Maternal Health Thematic Fund

Annual Report 2013

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

Cover photo: Nurses dancing during the celebrations for the 2013 International Day of the Midwife in Lilongwe, Malawi.
Credit: UNFPA/Malawi.

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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 multidonor support that has been generated to strengthen reproductive health. In particular, we would like to thank the governments of Austria, Australia, Canada, Finland, Germany, Iceland, Ireland, Luxembourg, the Netherlands, New Zealand, Norway, Poland, the Republic of Korea, Spain, Spain (Catalonia), Sweden and the United Kingdom. We would also like to thank our partners in civil society and the private sector, including Friends of UNFPA, Johnson & Johnson, Laerdal Foundation, Virgin Unite, Zonta International and the Women's Missionary Society of the African Methodist Episcopal Church, for their generous support. We extend a special thanks to our many individual donors and to our UN Trust Funds and Foundations.

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We are also grateful to our development partners for their collaboration and support in championing sexual and 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 into the future.

ACRONYMS & ABBREVIATIONS

AFD	Agence Française de Développement (French Development Agency)
AMDD	Averting Maternal Death and Disability Program (Columbia University)
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CDC	US Centers for Disease Control and Prevention
DFID	Department for International Development (United Kingdom)
EmONC	Emergency Obstetric and Newborn Care (B=Basic; C=Comprehensive)
FIGO	International Federation of Gynecology and Obstetrics
H4+	WHO, UNICEF, UNFPA, the World Bank and UNAIDS
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Society for International Cooperation)
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4+	UNAIDS, UNFPA, UNICEF, UN Women, World Bank and WHO
ICCRD,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
INGO	International non-governmental organization
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
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
NGO	Non-governmental organization
SIDA	Swedish International Development and Cooperation Agency
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
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

FOREWORD

by Dr. Babatunde Osotimehin – Executive Director, UNFPA

Millennium Development Goal 5 to improve maternal health remains an unfinished agenda. There is no room for complacency when 800 women die every day from complications of pregnancy and childbirth and many more suffer injury such as obstetric fistula.

Our work at UNFPA to accelerate progress on MDG5 is built on partnership, innovation and a belief in what is possible. Working together, we can realize a world where every pregnancy is wanted, every childbirth is safe, and every young person can realize their potential.

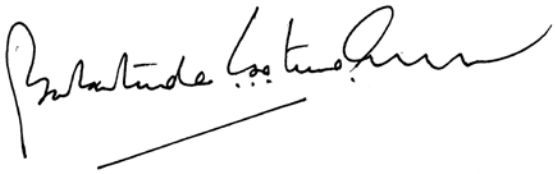
Our Maternal Health Thematic Fund, including the Midwifery Programme and Campaign to End Fistula, makes a major contribution to the improvement of maternal health, reducing maternal mortality and ensuring universal reproductive health. This report reflects the achievements and results in 2013, building on the findings from the independent mid-term evaluation of September 2012 and laying the foundation for a new phase in 2014 to accelerate action to achieve MDG5.[1]

Through technical and financial support for quality maternal health services in 43 countries with high maternal mortality and morbidity, the Fund supported national efforts to address health systems bottlenecks, train healthcare workers, expand access to services, and undertake evidence-based interventions.

The Maternal Health Thematic Fund complements the Global Program to Enhance Reproductive Health Commodity Security by promoting sexual and reproductive health throughout the lifecycle and strengthening the availability and access to comprehensive sexual and reproductive health services at the country level. This work is done in partnership with the UN Secretary General's Every Woman, Every Child initiative; the H4+ Partnership (UNAIDS, UNICEF, UN Women, World Bank, WHO and UNFPA), Family Planning 2020 and other vital partnerships, in line with UNFPA's new Strategic Plan for 2014 through 2017.

We move forward guided by the ICPD Beyond 2014 global report,[2] which documents significant progress and continuing challenges such as weak health systems, widening inequities in access to services for sexual and reproductive health, and poor quality of services. These findings-validate the focus and priorities of the Maternal Health Thematic Fund to address these issues head-on with a continuing focus on human rights and human dignity.

The many results highlighted in this report are a reflection of intensified collective commitment and action. I thank countries, donors, other partner organizations and colleagues for strong collaboration to achieve universal sexual and reproductive health and reproductive rights.



Dr. Babatunde Osotimehin
Executive Director, UNFPA

[1] http://www.unfpa.org/webdav/site/global/shared/documents/Evaluation_branch/Maternal_health_report/MHTF%20evaluation%20report%2001.02.2013.pdf
[2] http://www.unfpa.org/public/home/sitemap/ICPDReport

EXECUTIVE SUMMARY

Launched in 2008 to accelerate progress towards Millennium Development Goal 5 (MDG5), the Maternal Health Thematic Fund (MHTF) focuses on countries with high maternal mortality by providing targeted, additional support to reduce preventable maternal deaths and morbidities.

The Fund is catalytic in approach, aligning with country-led processes to address health system bottlenecks; promote innovation; strengthen partnerships and uniquely focus on evidence-based interventions aimed at advancing the reproductive health agenda with proven results at the country level. The MHTF has now been operating for five years, having concluded its first phase in 2013, and it is currently supporting interventions in 43 countries in five programmatic areas: emergency obstetric and newborn care, the Midwifery Programme, the Campaign to End Fistula, maternal death surveillance and response and advocacy and demand-creation for maternal and newborn health — all discussed in this report.

The MHTF's business plan identified maternal death and disability as an entry point for programmes to advance universal access to sexual and reproductive health. With the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) — the other UNFPA thematic fund — the MHTF complements UNFPA core resources, including the H4+ joint programme, and is used to both implement and scale up effective interventions, while identifying and strengthening transformative actions to promote maternal and newborn health and to improve women's health throughout the life course.

Overall results for the first phase of the MHTF (2008-2013)

What have we achieved during these 5 years?

Emergency Obstetric and Newborn Care (EmONC)

- The MHTF has supported EmONC needs assessments and post-assessment implementation guidance and interventions in **34 countries**;
- Recommendations derived from EmONC needs assessments have been used for evidence-based planning and implementation of maternal and newborn health services in **15 countries,** and district-by-district scale-up plans are currently being developed in **19 countries**.

The Midwifery Programme

- Midwifery gap analyses/needs assessments have been completed in **33 countries**;
- Results from gap analyses/needs assessments have been used for planning and management of the midwifery health workforce in almost all **33 countries**;
- Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies have been developed or strengthened in **33 countries**;
- Nine innovative, multimedia e-learning modules and a complementary Implementation Guide have been

launched and disseminated in over **30 countries** to support training in essential lifesaving skills;

- National Midwifery Councils (either stand-alone or included in nursing) are present and supported in **28 countries**;

- **Two hundred midwifery training institutions** are currently supported by the Midwifery Programme, with capacity to train **8,000** to **10,000** midwives annually.

The Campaign to End Fistula

- Currently supports approximately **half of all fistula surgical repairs** globally;

- Facilitated training of more than **3,900** healthcare workers, including surgeons, nurses, midwives and community health workers;

- Provided social reintegration services to **8,960** women and girls surgically treated for obstetric fistula.

Maternal Death Surveillance and Response

Since the start of its involvement in late 2011, the MHTF has contributed to the institution of mandatory notification of maternal deaths in **30 countries**, and the adoption of surveillance and response as a framework for the elimination of preventable maternal deaths in **18 countries.**

Highlights of 2013

1. Emergency obstetric and newborn care

Emergency Obstetric and Newborn Care (EmONC) is a key strategy to reduce preventable maternal deaths. EmONC needs assessments are national facility–based surveys and serve as a baseline for the current level of service delivery in all districts of a country.

Results in 2013

At country and regional level:

- Five new EmONC needs-assessment surveys were completed (**Bangladesh, Guinea, Mauritania, South Sudan** and **Togo**);

- Recommendations derived from the post needs-assessment national workshops in countries with recently completed EmONC surveys were included in national action plans and used to support the implementation of evidence-based interventions. Examples of such interventions include scaling up of EmONC services and facilities in countries such as **Burundi** and **Cambodia** (focused on training EmONC providers), **Haiti** (EmONC monitoring and data collection activities), **Burkina Faso** (task-shifting to perform Caesarean sections) and **Sudan** (availability of blood supplies for urgent transfusions).

At global level:

- To support countries' efforts to bring EmONC services to scale, representatives of Ministries of Health from **Ghana**, **Niger** and **Sierra Leone** met in 2013 with UNFPA, WHO, UNICEF, AMDD and Jhpiego. They agreed on the need to develop evidence-based guidance to support countries in their efforts to bring EmONC services to scale by addressing concrete issues related to cost-efficiency planning and performance implementation.

2. The Midwifery Programme

The Midwifery Programme focuses on strengthening and scaling up the midwifery workforce. In particular, it helps countries to train midwives and strengthen midwifery professional associations and regulations, according to specific countries' contexts.

