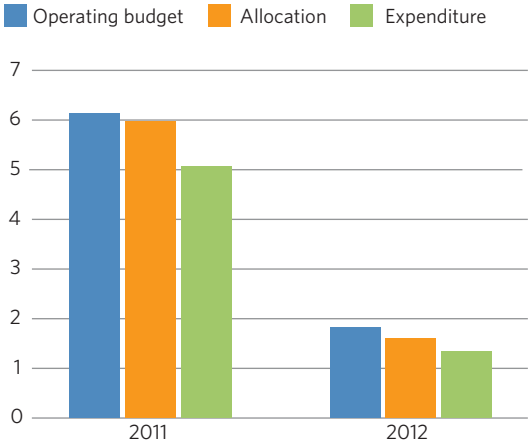


FIGURE 22

Operating budgets, allocations and expenditures for obstetric fistula in 2011 and 2012 (US$ millions)



supporting country-level activities, represented 68 per cent ($1.09 million) of the total in 2012, compared to 87 per cent ($5.19 million) in 2011; global programmes represented 32 per cent ($0.52 million) of the total in 2012, compared to 13 per cent ($0.79 million) in 2011. By region, sub-Saharan Africa received the lion's share of support at 31 per cent ($0.49 million), followed by the Arab States at 6 per cent ($0.10 million), and Asia and the Pacific at 5 per cent ($0.08 million). Table 8 shows approved allocations, expenditures and the financial implementation rate by region, country and globally in 2011 and 2012.

TABLE 8. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2011 and 2012

	2011			2012		
Regional office/country office/ global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**
Sub-Saharan Africa						
Africa Regional Office	204,000	110,062	54	-	-	-
Benin	200,000	188,402	94	-	-	-
Burkina Faso	150,000	136,994	91	-	-	-
Burundi	50,000	48,425	97	-	-	-
Cameroon	100,000	90,138	90	50,000	46,018	92
Central African Republic	100,000	97,641	98	50,000	49,672	99
Chad	200,000	192,479	96	-	-	-
Congo	175,000	157,153	90	50,000	44,639	89
Côte D'Ivoire	200,000	173,019	87	-	236	-
Democratic Republic of the Congo	300,000	286,879	96	-	-	-
Eritrea	42,800	26,217	61	-	-	-
Ghana	200,000	93,749	47	-	9,979	-
Guinea	140,000	139,802	100	50,000	38,305	77
Guinea-Bissau	100,000	95,331	95	50,000	49,528	99

(continued)

TABLE 8. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2011 and 2012 (continued)

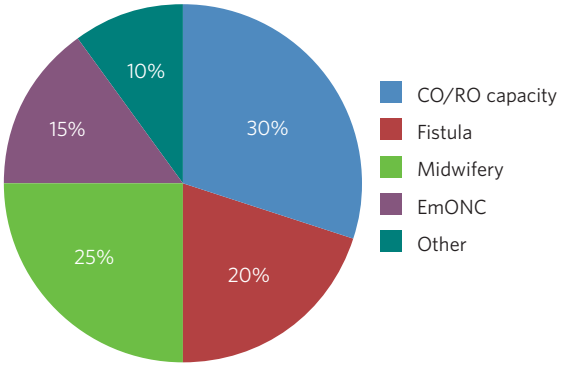
	2011			2012		
Regional office/country office/ global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**
Sub-Saharan Africa *(continued)*						
Kenya	150,000	106,615	71	75,000	75,817	101
Liberia	210,469	207,332	99	-	-	-
Madagascar	200,000	194,276	97	-	-	-
Malawi	160,000	162,728	102	-	-	-
Mali	50,000	53,978	108	-	-	-
Mauritania	125,000	95,676	77	75,000	42,939	57
Mozambique	48,000	35,186	73	-	-	-
Niger	250,000	218,598	87	-	-	-
Nigeria	180,000	139,199	77	-	5,268	-
Rwanda	50,000	50,885	102	-	-	-
Senegal	200,000	162,814	81	94,340	86,389	92
Sierra Leone	100,000	94,500	95	-	-	-
South Sudan	100,000	41,610	42	-	-	-
Uganda	100,000	99,258	99	-	-	-
Zambia	100,000	98,771	99	-	-	-
Sub-Saharan Africa total	**4,185,269**	**3,597,717**	**86**	**494,340**	**448,790**	**91**
Arab States						
Somalia	12,500	7,480	60	100,000	92,737	93
Sudan	100,000	78,250	78	-	-	-
Yemen	75,000	62,113	83	-	-	-
Arab States total	**187,500**	**147,843**	**79**	**100,000**	**92,737**	**93**
Asia and the Pacific						
Asia and the Pacific Regional Office	53,750	17,964	33	-	-	-
Afghanistan	100,000	120,037	120	-	-	-
Bangladesh	100,000	90,033	90	-	-	-
Cambodia	30,000	21,400	71	-	-	-
Timor-Leste	35,000	25,002	71	-	-	-
Nepal	50,000	38,485	77	-	-	-
Pakistan	200,000	199,965	100	75,000	79,827	106
Asia and the Pacific total	**568,750**	**512,886**	**90**	**75,000**	**79,827**	**106**
Global technical support						
Global technical support, including implementing partners	794,663	560,006	70	942,876	717,445	76
Information and External Relations Division	248,240	248,439	100	-	-	-
Global technical support total	**1,042,903**	**808,445**	**78**	**942,876**	**717,445**	**76**
GRAND TOTAL	**5,984,422**	**5,066,890**	**85**	**1,612,216**	**1,338,799**	**83**

LINKING RESULTS TO FINANCING

Figure 23 provides an approximate estimate of how MHTF resources are distributed. The exercise was made more difficult by the challenge of reporting at three levels (country, regional and global) and the need to avoid double-counting when specific activities synergistically cross more than one output. In fact, many activities at the country and regional levels are intrinsically linked and relate to several health system blocks. Nevertheless, the MHTF has since 2010 provided broad categories or areas of investment within the maternal health, including emergency obstetric and newborn care, midwifery, fistula (three new outputs defined in UNFPA's Strategic Plan) and others (including staffing for operations and strengthening of country and regional offices).

FIGURE 23

Approximate distribution of MHTF resources in 2012



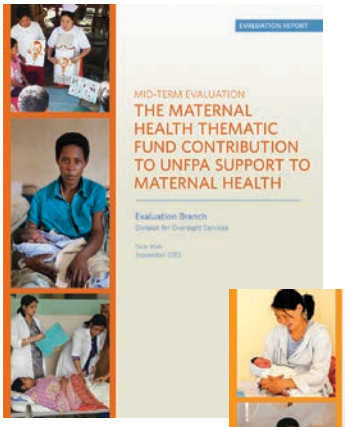
Given the above, it is fair to estimate that around one quarter of expenditures (about $5M) supported midwifery, around one fifth (about $4 million) supported fistula programming, around 15 per cent ($3 million) supported Emergency Obstetric and Newborn Care, and around 30 per cent (about $6 million) strengthened the capacity of priority country and regional offices. The remainder strengthened national capacity in areas such as overall planning and programming (including technical assistance missions), increasingly in maternal death surveillance and response and data for decision making; and for work on quality of care and life-saving medicines and more.

Overall, as previous chapters have noted, the MHTF has contributed to significant results using relatively modest resources spanning the 43 high maternal mortality countries.

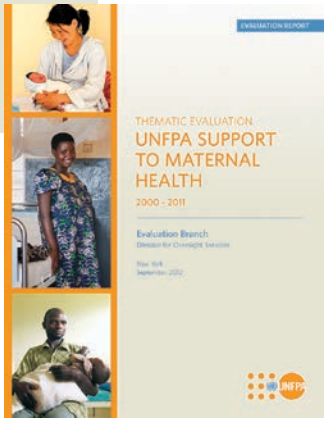
CHAPTER EIGHT

EXTERNAL EVALUATIONS

In 2011-12, an external thematic evaluation of UNFPA's overall support to maternal health over the past decade was done in conjunction with an external mid-term evaluation of the Maternal Health Thematic Fund.



The former was designed to assess the extent that UNFPA's overall assistance—its support from all sources, including core resources, co-financing and all thematic funds—has been relevant, effective, efficient and sustainable in contributing to improvements in maternal health in the last 10 years.



The purpose of the MHTF mid-term evaluation was to assess the design, coordination and added value of the Maternal Health Thematic Fund as a targeted effort to improve maternal health. The evaluation covered the period from the launch of the MHTF in 2008 until 2010, including information related to numerous interventions implemented in 2011. The review did not, however, include Campaign to End Fistula activities, since these were evaluated separately three years ago.

After finalization in September 2012, the maternal health evaluations results were published, presented to the Executive Board and shared widely. Key findings and recommendations of the evaluations are shared below, providing important inputs to the way forward discussed in Chapter Nine.

Findings of the mid-term review

Positive evaluation conclusions of the MHTF mid-term evaluation found that:

- The MHTF has rightly based its selection of beneficiary countries on the intensity of their maternal health needs;
- The MHTF has successfully acted as a catalyst in specific areas; for instance, to develop EmONC improvement plans;
- The MHTF focus on midwifery and EmONC is relevant and appropriate;
- The MHTF involvement in family planning is relevant (only) when fostering synergies with skilled birth attendance and EmONC;

◀ Healthy baby, happy mother.

UNFPA Mozambique

- MHTF input has been instrumental in the policy dialogue to refocus government maternal health priorities and led to increased national commitments;
- MHTF support has contributed to laying the groundwork for improving midwifery and EmONC services by establishing standards and regulation;
- The MHTF has increased resources and provided useful technical guidance, mechanisms and tools to strengthen the capacity of country offices to focus on key maternal health interventions.

As to areas that could use improvement, the findings of the mid-term evaluation pointed to these key issues:

- Lack of strategic long-term planning to ensure sustainability and coordination within the overall reproductive health component;
- MHTF has not sufficiently prioritized demand-creation, resulting in gaps in the strategy to address the numerous barriers preventing access to skilled attendance at birth and EmONC services;
- Insufficient emphasis was placed on identifying and addressing the specific needs of the most vulnerable groups;
- Improved technical capacity of country offices may not be sufficient for ensuring adequate follow-up of interventions initiated under the MHTF;
- Unclear accountability lines between country offices, regional offices and headquarters.

The evaluation made the following recommendations:

- Provide country offices with guidance for developing multi-year country strategic plans for using MHTF funds;
- Provide country offices with guidance for assisting governments in identifying the population groups most at risk and their particular needs in maternal health;
- In collaboration with regional offices, support country offices in developing projections of their needs for technical support at different phases of MHTF interventions;
- Provide country offices with support for ensuring that the MHTF adopts a more comprehensive approach to health system strengthening;
- Pay dedicated attention to barriers that prevent access to and use of maternal health services;
- Provide country offices with support for ensuring that MHTF interventions include mechanisms for maintaining the level of quality of the outputs.