Results in 2013

At country and regional level

- Over **7,000** midwives have received pre- and in-service capacity building training; in addition, approximately **1,000** midwifery tutors were trained in lifesaving skills for Basic EmONC, as well as family planning and teaching skills. This is an important achievement that contributes to addressing the worldwide shortage of midwifery tutors;

- **Two hundred** midwifery schools and training institutions were equipped with books, school furniture and training models. Following the devastating earthquake in 2010 in Haiti, the Midwifery School there reopened in October 2013;

Global Midwifery Symposium, held in Kuala Lumpur, Malaysia, in 2013.
Photo by UNFPA/Etienne Franca

- UNFPA/WHO/Intel/Jhpiego e-learning modules on essential maternal and newborn lifesaving skills were launched globally. UNFPA, in collaboration with Jhpiego and the Intel Corporation, inducted approximately **400** midwives in the use of these innovative multimedia training modules;

- Over **200** midwives from Africa, Asia and Latin America attended Master Trainer workshops for the skills-building program Helping Mothers Survive (HMS), which includes the first simulator-based training package Bleeding After Birth (BAB). These workshops were conducted in collaboration with Jhpiego, using Laerdal Global Health's innovative, low-cost and low-resource-setting appropriate training models;

- The Midwifery Programme provided support for the third International Confederation of Midwives (ICM) Africa Regional Conference in Nairobi, Kenya, during which the **Confederation of African Midwives Associations (CONAMA)** was officially launched. By unifying and strengthening African midwifery associations, CONAMA will help ensure that Africa has competent midwives who can provide quality care.

At global level

- A high-level **midwifery symposium** was organized during the third Women Deliver Conference, held in Kuala Lumpur, Malaysia. The symposium concluded with a Joint Declaration of Commitment, in which 29 UN agencies, international NGOs, private partners, national governments and donor agencies pledged their support towards strengthening availability, accessibility, acceptability and quality of care.

3. The Campaign to End Fistula

The goal of the Campaign to End Fistula is to make obstetric fistula as rare in developing countries as it is in the industrialized world. Since 2003, the campaign has supported over 47,000 repairs; its activities are based on three key strategies: prevention, treatment and social reintegration.

Results in 2013

At country and regional level

- The number of repairs that were supported doubled from 5,000 in 2010 to over **10,000** in 2013;
- The number of Campaign to End Fistula partners increased from 80+ to **91**.

At global level

- Raised awareness and generated funds through the first International Day to End Obstetric Fistula. The occasion was commemorated with parallel activities by national authorities and Campaign to End Fistula partners worldwide, with awareness-raising events and media outreach.

4. Maternal Death Surveillance and Response

Maternal Death Surveillance and Response (MDSR) has become the main instrument in the shift from reducing to eliminating preventable maternal mortality through mandatory notification of deaths and investigation at community and facility levels.

Results in 2013

At country and regional level:

- Over 100 providers were trained to audit maternal deaths in **Burkina Faso**, and **529 maternal deaths** were identified and notified; a National Observatory of Maternal Deaths has been created in the **Republic of the Congo** and **223 maternal deaths** were analyzed in 2013; the MDSR system was integrated into the WHO Integrated Disease Surveillance and Response and weekly maternal death surveillance was officially started in **Malawi;** a mandatory weekly reporting of maternal deaths in all health facilities was established and enabled the reporting of **289 cases of maternal deaths** in 2013 in **Niger**; the MDSR system was integrated into the WHO Integrated Disease Surveillance and Response and providers were trained in maternal deaths audits in **Rwanda**; a national MDSR meeting with review of the MDSR guidelines took place in **Zambia**.

5. Advocacy and demand-creation for maternal and newborn health

By fostering policy dialogue and capacity development at national level, the MHTF promotes a supportive political environment for sexual and reproductive health. Advocacy and demand-creation strategies supported by the MHTF in 2013 focused on socially acceptable and technically accurate messages to improve reproductive health services utilization and increase community awareness for maternal and newborn care.

Results in 2013

At country level:

- Advocacy and communications initiatives, done in collaboration with partners, helped raise visibility and increase support to maternal and newborn health priorities in the context of sexual and reproductive health. The MHTF contributed to fostering communication activities as well as policy dialogue and capacity development for policy makers at country level, with tangible results in countries such as **Guyana**, with a revision of legislation for midwifery practice and the development of a national sexual and reproductive health policy; **Lao People's Democratic Republic**, where the first phase of its Health Sector Reform focused on delivering the Maternal, Neonatal and Child Health (MNCH) service package; and **Malawi**, where the National Population Policy was revised to align with international development frameworks for sexual and reproductive health, like the International Conference on Population and Development (ICPD) Beyond 2014 and the Maputo Plan of Action.

At regional and global level

- The African Union Commission (AUC), UNFPA and other partners convened a special **high-level event on the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)**, held during the African Union summit. With UNFPA support, the event fostered better synergy with global initiatives and highlighted priorities in sexual and reproductive health for Africa. These included a request to the AUC, in collaboration with UNFPA, for the development of a continental structure to monitor and follow up on progress and facilitate the sharing of best practices among member states; and a request to the African Development Bank to develop a framework to establish a mechanism to source, pool and manage resources to support maternal, newborn and child health;

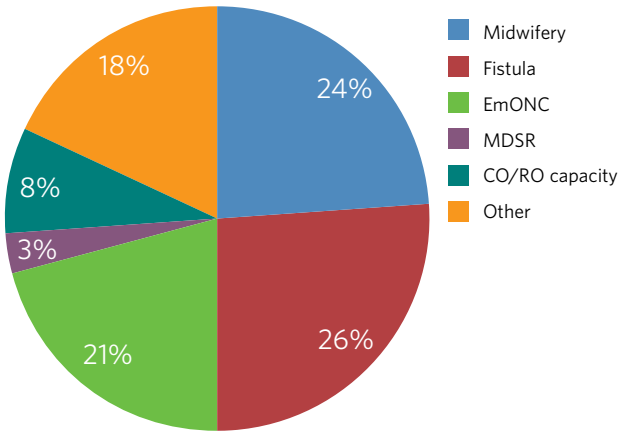
- The UN marked the **first International Day to End Obstetric Fistula** with a special launch event at the United Nations headquarters in New York on 23 May. This historic occasion featured numerous parallel activities by UNFPA country offices, authorities and Campaign to End Fistula partner agencies across the globe;

- Communications and media strategies were associated with and targeted key international events in the area, including the third **Women Deliver Conference** and the **Midwifery Symposium** in Malaysia.

Resources

In 2013, about one-quarter of expenditures (approximately $4.5 million) supported fistula and another quarter (approximately $4.2 million) supported midwifery programming. Around 21 per cent (about $3.8 million) supported Emergency Obstetric and Newborn Care, 3 per cent (about $0.6 million) supported development and implementation of MDSR, and around 8 per cent (about $1.4 million) was used to strengthen the capacity of priority country and regional offices. The remainder was used primarily to address national capacity strengthening in areas such as policy, planning and programming (including technical support), data collection and management, enhancing the evidence base, quality assurance activities, and lifesaving medicines and commodities for safe deliveries.

In 2013, the financial implementation rate for the MHTF was 94 per cent, compared to 91 per cent in 2012 and 88 per cent in 2011, showing a rising trend of implementation—an encouraging sign, despite the many challenges that countries with suboptimal governance or humanitarian problems face.



Way Forward

The MHTF now has an established system of operation that includes technical support and partnership, enabling further expansion of interventions. The new MHTF's Business Plan, covering the period 2014-2017 and aligned with the UNFPA Strategic Plan vision and goals, builds on the recommendations of the independent evaluation as well as on new scientific evidence in the field of maternal health. These include:

- Providing assistance for pilot interventions on selected core maternal health issues and supporting strategies to better target populations with high vulnerability to poor maternal health, especially first-time young mothers;
- Ensuring that MHTF-supported maternal-health related interventions encompass mechanisms to maintain the quality of outputs;
- Developing multiyear country strategic plans for the use of MHTF funds, with a focus on key maternal health issues.

The goal of the second phase of the MHTF is to **improve maternal health** in the overall context of *"increased national capacity to deliver integrated sexual and reproductive health services,"* as outlined in the UNFPA's Strategic Plan.

To support this goal, the MHTF will focus on the following target areas:

1. Continue to strengthen national capacity to implement comprehensive midwifery programs;

2. Continue to strengthen national capacity for emergency obstetric and newborn care, including quality integrated maternal health services;

3. Continue to strengthen national capacity for prevention, treatment and social reintegration for women and girls with obstetric fistula;

4. Continue to strengthen national capacity for maternal death surveillance and response;

5. Reach out to first-time young mothers to improve their access to quality maternal health services, focusing on delivery in health facilities.

The three principles of **equality, quality** and **accountability** will guide the work of the Fund throughout this second phase, as it focuses on scaling up activities pertaining to the planning, transmission of knowledge and development of information, monitoring and evaluation systems.

During its second phase, the MHTF is expected to become a more effective and efficient program that delivers sustainable results to ensure a maximum impact on reproductive, maternal and newborn health.

"Midwives deliver and not only babies. They save lives and promote good health in societies as a whole. They are an essential workforce in an effective healthcare system."

(UNFPA Executive Director, Dr. Babatunde Osotimehin, International Day of the Midwife 2011).

CHAPTER ONE

Background and Introduction

At the maternity home of the Integrated Health Centre in Bankilare (240 kilometres from Niamey, the capital of Niger), Nafissa Allassane, the director, offers dedicated midwifery services and expertise, thus giving women the confidence to go to the facility when needed.

Nafissa, 31, graduated as a registered nurse from the National School of Public Health in Niamey in 2003; she is a source of pride for the villagers of Bankilare, where she has been working since 2006. As the mother of a boy and a girl, she shares her time between the maternity home and her family. For her, there is no break or holiday. Every day is a working day.

Born in a village 20 kilometres from Bankilare, Nafissa speaks Tamasheq (the most widely spoken language in the area) in addition to Hausa and Zarma (the two most common languages of Niger). She said of her advantage as a multilinguist: "I easily communicate with patients and their escorts."

Since Nafissa arrived at the Bankilare health centre, death on deliveries has been a rare occurrence, a fact her colleagues confirmed. They said Nafissa's indefatigable skills have been put to the test in the remotest villages, hamlets and camps to promote the training of matrons (traditional midwives), who care for pregnant women during their deliveries, and on the use of misoprostol (which stops post-partum hemorrhage). Today, Nafissa's dream is to further her studies and specialize in reproductive health, with a view to "providing more support to Nigerien women," she said.

Meanwhile, Nafissa and her colleagues have put body and soul in the fight to upgrade the Bankilare health centre into a district hospital. This, she said, will help them handle emergencies.

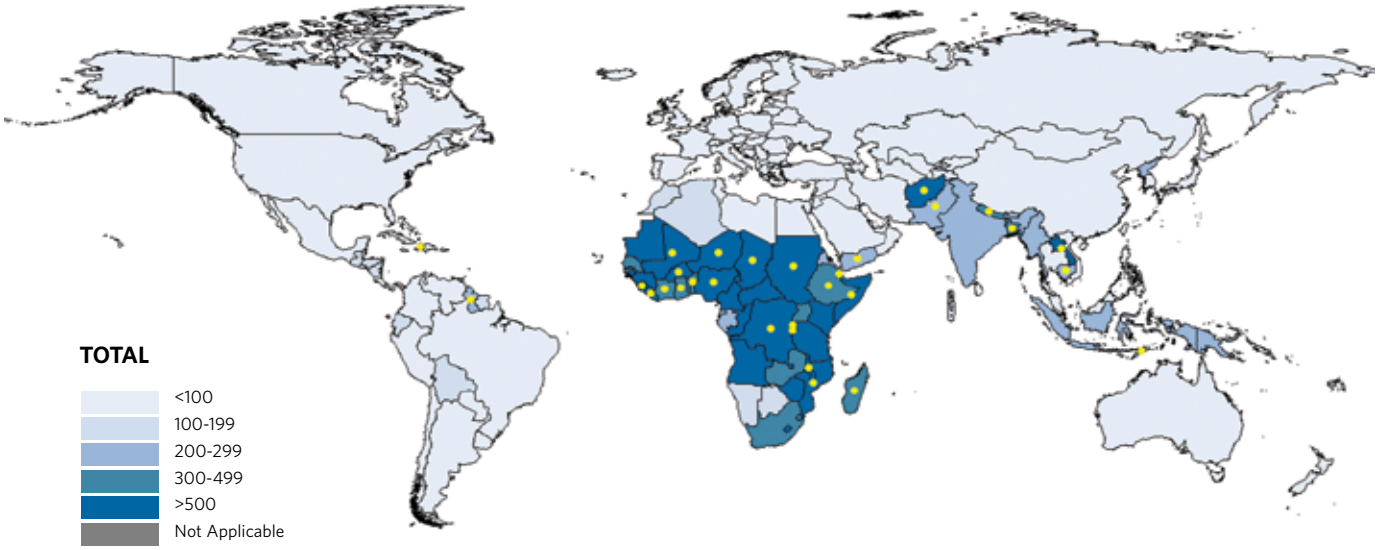
◀ Nafissa Allassane, right, is a midwife, trainer and campaigner from Niger.

Photo by UNFPA/Moussa Saley

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.[3])



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations or UNFPA concerning the legal status of any country, territory, city or area or its authorities or the delimitation of its frontiers or boundaries.

MHTF goals, outputs and resources

The Maternal Health Thematic Fund was established in 2008 to further enhance UNFPA's contributions to the health MDGs and, as stated in its 2008-2011 Business Plan, it "aims to boost support to high maternal mortality countries to reduce maternal mortality and morbidity." In the five years since its inception, the MHTF, which includes UNFPA's Midwifery Programme and the Campaign to End Fistula, has invested heavily in strengthening health systems and providing technical support for maternal and newborn health in all the supported countries (Figure 1 and Table 1). Funding decisions for the MHTF countries are made in full agreement with governments as part of UNFPA support to a country's sexual and reproductive health strategy and the national health plan more generally.

A scene from Chad.

Credit: UNFPA/Bintou Kasser

[3] 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, 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, Zambia and Zimbabwe. Ten additional countries receive support for obstetric fistula only: Cameroon, Central African Republic, Congo, Eritrea, Guinea, Guinea-Bissau, Kenya, Mauritania, Senegal and Somalia.

TABLE 1. Evolution of support to countries by the Maternal Health Thematic Fund since its inception.

Years of operation	2008: Launch of the MHTF	2009: First full year	2010: Second full year	2011: Third full year	2012: Fourth full year	2013: Fifth full year
Countries supported in maternal health overall	11	15	30	33*	33*	43
Countries supported by the Midwifery Programme		15	22	30	30	33
Countries supported by the Campaign to End Fistula		25	42	43*	43*	43
Total number of countries supported by the MHTF	**11**	**25**	**42**	**43***	**43***	**43***
Expenditures	**$1 million**	**$14 million**	**$21 million**	**$25 million**	**$21 million**	**$19 million**

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

The MHTF, working with countries and key partners, supports the implementation of effective, evidence-based and targeted interventions in the following key areas:

1. Emergency obstetric and newborn care
2. Midwifery
3. Obstetric fistula
4. Maternal death surveillance and response
5. Advocacy and demand-creation for maternal and newborn health

The MHTF constitutes an important UNFPA contribution to the UN Secretary General's Every Woman, Every Child initiative; to the H4+ work on reproductive, maternal, newborn, child and adolescent health (RMNCAH); and to helping to reach MDG5. The substantial reduction of maternal mortality in recent years is encouraging, and the focus of the MHTF now turns to safeguarding these achievements, addressing the long-term sustainability of the interventions and promoting sexual and reproductive health that specifically targets the most vulnerable and marginalized populations, such as poor and adolescent girls. These goals will be achieved while the Fund also addresses more critical key drivers such as equality, quality and accountability to facilitate greater advances in maternal and newborn health.

The 2013 MHTF Annual Report

Organization of the report

The report is structured around the key areas of intervention of the MHTF: Chapter Two focuses on emergency obstetric and newborn care; Chapter Three, the Midwifery Programme; Chapter Four, the Campaign to End Fistula; Chapter Five, maternal death surveillance and response, and Chapter Six presents results within the context of advocacy, policy and political environment. Chapter Seven gives an overview of the resources and management situation of the MHTF, and Chapter Eight discusses current challenges and the way forward for the second phase of the fund. Annex 1 contains the list of partners in the Campaign to End Fistula and Annex 2 contains the results framework towards the MHTF outputs.

CHAPTER TWO

Emergency Obstetric and Newborn Care

Emergency Obstetric and Newborn Care (EmONC) has gradually emerged as a crucial strategy for reducing maternal mortality. The MHTF has played a key role in both advocating for and supporting the development of EmONC services at country, regional, and global level, and it has invested heavily in human-resources capacity in the design, plan and implementation of EmONC services, as well as in monitoring and evaluation activities. These efforts have led to substantial progress in 2013.

Country Highlights

EmONC needs assessments completed in five countries

In 2013, five countries completed an EmONC needs assessment (**Bangladesh, Guinea, Mauritania, South Sudan** and **Togo**). These surveys of health facilities are designed to determine how many are providing EmONC; whether the facilities are adequately staffed (in quantity and quality) and whether women with obstetric complications are using the facilities. The quality of services is also measured.

To illustrate strategic data collected by EmONC assessment surveys, Table 2 presents some key indicators collected in Guinea, Mauritania, South Sudan and Togo.

What is emergency obstetric and newborn care (EmONC)?

Basic emergency obstetric and newborn care (B-EmONC) can be provided, when a skilled professional is present, in health centres, and includes:

- Administering antibiotics, oxytocics and anticonvulsants to manage bleeding, infections and fits;
- Manually removing the placenta;
- Removing retained uterine products;
- Assisting with vaginal delivery, with vacuum extractor or forceps;
- Performing newborn resuscitation.

Comprehensive emergency obstetric and newborn care (C-EmONC) includes all basic functions above, plus obstetric surgery (Caesarean section in particular), safe blood transfusion and care to sick and underweight newborns, and is usually delivered in district hospitals.

Source: WHO, UNFPA, UNICEF and AMDD. Monitoring Emergency Obstetric Care. 2009.

A scene from the Democratic Republic of the Congo.

Photo by Svenn Torfin /H4+

Bangladesh

ICDDR,B led the data collection on behalf of the Ministry of Health for a large needs assessment of the 24 most-disadvantaged districts in the country (4,000 sites). Data collection began in late April 2012. The report is currently being finalized for submission to the Ministry of Health.

Guinea

The EmONC assessment began in April 2012 with an inception visit led by Columbia University's Averting Maternal Death and Disability Program (AMDD) in collaboration with Guinea's Institute of Health Sciences Research (IRSS). In May 2013, the draft report was finalized and a validation workshop was held. In November 2013, UNFPA Regional Office led a post-assessment visit, with the aim of establishing a basic EmONC facility that could serve as a demonstration site.