The overall evaluation of UNFPA support to maternal health in the past decade had two recommendations among nine altogether that pertained directly to the MHTF:

- UNFPA should strengthen the capacity of the MHTF as a catalytic tool that facilitates implementing evidence-based maternal health interventions in programme countries;
- UNFPA should use MHTF funds to carry out pilot interventions in programme countries on select core maternal health issues. These include developing appropriate support strategies to better target populations with high vulnerability to poor maternal health.

CHAPTER NINE

CHALLENGES AND WAY FORWARD

The root causes of high maternal and newborn mortality include general development issues such as governance, poverty, gender inequality, traditional harmful practices and girls' education. These issues require medium- and long-term investments and represent serious bottlenecks for eliminating maternal deaths. Nonetheless, even under challenging circumstances, country experiences have shown that important gains can be made to reduce maternal mortality and morbidity. Strategic and catalytic investments of the Maternal Health Thematic Fund can contribute to achieving such gains and to overcoming more immediate challenges as discussed below.

GLOBAL AND REGIONAL LEVELS

Change in the landscape of development agenda

The year 2012 saw an unprecedented movement towards the revitalization of family planning. This is a positive development for an area neglected for the past two decades and can help to ensure that women, adolescents and families exercise their rights to decide when to bear children, how many and how often. This momentum should lead to a major contribution in accelerating progress in cutting the number of maternal deaths. However, the new focus carries a potential risk for maternal health as it could divert already scarce resources and create vertical programming. UNFPA and partners will, nevertheless, continue to work on creating synergies between the two programme areas, such as collaboration between the Global Programme to Enhance Reproductive Health Commodity Security and the Maternal Health Thematic Fund.

COUNTRY LEVEL

Aid effectiveness at stake

There has been an increased fragmentation of development assistance from donors towards maternal and newborn health in project funding. This is associated with high transaction costs and challenges in harmonization, alignment with countries' national processes and development effectiveness. Pooled funding, with one plan, one planning cycle and one monitoring evaluation framework, is well recognized as good practice and efficient operation by the International Health Partnership (IHP+). By directly supporting national efforts, the UNFPA works in accordance with the Paris Declaration and Accra Plan of Action regarding aid effectiveness.

National leadership, governance and management capacity

Governments are now committed to developing and scaling up midwifery services; eliminating all preventable maternal deaths; ending fistula; and reaching the elimination of mother-to-child transmission of HIV. However, such commitments need to be translated into clear strategic actions and domestic resource mobilization. UNFPA and partners will continue to advocate for and support instruments and mechanisms of accountability in countries.

Many actors in countries, including NGOs and academic institutions, address midwifery, EmONC and obstetric fistula with small-scale projects. This is a positive development, but it means that national coordination under a strong national plan and quality assurance must be essential. UNFPA works with national governments to strengthen the capacity of the Ministries of Health in their leadership, governance and management roles and functions.

Countries with high maternal mortality often have weak capacity at national government and non-governmental organization levels. This is a major bottleneck to scaling up maternal health efforts. With its partners, UNFPA will continue to invest in strengthening national and regional institutions to support maternal health situation analysis, policy development and strategic planning.

Human resources for health and the midwifery workforce

Managing midwifery workforces remains a real challenge, especially in countries with the highest maternal mortality rates—nearly all least developed countries. The education, recruitment (including fiscal space within government budget), appropriate deployment (where the services are most needed) and retention policies for midwives and others with such skills have yet to be fully embedded in national human resources for health policies, plans and programmes. With its partners, UNFPA is leading the movement with assessing midwifery workforce management in countries with the highest burden of maternal mortality and supporting national human resources development plans.

Increasing fistula backlog

Despite the concerted efforts of the partners in the Campaign to End Fistula, the number of annual repairs are still estimated to be significantly less than half of annual new cases of fistula. Therefore, the number of women and girls living with fistula increases every year. The challenge is primarily lack of sufficient funding within competing priorities in maternal health specifically, and reproductive health in general.

Insufficient funding for MDG 5

National budgets of developing countries tend to show an increased share for health. However, countries with high maternal mortality are nearly all least developed countries (LDCs). Consequently, even major relative increases in national budgets towards health translate—in the near term—to only modest increases in resources for maternal health in absolute terms.

As a result, there is an urgent need to increase resource flows for maternal health through low-transaction-cost pooled-funding mechanisms such as the MHTF or, in the future, other H4+ financing mechanisms, while ensuring close linkages between financing and technical support for national capacity building to enable optimal results and value for money.

WAY FORWARD

Following the UNFPA thematic evaluation on maternal health and the MHTF mid-term evaluation[12], the initial MHTF Business Plan was updated in late 2012 and will be completed in 2013 in consultation with donors. The new plan proposes an updated outcome as well as updated outputs for the Maternal Health Thematic Fund to address the recommendations of the evaluations and take into account recent scientific evidence and lessons learned from programming.

A key objective for the updated business plan is to align the Maternal Health Thematic Fund strategically with the UNFPA Strategic Plan 2014-17, allowing for catalytic multi-year programming to strengthen UNFPA's response to maternal health challenges in priority countries. It is envisaged that the way forward will focus on four key outputs in line with the UNFPA Strategic Plan 2014-17:

- Strengthened national capacity to implement comprehensive midwifery programmes;
- Strengthened national capacity for quality integrated maternal health services including emergency obstetric and newborn care (EmONC);

[12] UNFPA Support to Maternal Health, including the Contribution of the Maternal Health Thematic Fund. http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094

- Enhanced national capacity for prevention, treatment and social reintegration for obstetric fistula;

- Enhanced national capacity for maternal death surveillance and response.

The use of innovative technologies and deployment of strategic partnerships with the private sector and civil society organizations in developing, implementing and scaling up human resources for health programming will highly contribute to rapidly improving maternal and newborn health.

Such interventions are part of a broader set of actions in sexual and reproductive health that aim to strengthen health systems in general, improve quality of care and address the wider social factors contributing to maternal death and disability. In particular, the role of the MHTF in strengthening health systems will be further explored for the new phase of the MHTF after 2013.

Priorities in Ensuring a Stronger Response in Maternal Health

At the first 2013 regular session of the UNFPA Executive Board, UNFPA presented the external thematic evaluation on maternal health covering the period 2000-2010 with some contributions for part of 2011. The management response to the thematic evaluation was presented in the statement to the board by the Deputy Executive Director Programme.

The **following priorities** have been identified to ensure a stronger response in maternal health as part of integrated sexual and reproductive health and women's empowerment:

1. **Rapid implementation of a new Family Planning Strategy** focused on 46 countries as UNFPA's contribution to FP2020 in sexual and reproductive health. Following on the UN Commission on Life-Saving Commodities for Women and Children (UNFPA Executive Director Dr. Babatunde Osotimehin was vice-chair), UNFPA will redouble its efforts on both contraceptives and essential life-saving maternal health commodities. These efforts will be supported from both core resources and the Global Programme to Enhance Reproductive Health Commodity Security.

2. **Rapid implementation of a new Adolescents and Youth Strategy.** UNFPA's work on keeping girls in school, comprehensive sexuality education, delaying the age of marriage and preventing unwanted pregnancy and HIV infections, and empowering girls with economic, health and social skills to shape their own destiny will have a major impact on reducing maternal mortality and morbidity.

3. **As a follow-up to the African Union Summit on 27 January addressing the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)**, active in 30 countries, UNFPA will further strengthen its focus on Africa to improve maternal health. It will support national governments in scaling up quality integrated family planning and maternal health services.

4. **Maternal Health will be central to UNFPA's Strategic Plan 2014-17**, to be presented at the September session of the Executive Board. Focus will be on better accountability and more measurable results, noting that the specific approach and delivery, the resources and the resource management will be presented to the Executive Board as part of the Strategic Plan. An enhanced monitoring system will enable us to better track progress on the results framework of the Strategic Plan.

5. **Strengthening Midwifery will continue to be a cross-cutting priority to improve maternal health,** as a means to empower young girls and women who access the profession, and to offer life-saving Emergency Obstetric and Newborn Care, family planning, HIV prevention and other services.

6. Through its **Campaign to End Fistula**, UNFPA will continue to lead global and national efforts towards ending obstetric fistula and offering the women and adolescents with this condition renewed hope and a dignified life.

7. **Maternal Deaths Surveillance and Response**, a system in which every death is counted and information is provided to effectively guide actions, thus ensuring an assessment of the true magnitude of maternal mortality and the impact of actions to reduce it.

CONCLUSION

Since 2008 and operating with around $82 million from 2008-12, the Maternal Health Thematic Fund has significantly contributed to reducing maternal mortality and building national capacity for sustained impact. Its work in strengthening priority countries in Emergency Obstetric and Newborn Care, Midwifery, Obstetric Fistula and, more recently, Maternal Death Surveillance and Response, are playing a critical role in paving the way forward towards ending preventable maternal mortality and obstetric fistula within a generation.

Building on the recommendations of the evaluations (including the mid-term review) of UNFPA support to maternal health, and with sufficient and sustained funding to 2017 and beyond, the MHTF has a continuous role to play to further reduce maternal mortality and morbidity and strengthen health systems and thus serve as a focused contribution to UNFPA's 2014-2017 Strategic Plan.

We can now contemplate ending preventable maternal deaths and obstetric fistula within a generation. So now is the time to redouble our efforts and to further accelerate progress. Women in the poorest countries of the world, and the most vulnerable, deserve our attention.