Mauritania

The assessment began in mid-March 2012 with an inception visit completed by AMDD. In November 2013, a report-writing workshop was organized. In early December, workshops on report validation and action planning were held. They were attended by representatives from UNFPA, UNICEF, AFD (Agence Française de Développement, or French Development Agency), WHO and health professionals. Follow-up actions

TABLE 2. Sample indicators for Emergency Obstetric and Newborn Care in supported countries

EmONC indicators	Guinea	Mauritania	South Sudan	Togo*
Maternal Mortality Ratio[4]	650 [390 - 1100]	320 [180 - 590]	730 [420-1300]	450 [250 -850]
Total numbers of facilities assessed	502	254	407	864
Availability of Basic EmONC facilities[5]	0	5	10	8
Expected B-EmONC according to minimum international standards	92	26	87	52
Availability of Comprehensive EmONC facilities[6]	15	7	14	24
Expected C-EmONC according to minimum international standards	23	7	22	15
EmONC geographic distribution[7]	None of the 8 regions meets the required number of functioning EmONC facilities	None of the 13 regions meets the required number of functioning EmONC facilities	None of the 10 states meets the required number of functioning EmONC facilities	Only Lomé province meets the required number of functioning EmONC facilities
Proportion of all births in EmONC facilities	7.1 %	—	4.2 %	10 %
Met need for EmONC[8]	30 %	19.8 %	9.5 %	23.7 %
Direct obstetric fatality case rate[9]	1.5 %	2 %	3.5%	1.3 %
Intrapartum and very early neonatal death rate	39 per 1000 deliveries	—	28.2 per 1000 deliveries	83.7 per 1000 deliveries
Caesarean sections as a proportion of all birth (normal range 5%-15%)	1.4 %	2.5 %	0.5 %	5.8 %

* Togo received MHTF support for its EmONC needs assessment, which was carried out with technical assistance from AMDD. The country is now included in the list of MHTF-supported countries for 2014.

[4] Maternal mortality estimates [confidence interval]. From Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division. Available at http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/

[5] Partly functioning facilities are not included. Figures are based on signal functions performance. Basic EmONC facilities include those with the seven basic signal functions available (Signal functions are key medical interventions used to treat the direct obstetric complications that are responsible for the majority of maternal deaths around the world).

[6] Partly functioning facilities are not included. Figures are based on signal functions performance. Comprehensive EmONC facilities include those with the nine signal functions available.

[7] Proportion of subnational areas with the required number of functioning EmONC facilities (minimum acceptable level, according to international standards, is 5, including one comprehensive EmONC facility for every 500,000 inhabitants).

[8] 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.

[9] Case fatality rate among women with direct complications in emergency obstetric care facilities (should not exceed 1%).

A scene from Madagascar.

Credit: Magnum Photos/Dominic Nahr

focus on priority interventions to promote the use of EmONC services, with the objective of increasing the rate of assisted deliveries from 75 to 85% by 2015.

South Sudan

The EmONC assessment began in June 2012. It was led by the Ministry of Health, with UNFPA and AMDD guidance and supported by the H4+ partnership. Data entry was difficult, requiring extensive cleaning, delaying the analysis process. The final report was validated through a successful workshop in October 2013. Regions are developing action plans, based on regional fact sheets, and key recommendations include:

- Development of a health human resources management framework with benchmarks for refresher training and rotation of staff from heavy workload facilities to low workload facilities and vice versa;
- Updating of staffing norms and the training and recruitment of nurses, midwives and medical officers;
- Accelerated training of midlevel health cadres, especially midwives;
- Strengthen/support the task shifting initiative (Non-Physician Clinician initiative).

Togo

The EmONC assessment began in March 2012 with an inception visit led by AMDD in collaboration with IRSS and led by the Ministry of Health. The final report was validated in July 2013. With UNFPA's support, EmONC survey data was immediately used by the Ministry of Health to organize two regional workshops to design a national EmONC facilities network mapping as well as a plan for EmONC monitoring activities. In addition, a three-week training course for 50 health providers was organized to upgrade their skills in emergency obstetric and newborn care.

Main findings of the needs assessments

Although the core EmONC indicators provided by an EmONC survey in these countries show different situations, they all have in common very low coverage and use of EmONC, as well as an insufficient number of fully functional EmONC facilities. Maternal mortality ratios, even if the degree of uncertainty around these estimates is large, reflect specific country contexts influenced by cultural, political and governance aspects; and health system weaknesses, including the lack of skilled staff in obstetric care, are among the main contributing factors.

One of the most common findings of EmONC needs assessments is the shortage of Basic EmONC facilities and the frequent absence of Comprehensive-C-EmONC/B-EmONC referral linkages. Not surprisingly, this is also the case for the four countries shown in Table 2.

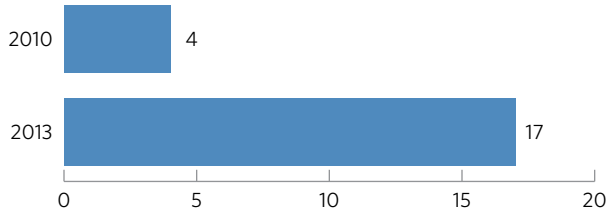
As a result, the proportion of all births in EmONC facilities and the number of women treated in EmONC facilities for obstetric complications are very low in all four countries, which translates into high rates of intrapartum and early neonatal deaths.

With respect to C-EmONC facilities, these are usually located in hospitals with obstetric and surgical facilities, and they are more present at regional and sometimes at district level. According to the international minimum standards, Mauritania has just reached the minimum number (seven) of C-EmONC facilities requirements, whereas Togo, with 24 C-EmONC available, is far above its minimum (15).

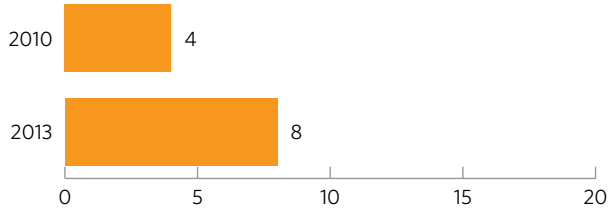
Caesarean section, a key signal function for C-EmONC, is used as a proxy for all surgical emergencies related to obstructed labour and should be in the range of 5 to 15 per cent of all births. However, this percentage is well below the minimum in Mauritania (2.5 per cent), and it has just reached the minimum acceptable level in Togo (5.8 per cent).
These figures indicate a lack of use of available comprehensive EmONC services, a common finding in countries with high burdens of maternal mortality. In addition, none of the countries illustrated in the table (except for Lomé province in Togo) has developed a national EmONC network of facilities that reaches the international minimum standard of 1 C-EmONC and 4 B-EmONC per 500,000 inhabitants in all the regions/provinces of a country, which further restricts access to EmONC services.

FIGURE 2

Number of MHTF-supported countries reporting regularly on EmONC functioning status



Number of MHTF-supported countries able to report equitable EmONC geographic distribution at sub-national level*



*Current recommendation is for all subnational areas to have the minimum acceptable numbers of EmONC facilities: 1 comprehensive plus 4 basic EmONC facilities per 500,000 population.

Overall, EmONC surveys represent a key initiative for a country, providing a detailed map of the status of EmONC facilities at national and subnational levels, and also providing a baseline against which progress will be measured. Figure 2 illustrates improvement in the number of MHTF-supported countries that now report on the status (top panel) and distribution (bottom panel) of their basic and comprehensive EmONC facilities.

Key outputs for 2013 following the results of EmONC needs assessments in selected countries

Recommendations derived from EmONC post-needs assessment national workshops were included into national action plans, and provide the basis for evidence-based interventions.

Burkina Faso: implementing task shifting, formative supervision and EmONC monitoring

In Burkina Faso, implementation of the delegation of tasks (task shifting) related to essential surgery has made substantial progress, and a total of 20 medical doctors were trained in 2013. This training has strengthened a key signal function of C-EmONC, i.e., the possibility of immediately performing a Caesarean section when required in 20 facilities. All 13 regions and 63 health districts were supported for the formative supervision of health providers trained in EmONC, and a national supervision grid was developed for this purpose. All regions have produced a summary report for each health district, detailing the identified problems and proposed recommendations.