Annex 1. Partners in the Campaign to End Fistula

1. Abbo Fistula Centre (Sudan)
2. Aden Hospital (Yemen)
3. African Medical & Research Foundation
4. African Women Solidarity Fund
5. American College of Nurse-Midwives
6. Babbar Ruga Fistula Hospital (Nigeria)
7. Bangladesh Medical Association
8. Bill & Melinda Gates Institute for Population & Reproductive Health
9. Bugando Medical Center (Tanzania)
10. CARE
11. CCBRT Hospital (Tanzania)
12. Centers for Disease Control and Prevention (US)
13. Centre Mère-Enfant (Chad)
14. National Centre for Reproductive Health and Fistula (Chad)
15. Columbia University's Averting Maternal Death and Disability Program (AMDD)
16. Cure Hospital (Afghanistan)
17. Direct Relief International
18. East Central and Southern Africa Association of Obstetrical and Gynecological Societies (ECSAOGS)
19. EngenderHealth
20. Equilibres & Populations
21. International Federation of Gynecology and Obstetrics
22. Family Care International
23. Fistula Foundation
24. Fistula Foundation (Nigeria)
25. Friends of UNFPA
26. Girls' Globe
27. Geneva Foundation for Medical Education and Research (Switzerland)
28. Gynocare Fistula Center (Kenya)
29. Hamlin Fistula (Ethiopia)
30. Healing Hands of Joy (Ethiopia)
31. Health and Development International
32. Health Poverty Action (Sierra Leone)
33. Hope Again Fistula Support Organisation (Uganda)
34. Human Rights Watch
35. Institut de Formation et de Recherche en Urologie Santé de la Famille (IFRU)
36. International Forum of Research Donors
37. International Confederation of Midwives
38. International Continence Society
39. International Nepal Fellowship
40. International Planned Parenthood Federation
41. International Urogynecological Association
42. International Society of Obstetric Fistula Surgeons
43. Johnson & Johnson
44. Johns Hopkins Bloomberg School of Public Health
45. Lake Tanganyika Floating Health Clinic
46. London School of Hygiene and Tropical Medicine
47. Maputo Central Hospital (Mozambique)
48. Médecins du Monde
49. Médecins Sans Frontières (MSF)
50. Mercy Ships
51. Moi University (Kenya)
52. Monze Mission Hospital (Zambia)
53. Mulago Hospital/ Medical School (Uganda)
54. Obstetrical and Gynaecological Society of Bangladesh
55. 'One by One' Project (Kenya)
56. Operation Obstetric Fistula
57. Pakistan National Forum on Women's Health
58. Pan African Urology Surgeon's Association
59. Population Media Center
60. Psychology Beyond Borders
61. Regional Prevention of Maternal Mortality Network (Ghana)
62. Sana'a Hospital (Yemen)
63. Selian Fistula Project (Tanzania)
64. Société Africaine de Gynecologie et Obstetrique (SAGO)
65. Société Internationale d'Urologie
66. South East Fistula Center (Nigeria)
67. The Association for the Rehabilitation and Re-orientation of Women for Development (TERREWODE, Uganda)
68. Uganda Childbirth Injury Fund
69. UNFPA
70. United States Agency for International Development
71. University of Aberdeen (Scotland)
72. University Centre Hospital (Cameroon)
73. Virgin Unite
74. White Ribbon Alliance
75. Women and Health Alliance International (WAHA)
76. Women's Health Coalition
77. Women's Hope International (Switzerland)
78. Women's Missionary Society
79. Women's Project (Eritrea)
80. World Health Organization
81. Worldwide Fistula Fund
82. World Vision
83. Zonta International

Annex 2. Consolidated results framework for 2012

	MDG5.a AND MDG5.b INDICATORS					
Countries with 4 years of implementation (M) and (F) indicate midwifery or fistula funding	a) Maternal mortality ratio	a) Skilled attendance at birth, %	b) Adolescent birth rate (per 1,000 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)	350	74	114	85.8	29.9	7.9
Burkina Faso (M, F)	300	67.1	104	72.3/22.3	29	15
Burundi (M, F)	800	33.6	30	92.4	29	9.1
Cambodia (M, F)	250	74.68	52.3	100/55	25.1	30.48
Côte d'Ivoire (M, F)	400	69	129	84.8 /44.2	27.1	14
Djibouti (M, F)	200	87,4	27	92.3/7.1	-	17.8
Ethiopia (M, F)	350	10	79	34	25	27
Ghana (M, F)	350	69	70	94.3/78	26	24
Guyana (M)	280	83	32.6	100/41	36	11
Haiti (M, F)	350	26.1	68.6	84.5/53.8	37.5	32
Madagascar (M, F)	240	51.3	148	79.9/49.3	23.6	39.9
Malawi (M, F)	460	71	152	96	26	42
South Sudan (M, F)	730	14.7	34.5	9.5	23.9	1.7
Sudan (M, F)	730	80	72	78	26	7.6
Uganda (M, F)	310	58	24	34	34	30
Zambia (M, F)	440	52	13.8	100/80	26.5	40.8

MHTF OUTPUT 1 COUNTRY INDICATORS		MHTF OUTPUT 2 COUNTRY INDICATORS	MHTF OUTPUT 3 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 an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care, is costed
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
No	✓	✓	✓	✓
✓	No	✓	No	No
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	Partial	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
No	✓	No	✓	In progress
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
Drafted	✓	✓	✓	In progress

Annex 2. Consolidated results framework for 2012 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 4 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies**	**Annual number of midwifery graduates from national midwifery training institutions**	**Midwives authorized to administer core lifesaving 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**
Benin (M, F)	1	-	✓	✓	✓
Burkina Faso (M, F)	3	323	✓	✓	✓
Burundi (M, F)	5	-	-	-	✓
Cambodia (M, F)	5	685	Partial	✓	✓
Côte d'Ivoire (M, F)	4	348	✓	✓	✓
Djibouti (M, F)	1	-	✓	✓	✓
Ethiopia (M, F)	25	1640	✓	✓	✓
Ghana (M, F)	29	400	✓	✓	✓
Guyana (M)	5	-	✓	✓	✓
Haiti (M, F)	1	-	✓	-	✓
Madagascar (M, F)	6	120-140	✓	✓	✓
Malawi (M, F)	-	-	✓	✓	✓
South Sudan (M, F)	Yes	17	No	No	In progress
Sudan (M, F)	1	653	No	✓	✓
Uganda (M, F)	No	-	✓	No	No
Zambia (M, F)	13	385	✓	✓	✓