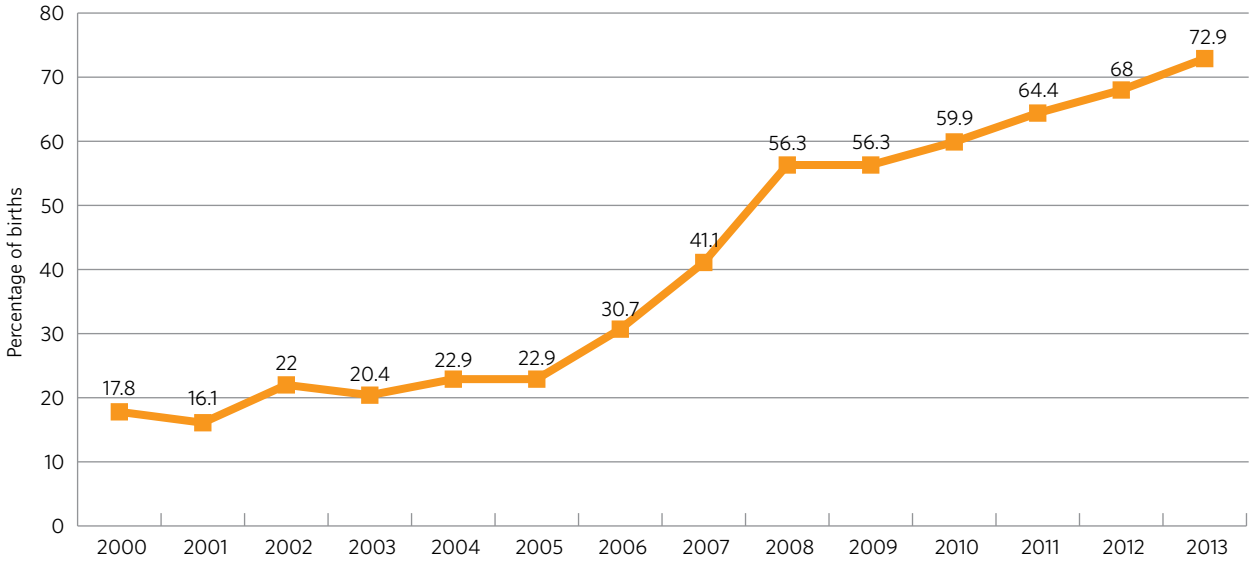
The institutionalization of EmONC has begun in two areas. The biannual EmONC monitoring reviews the signal EmONC functions, the level of activity in the treatment of obstetrical complications and the obtained results. A micro-plan to address the issues observed at facility level is then drafted and attached to the monitoring document for further follow-up actions.

Burundi: preparing for EmONC scale-up

With support from UNFPA, seven national trainers trained 58 providers in EmONC. As a result, the health facilities providing EmONC increased from 2 to 29 (23

FIGURE 3

Increasing percentage of births in health facilities in Burundi from 2000 to 2013 (data from the Ministry of Public Health, Burundi).



hospitals offering C-EmONC and 6 health centers offering B-EmONC) in the six provinces currently representing the focus area for UNFPA.

This training process, based on understanding and acquisition of necessary skills, will be complemented by formative supervision (led by two trainers in each site per year). This supervision not only allows skills to be strengthened during the training, but also facilitates the flow of information — indicators — on the effective provision of EmONC and other associated events (births, complications, maternal deaths). This mechanism enables the database on the availability of EmONC functions to be developed and updated.

In addition, a multisectoral coordination group was organized to support the Reproductive Health National Program, and included partners working in the field of reproductive and maternal health. It provided a framework for sharing information on actions needed to promote complementarities and synergy in interventions aimed at developing and improving the quality of EmONC. During the period this report covers, the rate of assisted deliveries increased from 68 per cent in 2012 to almost 73 per cent in 2013 (Figure 3, data from 2000 to 2013).

Cambodia: EmONC training ad scale-up of facilities

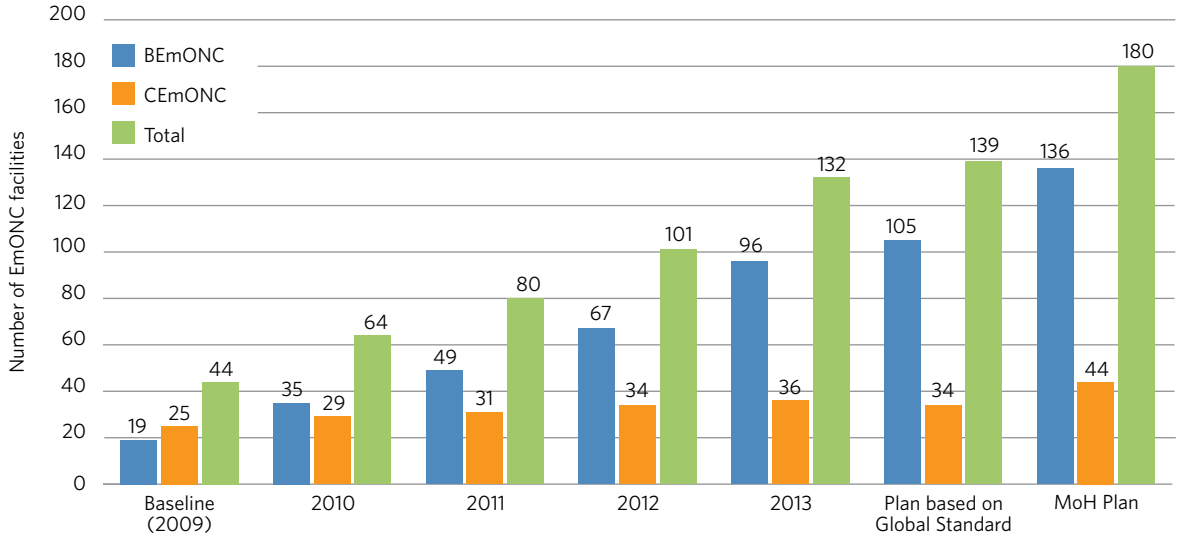
Building on previous efforts to support the development of the EmONC Improvement Plan 2010-2015, UNFPA, through the MHTF, has worked with the Cambodia Ministry of Health and the National Maternal and Child Health Centre (NMCHC) to scale up EmONC health facilities and achieve the Improvement Plan's targets by 2015.

The EmONC coordination team of the NMCHC followed up and supervised midwives and physicians in a continuous effort to improve their skills and ensure quality of care. In 2013, 37 field trips were conducted to follow up 233 midwives at 57 EmONC facilities. At the same time, 583 midwives from 273 health centers that are not EmONC facilities were invited to participate in the coaching processes.

Leveraging and advocacy with the Ministry of Health and partners has enabled subnational rollout of EmONC training, renovation of facilities and provision of appropriate medical equipment. It has contributed to an increase from 80 EmONC facilities in 2011 to 101 in 2012 and to 132 functioning EmONC facilities in 2013, as shown in Figure 4. This has had a positive impact on the

FIGURE 4

Progress on scaling up EmONC facilities in Cambodia, compared with international global standard and planned number of EmONC facilities proposed by the Ministry of Health (MoH)



proportion of births at EmONC facilities, which reached 23 per cent in 2013.

Liberia: continuous EmONC monitoring to address the gaps

The Ministry of Health and Social Welfare (MOHSW), with support from UNFPA, identified key counties and health facilities for capacity strengthening in EmONC service provision in the 2013-2017 Country National Program. In 2013, a rapid assessment of EmONC services to ascertain the actual gaps was completed for 10 B-EmONC and 2 C-EmONC facilities in five underserved counties. A 10-day assessment of all 12 health facilities was completed, considering core areas, as per guidelines from the MOHSW. Results from this assessment revealed that nearly 75 per cent of health facilities lacked basic supplies, such as delivery kits and essential commodities to ensure the provision of quality EmONC services. In addition, following the rapid assessment, the need emerged to continuously provide training in EmONC due to the high turnover of staff. Sixteen midlevel skilled providers from the facilities were trained in Basic Life Saving Skills (BLSS). In response to the supply and equipment gaps identified and the urgent nature of the response, 216 reproductive health kits were procured and dispatched to all 12 EmONC facilities in the counties. Four were dispatched to one-stop centers for rape survivors in Monrovia.

These measures were intended to ensure that the signal functions were fully restored at these facilities. By October 2013, all of the targeted health facilities reported data showing

Examples of additional key outputs following several EmONC needs assessments conducted during the first phase of the MHTF include:

- Task-shifting to improve coverage and quality of services (**Ethiopia**)
- Development of national costed operational plans to strengthen EmONC services (**Cambodia, Lao People's Democratic Republic, Madagascar**)
- Training-of-trainers courses for the upgrading of competencies in the midwifery workforce (**Madagascar**)
- Mandatory notification of maternal death and inclusion of maternal death reviews as indicators in the national health information system (**Burundi**)
- Development and implementation of national systems for maternal death surveillance and response (**Cambodia, Burkina Faso**).

A scene from Côte d'Ivoire.

Credit: UNFPA/Affoue N. Guessan

that of all deliveries, 38 per cent were community-based and 62 per cent were performed at health facilities. UNFPA, through the MHTF, will continue to provide support to the MOHSW and partners to achieve greater access to quality reproductive health services to these difficult-to-reach counties.

Haiti: strengthening EmONC monitoring activities and quality of care

In 2013 the Ministry of Health, supported by UNFPA, continued the process of EmONC monitoring activities in 10 regions of the country. The standard national monitoring tool was used to provide key information on EmONC facilities development. The team that conducted EmONC monitoring reviewed all signal functions availability, which also represented a good opportunity for the team to discuss maternity ward organizational issues with the staff, using an approach based on constructive supervision and support.

This approach aims to create a direct impact on the quality of care, on registers maintenance and on data quality management. Each EmONC fact sheet is recorded and compiled into a regional EmONC document. Challenges remain, specifically on weak national capacity at central and departmental levels. A thorough process of data analysis has recently started in some regions, which will lead to identification of the main issues to be addressed at the relevant level of the system.

Sudan: availability of blood supplies for urgent transfusions

In Sudan, to reinforce the weak status of the comprehensive EmONC functions, two blood donation campaigns were conducted in three states: Blue Nile, White Nile and Kassala. These campaigns have made blood available for urgent transfusions in areas with previous substantial deficits, thus potentially saving women's lives that were threatened by bleeding during obstetric emergencies. In Blue Nile, a C-EmONC hospital has performed several blood transfusions.