MHTF OUTPUT 4 COUNTRY INDICATORS		MHTF OUTPUT 5 COUNTRY INDICATORS			
Country has a national midwifery council or board (stand-alone or included in nursing)	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
✓	13	3	0	136	136
✓	39	9	1	1486	1110
✓	-	1	-	-	-
✓	2	-	-	14	-
In progress	118	6	4	134	30
No	1	2	-	-	-
No	-	11	11	-	-
✓	-	9	0	50	79
✓	-	-	-	-	-
-	-	-	-	-	-
✓	14	6	6	124	80
✓	13	8	3	178	0
No	0	-	-	63	-
✓	30	3	3	560	480
✓	-	13	0	1300	0
✓	9	5	0	368	0

(continued)

Annex 2. Consolidated results framework for 2012 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)							
Countries with 4 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**Availability of basic emergency obstetric and newborn care: national number of facilities**	**Availability of comprehensive emergency obstetric and newborn care: national number of facilities**	**Geographic distribution: proportion of subnational 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)	15	27	7	16.2	6.8	1.4	26	4.6
Burkina Faso (M, F)	4	21	15	7.91 (urban 27/ rural 0.5)	14.2	0.51	22	7.15
Burundi (M, F)	7	38	7.5	2.2	13.1	0.7	94	5.8
Cambodia (M, F)	67	34	2.2	13.91	35.98	0.37	37	3
Côte d'Ivoire (M, F)	17	11	0	2	39	3	15	1.9
Djibouti (M, F)	11	2	-	31.6	-	-	-	14
Ethiopia (M, F)	140	65	4	10	7	2.8	62	1
Ghana (M, F)	111	76	-	21	17	1	32	7% (urban 11%, rural 5%)
Guyana (M)	-	-	-	-	-	-	-	-
Haiti (M, F)	-	12	-	-	60	-	37	3
Madagascar (M, F)	3	19	-	18.4	9.59	2.51	121	1.53
Malawi (M, F)	120	53	-	73	24	2	33	3.4
South Sudan (M, F)	-	-	-	-	-	-	-	0.5
Sudan (M, F)	-	-	70	16	-	-	-	5
Uganda (M, F)	-	-	-	-	-	-	27	-
Zambia (M, F)	232	56	68	-	-	-	-	3

MHTF OUTPUT 6 COUNTRY INDICATORS			MHTF OUTPUT 7 COUNTRY INDICATORS	
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$
✓	✓	✓	7.2 (2008)	-
✓	✓	No	15.5 (2009)	-
✓	✓	-	4.7 (2009)	-
✓	✓	✓	56	-
✓	No	No	4.36	-
✓	✓	✓	14 (2011)	-
No	✓	No	7	-
✓	Partial	-	12	-
✓	✓	-	6.7 (2011)	-
✓	✓	✓	-	-
✓	✓	✓	6 to 7	15.1 overall (2009)
✓	✓	✓	-	-
No	No	No	4.2 (2010)	6 overall (2010)
✓	✓	No	8	1 (2011)
✓	✓	✓	8	229,403,514 overall 32.5 per capita
Partial	Partial	✓	11	-

Annex 2. Consolidated results framework for 2012 *(continued)*

	MDG5.a AND MDG5.b INDICATORS					
Countries with 3 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**a) Maternal mortality ratio**	**a) Skilled attendance at birth, %**	**b) Adolescent birth rate (per 1,000 women)**	**b) Antenatal care coverage, % (at least one/ at least 4 visits)**	**b) Unmet need for family planning, %, total**	**b) Contraceptive prevalence rate, %, any method**
Afghanistan (M, F)	460	14.3	151	16.1	-	15.5
Bangladesh (M, F)	240	24	60	55/20.6	12	61
Cameroon (M, F)	690	63	127	85/62	22	14.4
Central African Republic (F)	890	53.4	132.9	69.3/39.7	16.2	19
Chad (M, F)	1100	22.7	203.4	-	28.3	1.6
Congo (F)	560	86.1	131.5	85.8/74.7	16.2	44.3
Democratic Republic of the Congo (M, F)	540	87	24	85/47	24.4	5.4
Eritrea (F)	240	28.3	85	70.3/40.9	27	3.5
Guinea (F)	610	49	146	85.2/50.3	40	7
Guinea-Bissau (F)	790	44	249	70	6	14
Kenya (F)	360	42	145	91.4/47	26	46
Lao People's Democratic Republic (M, F)	470	42	94	54	20	50
Liberia (M, F)	770	80	226	79.3/66	35.6	16
Mali (M, F)	540	49	190	70.4/35.4	31.2	8.2
Mauritania (F)	510	67.2	236	85.5/48.4	37.2	11.4
Mozambique (M, F)	490	55.3	185	92.3/53.1	18.4	11.3
Namibia (M, F)	200	81.4	74	94.6/70.4	6.7	55.1
Nepal (M, F)	170	36	106.3	58/29.4	27	43.2
Niger (M, F)	590	42.22	1400%	93.9	15.8	12
Nigeria (M, F)	630	48.7	89	66.2/56.6	19.4	17.5
Pakistan (M, F)	260	38.8	20.3	60.9/28.4	24.9	27
Rwanda (M, F)	340	69	41	98	19	45
Senegal (F)	370	94	96	93	29	13
Sierra Leone (M, F)	890	43	122	93/75	27	11
Somalia (F)	1000	33	123	26.1/6.3	-	14.6
Timor-Leste (M, F)	300	30	51	86	31	22
Yemen (M, F)	200	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	
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 an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care, is costed
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
-	-	✓	✓	✓
-	-	-	-	-
-	✓	✓	✓	✓
-	-	-	-	-
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	No	✓	✓	✓
-	-	-	✓	✓
✓	✓	✓	-	-
-	✓	-	✓	✓
✓	✓	✓	-	-
-	-	-	-	-
✓	✓	✓	✓	✓
In progress	✓	✓	No	No
-	-	-	-	-
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	-	-	-
-	-	-	-	-
✓	✓	No	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
-	-	-	-	-
✓	-	-	-	-
-	-	-	-	-