The campaigns also included advocacy elements for maternal health in general and blood donations in particular, and were attended by large numbers of local community members and representatives from partner institutions. In White Nile, the focus was on the advocacy component of the campaigns, enhancing the sustainability of blood donation by raising awareness about its importance. The donated blood was given to a central blood bank that distributes it to C-EmONC facilities every month. The monthly distribution is also a response to the unstable electric supply in White Nile's hospitals, limiting their capacity to store blood in high quantities.

Regional highlights

UNFPA and AMDD continued to collaborate with the Center for Training and Research in Reproductive Health

(CEFOREP) and Cheikh Anta Diop University (Senegal), Health Sciences Research Institute (IRSS; Burkina Faso), Evidence for Action (E4A; Ghana), University of Ghana School of Public Health, Institute of Public Health, Obafemi Awolowo University (Nigeria) and International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), to increase regional capacity to support EmONC development at country level.

Two regional workshops to strengthen national capacity for EmONC data analysis, monitoring and reporting were conducted in 2013. One workshop took place in Dakar, Senegal, from 9-14 September. It was attended by delegates from nine Francophone countries (Benin, Burkina Faso, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Mauritania, Niger and Togo), and two regional institutions (IRSS and CEFOREP). The second one took place in Mankessim, Ghana, from 16-21 September. It was attended by delegates from six countries (Gambia, Ghana, Liberia, Malawi, Mozambique, South Sudan) and two regional institutions (Institute of Public Health, Obafemi Awolowo University in Nigeria, and the University of Ghana School of Public Health). Both workshops concluded with action plans to strengthen data collection, analysis and reporting for EmONC services, and implementation is expected to start in 2014.

Global highlights

Technical partnership

The five new EmONC need-assessment surveys completed in 2013 were conducted using the EmONC assessment tool developed by Columbia University's AMDD Program, with UNICEF and UNFPA support.

The availability and accessibility of EmONC services are tracked as part of the Countdown to 2015 collaboration[10] and by UNFPA. In December, UNFPA hosted a meeting with the Countdown team, USAID, AMDD, Evidence for Action (E4A) and Integrare ICS. Participants agreed on supporting and further developing more accurate data

A scene from Bangladesh.

Credit: UNFPA/William A. Ryan

[10] http://www.countdown2015mnch.org/

reporting, such as the number of functioning EmONC facilities instead of designated EmONC facilities, as well as making data available for cross-country analysis. Our partners are initiating the evaluation of promising country-level EmONC monitoring systems, such as those in Haiti and Togo.

Implementation guidance on scaling up EmONC services

Key elements to achieving effective coverage of EmONC services are cost-efficiency planning and performance implementation — active implementation approaches that respond to a given context. With almost a decade of country experience in EmONC strengthening initiatives as well as increasing evidence in the literature on effective implementation strategies for health and other social services, the time is right to develop guidance to support countries in their efforts to bring EmONC services to scale.

Representatives from the Ministry of Health of Ghana, Niger and Sierra Leone met in 2013 with UNFPA, WHO, UNICEF, AMDD and Jhpiego. They agreed on the need to develop evidence-based guidance through an interagency collaborative process to address issues in three prioritized areas for efficient and effective EmONC services:

- **Planning and stewardship:** moving from data/evidence to national and subnational strategic planning, resource mobilization and donor coordination;
- **Human resources for health:** recruitment, training, deployment and supervision of human resources, as well as paying attention to other important aspects of a functional system such as infrastructure, drugs, supplies and equipment;
- **Systems performance:** data collection and integration of related inputs for quality improvement, accountability mechanisms and monitoring and evaluation.

Emergency Obstetric and Newborn Care: key achievements during the first phase of the MHTF

- The MHTF has supported EmONC needs assessments and post-assessment implementation guidance and interventions in **34 countries;**
- Recommendations derived from EmONC needs assessment have been used for evidence-based planning and implementation of maternal and newborn health services in **15 countries**, and district-by-district scale-up plans are currently being developed in **19 countries.**

CHAPTER THREE

The Midwifery Programme

In 2013, the Midwifery Programme completed its fifth year of implementation under the MHTF, providing support to 33 countries to strengthen competency-based midwifery education and training, midwifery associations and regulations and workforce policies. As a result of investments in these countries, an additional 20 UNFPA country offices gave high priority to midwifery by building synergies with the UNFPA-ICM midwifery programme.

At the end of 2013, there were 22 midwifery advisers placed at country level; two were funded by Swedish International Development and Cooperation Agency (SIDA) and one by Deutsche Sesellschaft fur Internationale Zusammenarbeit (GIZ). In addition, four ICM advisers supported the programme at regional level. A global programme coordinator provided strategic guidance and coordination in collaboration with global and regional UNFPA and ICM advisers. In 2013, **over 7,000 midwives** received pre- and in-service capacity building training; approximately **1,000 midwifery tutors** were trained and **200** midwifery schools and training institutions were enhanced with books, equipment and training models with UNFPA support.

Midwifery becomes a key indicator in UNFPA's new Strategic Plan

The significance of strengthened midwifery in supporting the achievement of MDG5 was reinforced when UNFPA's new Strategic Plan (2014-2017) identified midwifery as a key indicator. With this endorsement, midwifery has become mainstreamed in the core work of UNFPA, and all country offices are now mandated to scale up midwifery skills and capacities and strengthen comprehensive midwifery workforce policies at national level.

Country highlights

National needs assessments

In 2013, two new needs assessments were completed by **Nigeria** and **Sierra Leone**, bringing the total number of assessments completed to 33. Following the analysis, countries determined priorities and goals and developed strategic action plans to strengthen midwifery.

The Midwifery Programme was launched in 2008 as a partnership of UNFPA and the International Confederation of Midwives (ICM) and completed its first phase of implementation in December 2013. The programme aims to build national capacities by:

- Introducing ICM/WHO competency-based midwifery training curriculum;
- Developing strong regulatory mechanisms;
- Strengthening and establishing midwifery associations;
- Advocating with governments and stakeholders to encourage investment in quality midwifery services.

A midwifery school in Sierra Leone.

Photo by Abbie Trayler-Smith/H4+

Nigeria

Major gaps identified during the needs assessment in the education core area include: inadequate midwifery tutors with lack of incentives for them to develop careers in teaching; and inadequate number of midwifery schools to meet national needs. Teaching resources, facilities and services were reported to be outdated and/or limited in scope and quality for student training. For the regulation core area, gaps included outmoded legislative instruments, which dates back to the 1970s, and a scope of practice that is limited in scope to nursing only. For the professional association governance core area, a representative leadership has yet to be put in place, as only an interim executive body currently exists.

In September 2013, UNFPA Nigeria, in collaboration with ICM, the Nursing and Midwifery Council and the Nigerian Midwives Association, convened the first Nigeria midwifery gap analysis workshop to develop a strategic plan for strengthening midwifery in the country across education, regulation, association and advocacy core areas.

The recommendations for strategic directions to rectify the gaps towards improvement fed into the strategic plan being finalized. The workshop was supported by the government, which will also provide support to implement the strategic plan. In the coming year, the final document will be put forward for adoption, production and dissemination to all stakeholders, and a high-level launch will be organized to create visibility for the strategic plan and for midwifery.

Sierra Leone

Results from the midwifery gaps analysis were available in July 2013, and substantial gaps in midwifery education, association, regulation and practice were identified. Midwifery education in Sierra Leone depends on the limited capacity of the two midwifery schools that offer post-basic midwifery certificates to registered and enrolled nurses, and it is further constrained by inadequate tutors/clinical instructors and poorly equipped clinical training sites.

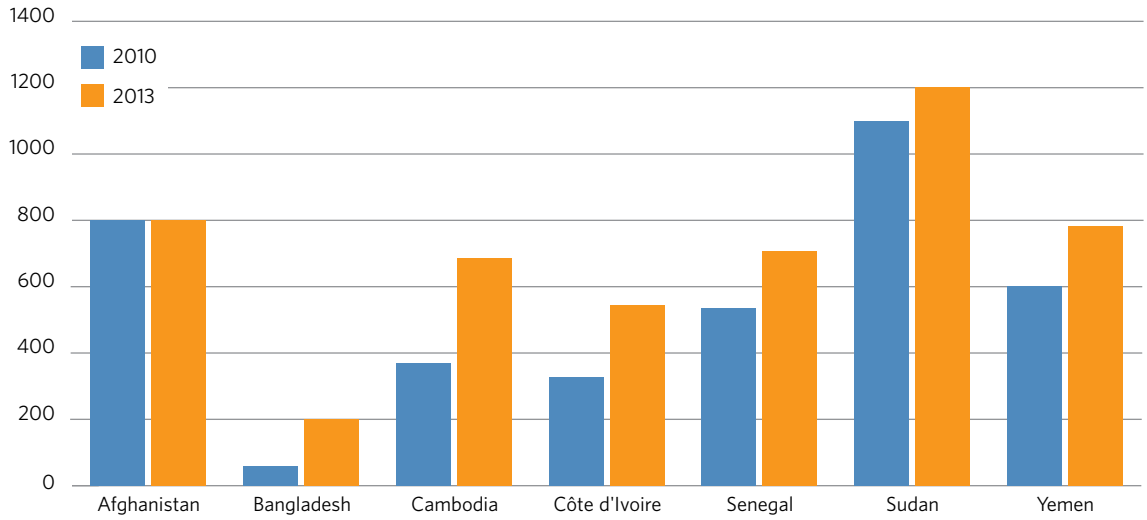
Moreover, midwifery education lacks a strategic vision on career development and retention of graduate midwives. Midwifery regulations were found inefficient in monitoring quality and availability of services. The lack of information on geographical distribution of midwives across the country and midwives' perceptions about the factors limiting their ability to provide quality services led to a midwifery mapping exercise.

The preliminary results show vast disparities in midwife distribution (over 40 per cent concentrated in the capital), compounding an already significant gap in the number of practicing midwives.

The role of the midwifery association in advocating and strengthening midwifery services and practice was also found to be weak, with unclear policy/plan on continuous professional education. Midwives are not well represented in sexual and reproductive health/maternal newborn child

FIGURE 5

Annual number of midwifery graduates in selected countries supported by the Midwifery Programme (2010 and 2013)



health committees or boards and are not part of the front-line government position to advocate for midwifery career and services. Recommendations to act on the identified gaps are being finalized to help develop a strategic action plan for midwifery.

Midwifery education

- **Burkina Faso** began an innovative mentoring project called 'Project Midwife,' which recruits retired midwives with at least 15 years of experience to provide teaching support to the National School of Public Health and to a private teaching institution. These mentors have provided support to over 75 midwifery teachers and helped to dramatically improve the teacher-to-student ratio from 1:40 to 1:14. This has resulted in a rise in students' success rates in examinations from 70 per cent to 90 per cent;

- In **Niger**, UNFPA supported eight health districts with experienced senior midwives providing on-site training and mentoring to young midwives and recent graduates of the medical school;

- In **Somalia**, UNFPA supported midwifery tutors from eight midwifery training schools throughout the country's three zones to ensure quality training and improved educational outcomes. An additional 121 midwives in Somaliland and Puntland completed a two-week in-service training on B-EmONC. MHTF funds were also used to complement funds from the Joint Health and Nutrition Programme (led by the Somali Health Authorities with support from the joint UN partners —UNFPA, UNICEF and WHO) to support the opening of two more midwifery schools in Somalia. Efforts are underway to support the Ministry of Health in opening two new midwifery schools in Mogadishu, the capital, in 2014;

- With support from UNFPA, **Ethiopia's** Ministry of Health made impressive gains towards achieving the national Human Resources for Health Strategy target of training 8,635 midwives by 2015 with the Accelerating Midwifery Training Programme. Additionally, 1,642 midwives graduated in 2013 from 15 health science colleges;

- **Pakistan** began a two-year bachelor's degree programme in midwifery at the Aga Khan University in Karachi. The curriculum is based on ICM guidelines; its first step will be training tutors on the curriculum, so it can be launched in the schools;

International United Nations Volunteer Midwives: Strengthening Midwifery Schools and Services in South Sudan

To address high rates of maternal mortality and morbidity, UNFPA, through the MHTF and with funding from Canada, supported four national health training institutes in Juba, Maridi, Kajo Keji and Wau counties in South Sudan by equipping laboratories and libraries with over $400,000 worth of books, vehicles, teaching and learning materials. Over 270 students are currently pursuing nursing and midwifery diplomas/certificates at these institutions, and additional midwives have received scholarships to study at national health training institutes in Uganda. The first national examinations for nursing and midwifery were held in July 2013 with a 100 per cent passing rate. Following graduation, these midwives have been deployed throughout the country.

To complement the focus on nursing and midwifery training, UNFPA targeted the acute shortage of qualified midwifery trainers/supervisors mentors in remote regions of the country and recruited 32 midwives to serve as International United Nations Volunteers (IUNV). These volunteers provide the necessary supervision and mentoring and also supplement clinical services to help scale up the national humanitarian response following the recent conflict in the country.

In 2013 alone, this initiative has provided antenatal care to a record number of more than 33,000 pregnant women across South Sudan; 8,430 women have been assisted at labour and delivery units; over 7,000 normal and safe births were conducted; almost 4,000 women were provided with follow-up post natal care; some 1,200 women were provided with family planning services; neonatal care is being provided to over 1,600 babies; and some 12,000 individuals were counselled and tested for HIV.

- The Federal Ministry of Health/Academy of Health Science in collaboration with the National Reproductive Health Programme of **Sudan** updated the basic training curriculum of community midwives to include the health consequences of female genital mutilation/cutting (FGM/C), complications of child marriage and socio-cultural aspects of both practices.

- The National School of Midwives in **Benin** reopened in 2011, and now follows an ICM competency/skills-based curriculum. Both training and the laboratory equipment have significantly improved, and internships in rural areas have become mandatory. The first group of 21 midwives graduated in December 2013.

- In **Bangladesh**, 168 midwives were educated in the six-month post-basic Certificate in Midwifery programme in 10 training institutes. Four hundred nurse-midwives enrolled in the programme in 20 centres nationwide. To date, 710 certified midwives have graduated from the programme, and 60 midwifery teachers have completed Training of Trainers programmes;

- With support from Jhpiego and UNFPA, Ghana's Ministry of Health developed a road map for the launch of the midwifery e-learning program. A pilot training course was organized at 10 pre-service midwifery schools and 2 regional hospitals. UNFPA provided 12 computers and other supplies for the training coordination office at the Ministry of Health and a regional training unit in the Ashanti region.

Midwifery regulation

- In 2013, several countries, including **Burkina Faso, Cambodia, Côte d'Ivoire** and **Madagascar**, passed a new or updated **Code of Ethics** for midwifery, which were disseminated with support from UNFPA and ICM;

- In **Lao People's Democratic Republic**, UNFPA supports the Ministry of Health for the implementation and management of the Skilled Birth Attendants Plan. This plan includes a strengthened accreditation process through a national examination system, ensuring deployment of trained staff to particularly hard-to-reach areas;

A New Midwifery School Brings Hope to Haitian Women

PORT-AU-PRINCE, Haiti — Students and teachers in the capital of Port-Au-Prince had dreamed of a better training space ever since the devastating earthquake hit the country on 12 January 2010. Their wish came true with the October 2013 inauguration of a new National Midwifery School (École Nationale des Infirmières Sages-Femmes), housed in a brand new earthquake-resistant building, with support from UNFPA in collaboration with the United Nations Stabilization Mission in Haiti.

Located next to one of the largest maternity hospitals in the country, which will serve as a practical clinical training site for its students, the new midwifery school offers two study options: a three-year direct-entry midwifery course immediately after high school or an 18-month midwifery training programme for existing nurses. Up to 80 students will be trained in the first year, including 39 nurses and 41 direct-entry midwives.

Haiti has a very low ratio of health workers, with only 1 doctor for every 8,000 inhabitants, 1 nurse for every 6,000 inhabitants and 1 midwife for every 50,000 inhabitants. Haiti also has the highest maternal mortality ratio in the Western Hemisphere: 630 deaths per 100,000 live births, according to national statistics. These future midwife graduates will pave the way for reducing maternal deaths in their country.

Through the programmes offered at the new school, the Department of Health hopes to quickly train 600 midwives who can meet the need for qualified personnel in Haitian maternities, said the Chief of Family Health, Dr. Reynold Grand Pierre. Classes began in October 2013 and the new students could not hide their enthusiasm.

"My dream has always been to help moms and newborns, to give advice to young people on family planning, and to help families to better plan their lives," said Mathurin Bethany, a midwifery freshman. "My admission to the training programme has finally offered me this opportunity."

- UNFPA supported **Malawi's** Midwifery Registration Council to review and align the midwifery scope of practice with ICM standards and develop the curriculum for the direct-entry midwifery programme;

- In **Uganda**, with support from UNFPA, seven additional Regional Registration and Licensing Coordination Centres based at regional referral hospitals were established in 2013, bringing the total number to 13 countrywide. This will improve supervision of nurses and midwives, quality of services and professionalism;

- **Cambodia** made impressive strides in increasing the number of midwives registered with the Cambodian Midwifery Council, growing from 2,870 in 2012 to 4,110 in 2013, representing about 80 per cent of the 5,128 midwives in the country;

- UNFPA supported the **Democratic Republic of the Congo's** Ministry of Higher Education in the development and validation of a draft ministerial order creating the category of midwives as an autonomous cadre at the Institute of Medical Technology, a first for the country;

- In **Nepal**, the Ministry of Health and Population established a Task Force Committee on Midwife Cadre and Education with representatives from the government, regulatory bodies, academic institutions, UN agencies and other external development partners;

- A midwifery desk has been created at the office of the **Liberia** Board of Midwifery and Nursing (LBMN) to improve the coordination of all midwifery-related activities at both national and subnational levels and to ensure collaboration among all stakeholders to identify gaps and sustainable solutions for the midwifery workforce, particularly in rural settings;

- In **Afghanistan**, support was provided to develop and approve the Nursing and Midwifery Council Strategy and to help secure a role for midwives in the Ministry of Public Health's Consultative Group on Health and Nutrition.

Midwifery associations

- UNFPA and ICM supported the Midwifery Association of **Côte d'Ivoire** to conduct several free prenatal and community health consultations, providing over 11,000 people with services that include HIV testing and counselling, family planning and cervical cancer screenings;

- UNFPA supported the establishment of the **South Sudan Nurses** and **Midwives Association**, which was registered as an NGO in September 2013;

- Midwifery associations were established for the first time in Central State and Puntland State, **Somalia**;

- To help make the **Liberian Midwifery Association** (LMA) more active at the subnational level, a chapter

In **Afghanistan,** UNFPA has been promoting Family Health Houses to scale up skilled attendance at birth in isolated pockets of the country. In 2013, this innovative strategy was officially included in the National Reproductive Health Policy and Nursing/Midwifery Strategy.