Annex 2. Consolidated results framework for 2012 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 3 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**Midwifery training institutions with national midwifery curricula based on WHO/ ICM essential competencies**	**Annual number of midwifery graduates from national midwifery training institutions**	**Midwives authorized to administer core lifesaving 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**
Afghanistan (M, F)	34	-	Partial	-	-
Bangladesh (M, F)	40	542	No	No	No
Cameroon (M, F)	0	-	-	-	-
Central African Republic (F)	-	-	-	-	-
Chad (M, F)	23	-	✓	Partial	✓
Congo (F)	-	-	-	-	-
Democratic Republic of the Congo (M, F)	0	535	✓	-	-
Eritrea (F)	1	100	✓	✓	✓
Guinea (F)	1	-	✓	✓	✓
Guinea-Bissau (F)	-	46	-	✓	✓
Kenya (F)	-	-	✓	✓	✓
Lao People's Democratic Republic (M, F)	8	197	Partial	In progress	✓
Liberia (M, F)	Yes	176	✓	✓	✓
Mali (M, F)	Yes	-	-	✓	-
Mauritania (F)	Yes	58	✓	No	✓
Mozambique (M, F)	-	-	-	-	-
Namibia (M, F)	-	-	-	-	-
Nepal (M, F)	-	-	✓	-	-
Niger (M, F)	Yes	300	✓	✓	✓
Nigeria (M, F)	-	3000	✓	Partial	✓
Pakistan (M, F)	-	-	-	-	-
Rwanda (M, F)	Yes	120	✓	✓	✓
Senegal (F)	Yes	500	✓	✓	✓
Sierra Leone (M, F)	Yes	126	✓	-	Partial
Somalia (F)	-	-	-	-	-
Timor-Leste (M, F)	-	37	✓	✓	✓
Yemen (M, F)	-	-	-	-	-

MHTF OUTPUT 4 COUNTRY INDICATORS			MHTF OUTPUT 5 COUNTRY INDICATORS			
Country has a national midwifery council or board (stand-alone or included in nursing)	Number of doctors trained in surgical obstetric fistula repair	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
-	-	-	1	-	-	-
Partial	300	550	10	1	269	18
-	-	-	6	-	-	-
-	-	-	2	-	-	-
✓	-	-	4	1	-	-
-	4	15	4	2	5	56
No	5	9	27	0	261	112
No	3	12	2	-	83	-
No	12	13	5	3	165	150
✓	9	36	2	1	35	23
✓	25	104	12	3	200	35
No	0	0	0	-	-	-
✓	-	-	4	4	222	16
-	-	-	5	1	-	-
✓	19	19	5	3	30	10
-	23	23	4	0	-	-
-	-	-	-	-	-	-
✓	18	18	3	0	56	56
No	5	5	6	5	482	350
✓	-	-	12	12	2000	-
-	-	-	15	4	-	-
✓	8	8	5	0	0	0
✓	6	30	7	0	150	0
✓	1	-	2	2	186	186
-	-	-	1	-	-	-
-	3	28	1	-	7	-
-	-	-	1	-	-	-

Annex 2. Consolidated results framework for 2012 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)			
Countries with 3 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**Availability of basic emergency obstetric and newborn care: national number of facilities**	**Availability of comprehensive emergency obstetric and newborn care: national number of facilities**	**Geographic distribution: proportion of subnational areas with the required number of emergency obstetric and newborn care facilities, %**	**Proportion of all births in emergency obstetric and newborn care facilities, %**
Afghanistan (M, F)	-	-	-	15
Bangladesh (M, F)	-	-	-	-
Cameroon (M, F)	61	32	0	6.1
Central African Republic (F)	-	-	-	-
Chad (M, F)	23	20	10	4.6
Congo (F)	-	-	-	-
Democratic Republic of the Congo (M, F)	-	-	-	-
Eritrea (F)	32	12	100	32
Guinea (F)	72	19	57.5	40.3
Guinea-Bissau (F)	-	6	-	44
Kenya (F)	3600	383	3.4	42
Lao People's Democratic Republic (M, F)	4	5	14	25
Liberia (M, F)	1	9	40	9.9
Mali (M, F)	-	-	-	-
Mauritania (F)	-	-	-	-
Mozambique (M, F)	45	33	-	17
Namibia (M, F)	-	-	-	-
Nepal (M, F)	-	-	-	-
Niger (M, F)	44	29	12	28.3
Nigeria (M, F)	-	-	-	-
Pakistan (M, F)	-	-	-	-
Rwanda (M, F)	-	45	100	69
Senegal (F)	-	-	-	-
Sierra Leone (M, F)	0	17	1.2	50
Somalia (F)	-	-	-	-
Timor-Leste (M, F)	8	6	-	-
Yemen (M, F)	-	-	-	-

UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)				MHTF OUTPUT 6 COUNTRY INDICATORS		
Met need for emergency obstetric and newborn care, %	Direct obstetric case fatality rate, %	Neonatal mortality (intrapartum and very early neonatal deaths), per 1,000 deliveries	Proportion of births with Caesarean sections as a proportion of all births, %	Mandatory notification of maternal deaths	Routine practice of maternal death audits/ reviews	Confidential enquiries system for maternal deaths in place
20	87	29	1.1	-	-	-
-	-	32	-	No	Partial	No
34.8	2.1	22	2.3	-	No	No
-	-	-	-	✓	-	-
4	6.7	39	1.5 (urban 4, rural 0.7)	✓	-	-
-	-	-	-	-	-	-
-	-	-	5	✓	No	No
-	34	-	1.8	✓	✓	✓
-	-	-	2.4	✓	✓	✓
-	-	-	3.5	✓	✓	-
-	-	37	5	✓	✓	✓
13.9	0.16	4.4	2.6	✓	Partial	-
5.5	2.6	24.1	2.8	✓	✓	✓
-	-	-	-	-	-	-
-	-	-	-	No	No	No
11	5.2	10	2.2	✓	✓	✓
-	-	-	-	-	-	-
-	-	33	-	✓	✓	✓
74	2.7	21	1.3	✓	Partial	No
-	-	40	1.8 (urban 3.7 rural 1)	No	No	No
-	-	-	-	-	-	-
-	-	27	-	✓	✓	No
-	-	-	-	✓	✓	No
7	7	36	1.9	✓	No	In progress
-	-	-	-	-	-	-
-	-	-	1.3	-	✓	-
-	-	-	-	-	-	-

Annex 2. Consolidated results framework for 2012 *(continued)*

	MHTF OUTPUT 7 COUNTRY INDICATORS	
Countries with 3 years of implementation **(M) and (F) indicate midwifery or fistula funding**	**Share of government expenditure for health, %, as per annual government figures**	**National budget for maternal and newborn health care overall and per capita (including all flows, domestic and external), as measured through national health accounts where they exist, %/US$**
Afghanistan (M, F)	6 (2011)	10.29 (2008)
Bangladesh (M, F)	6.5	-
Cameroon (M, F)	6 (2011)	-
Central African Republic (F)	-	-
Chad (M, F)	5.3 (2010)	-
Congo (F)	-	-
Democratic Republic of the Congo (M, F)	-	-
Eritrea (F)	-	-
Guinea (F)	2.5	-
Guinea-Bissau (F)	-	7%
Kenya (F)	0.8 (2009/10)	-
Lao People's Democratic Republic (M, F)	19 (2007)	Under discussion
Liberia (M, F)	15	-
Mali (M, F)	-	-
Mauritania (F)	10.7 (2011)	-
Mozambique (M, F)	7	-
Namibia (M, F)	-	-
Nepal (M, F)	7.1 (2010/11)	-
Niger (M, F)	7.85	7.85%
Nigeria (M, F)	5.7	-
Pakistan (M, F)	-	-
Rwanda (M, F)	-	-
Senegal (F)	8.04 (2011)	-
Sierra Leone (M, F)	7.4	-
Somalia (F)	-	-
Timor-Leste (M, F)	-	3.7M
Yemen (M, F)	-	-

The Maternal Health Thematic Fund: Accelerating Progress towards Millennium Development Goal 5

UNFPA's Maternal Health Thematic Fund (MHTF) provides strategic technical assistance and catalytic funding to countries most in need to accelerate progress towards Millennium Development Goal 5: Improve maternal health.

Launched in 2008, the MHTF has contributed to the following results:

- ✓ Maternal health is now high on global and national agendas through evidence-based communications and advocacy efforts, joint work by the H4+ group and support to the UN Secretary-General's *'Every Woman Every Child'* initiative and the African Union's Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA).
- ✓ National needs assessments in Emergency and Newborn Care have been carried out in 34 countries and being followed up with district-by-district scale-up plans.
- ✓ Work is under way in 30 countries to strengthen and scale up the midwifery workforce, a critical element in filling the human-resource gap in maternal health. To date over 31 midwifery gap analyses and 4 in-depth midwifery workforce assessments have been completed, 175 midwifery schools strengthened in high maternal mortality countries and the skills of several hundred midwifery tutors enhanced. A particular highlight from 2012 is an innovative e-learning programme for midwives and frontline healthworkers being developed in partnership with WHO, Jhpiego and Intel Corporation.
- ✓ More than 35,000 women suffering from obstetric fistula have benefited from surgical repairs since 2003, mostly since scaling up the campaign under the Maternal Health Thematic Fund. This is a direct result of UNFPA's work as a leader and a major contributing partner to the Campaign to End Fistula.
- ✓ Building on lessons learned from the control of infectious diseases, Maternal Death Surveillance and Response has been developed in partnership with WHO and the CDC to identify every maternal death and to initiate corrective action to avert future deaths.
- ✓ Maternal mortality has been reduced by half from 1990 to 2010. Ending preventable maternal deaths and obstetric fistula within a generation is now within sight, grounded in solid, proven, evidence-based strategies.

The MHTF has contributed to these results with around $21 million in 2012 and $82 million since its inception.

No woman should die giving life.

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