UNFPA also supported two Community Midwifery Education programmes to train 44 community midwives; 82 previously graduated community midwives are already deployed in 82 Family Health Houses in their communities. Each Family Health House provides care for 1,500 to 4,000 individuals. The total nationwide coverage is estimated at 300,000 people. UNFPA has extended the establishment of the Family Health Houses to new districts in Herat and Daikundi provinces.

The **Bangladesh Midwifery Society (BMS)** celebrated its third anniversary and tremendous growth in membership from 24 members in 2010 to over 770 today. BMS has recently become a member of the ICM, and its members support the Bangladesh Nursing Council's initiative to introduce ICM midwifery educational standards throughout the country. Members engage in policy discussions advocating for the acceptance of midwifery as an autonomous profession both within Bangladesh and throughout South Asia. Eleven members of BMS completed a leadership workshop organized by the Regional Midwife Adviser and UNFPA Country Office. BMS is also working with legislative and regulatory bodies to uphold professional practice standards and promote additional research and the continuing development of midwifery services.

was established in each of the 15 counties, a milestone for the country. UNFPA also supported leadership development by training 75 members of the LMA;

- In **Zambia**, a three-day leadership workshop was conducted to support young leadership development within the Midwives Association of Zambia (MAZ).

Regional highlights

Capacity building initiatives

To strengthen and enhance the skills of midwives and other frontline healthcare workers, UNFPA sponsored several capacity building workshops in 2013, including:

- Induction of approximately **400 midwives** on the e-learning modules at various international conferences, including Women Deliver; regionally at such conferences as those held by ICM in Latin America and Africa; and at national level in Afghanistan, Ghana, India and Zambia;

- In collaboration with Jhpiego and Laerdal Global Health, UNFPA supported multiple master training-of-trainer workshops at international, regional and country levels. Approximately **200 midwives** from Africa, Asia and Latin America benefited from the Helping Mothers Survive (HMS)/Bleeding After Birth (BAB) training package using Laerdal's innovative, low-cost and low-resource setting-appropriate training models called Mama and NeoNatalies. HMS/BAB trainings were conducted during the Women Deliver conference and at the ICM conference in Nairobi. After the training, national workshops were organized in Ethiopia, Nepal, Timor-Leste and Uganda.

- A workshop on Strengthening Midwifery Associations via Leadership Twinning and Mentoring was conducted in Accra, Ghana. Thirty-six participants from 12 African countries attended and participated in tutorials on creating successful Midwifery Association Twinning and Mentoring partnerships, using the Member Association Capacity Assessment Tool and creating country action plans based on the assessment results. Participants were also introduced to Jhpiego's reference manual on preceptorship in midwifery education.

Assessing capacity of midwifery training institutions

A regional meeting held in Cotonou, Benin, in October 2013 with 13 countries assessed progress and discussed key midwifery issues, including training capacity. This led to the development of numerous recommendations and country action plans. Progress will be further assessed at the ICM Triennial Congress in June 2014 and additional assessments will be conducted in 2014.

ICM regional conferences

- The fourth **ICM Regional Conference of Professional Midwifery in the Americas** (26-27 April) was organized by the National Midwifery Association of Ecuador with support from the Caribbean Regional Midwifery Association and the Latin American Federation of Midwives. More than 1,000 midwives, programme managers and policy makers from 24 countries attended. Midwifery participants shared their experiences and learned about the latest ICM/WHO standards and the ongoing development of basic and continuing education programs, as well as the development of professional associations. Participants also attended a panel session about the latest e-learning modules developed by UNFPA, Intel and Jhpiego.

- In July 2013, more than 450 participants from 30 African countries attended the third **ICM Africa Regional Conference** in Nairobi, Kenya, which was also supported by the MHTF. Key outcomes included the launch of the Confederation of African Midwives Associations (CONAMA) and dissemination of e-learning modules.

South-South Collaboration

- The Midwifery Associations of **Ethiopia** and **Ghana** launched a twinning relationship to promote mentorship that facilitates increased sharing of knowledge and best practices;

- To address its acute shortage of midwives, **South Sudan** continues to work with **Uganda** to train midwives. In 2013, approximately 20 midwifery students from South Sudan received such training in Uganda;

- **Afghanistan** collaborated with **Iran** on a review of the midwifery program and the curricula.

Other initiatives:

In September 2013, ICM hosted a workshop on **"Strengthening the Midwifery Workforce in Sub-Saharan Africa" i**n Kampala, Uganda. Thirty participants from 8 countries shared key achievements, best practices and common challenges. Participants were briefed on ICM's Global Standards for Education and Regulation and the Member Association Capacity Assessment Tool.

Global highlights

International Day of the Midwife celebrated

Once again, 5 May marked the worldwide celebration of the **International Day of the Midwife** with the theme "The World Needs Midwives Now More Than Ever." The day, which was celebrated in over 40 countries, recognized the contributions that have been made by midwives to sexual and reproductive healthcare, including maternity care.

This year's events included marches, awareness-raising demonstrations, educational workshops and conferences and film screenings. Several midwives engaged in media outreach and appeared on television and radio programs. Some midwifery associations used this opportunity to motivate midwives by recognizing contributions made by outstanding practitioners.

Several midwifery associations in various countries organized free family planning camps, breast cancer and cervical cancer screenings, free antenatal check-ups, and midwifery career promotion seminars. In Burkina Faso, 140 midwives provided 229 women with free cervical and breast cancer screenings. The midwifery associations of Chad, Sierra Leone and Mauritania provided pregnant women with free antenatal check-ups. Nigerian midwives provided free HIV testing and community education on family planning. To increase the number of midwives in rural and remote areas, Burundi's Association of Midwives educated 483 senior-year students from rural paramedical schools on the essential role midwives play in saving lives of mothers and babies.

UNFPA and ICM supported advocacy at country level with social media kits, an event planning checklist and strategies for engaging government and civil society leaders in the day's celebrations, as well as key messages on three selected themes, including:

- The role of midwives in family planning;
- Investing in midwives;
- Midwifery beyond the 2015 MDGs.

These activities resulted in wide media coverage that helped to elevate the status of midwives and secure renewed government and civil society commitment to the practice.

CONAMA Launch

The MHTF provided support for the third ICM Africa Regional Conference in Nairobi, Kenya, during which the **Confederation of African Midwives Associations (CONAMA)** was officially launched. An 11-member board representing all five African regions was created, and a 60-member council was elected with 2 representatives from each of the 30 member countries.

CONAMA's mission is to strengthen autonomous midwifery associations that promote quality education and practice, regulation, professional development and leadership within communities and at national and regional levels. By unifying and strengthening African midwifery associations, CONAMA is helping to ensure that across the continent competent midwives provide quality midwifery care while working with women and communities to achieve improved maternal, newborn and child health.

International Day of the Midwife

Joint Statement, UNFPA and the ICM, 5 May 2013

"Economic differences, inequalities in countries and inaccessibility of services in some areas contribute to a shortage of some 350,000 midwives at a time when the world needs midwives more than ever.

We urge all nations to work together to address the inequalities and inaccessibility of midwifery services. We encourage them to support quality training, innovative technologies and an enabling environment for midwives to match the vital role they play in communities and societies, especially in developing countries."

Twins born on the 2013 International Day of the Midwife in Benin. From left, the country midwife adviser, the mother of the twins and the midwife who helped deliver them.

Credit: UNFPA/Benin

Increased national commitments towards midwifery in response to Secretary-General's Every Woman Every Child strategy

By the end of 2013, over 40 countries had pledged support towards strengthening midwifery services and skilled attendance at birth. This growing commitment to address maternal mortality and morbidities is the result of sustained advocacy by UNFPA, ICM and other key partners, as well as new evidence generated by national midwifery needs and workforce assessments and gap analysis and the State of the World's Midwifery 2014 report.

Second Global Midwifery Symposium during the third Women Deliver Conference

The two-day high-level midwifery symposium, held 26-27 May 2013 in Kuala Lumpur, Malaysia, as part of the Women Deliver conference, was attended by over 230 midwives, policy makers, programme managers and senior representatives from UN agencies, major international NGOs and donors. It brought further visibility and global commitment towards improving the availability, accessibility, acceptability and quality of care of midwifery. Eminent speakers from around the globe discussed the evidence base, good practices, lessons learned and innovations for addressing the myriad challenges facing midwives and other frontline health workers today.

Key outcomes of the symposium also included:

- The first joint **Declaration of Commitment** to improve availability, accessibility and quality of midwifery services, signed by 29 partners;[11]
- Official launch of the UNFPA/Intel e-learning modules and Laerdal Global Health's **Helping Mothers Survive Training Package** (see below);
- The launch of the **Second State of the World's Midwifery Report** in 2014 by UNFPA.

UNFPA and Intel Partnership for innovative multimedia e-Modules

Helping Mothers Survive (HMS) is a simulator-based training package for frontline providers in countries with high burdens of maternal mortality. The training is directed to all health workers who attend births, including skilled birth attendants such as midwives as well as other health professionals. These highly innovative, multimedia e-modules with built-in assessments provide training on all major B-EmONC and family planning skills for frontline healthcare workers. Using Intel's free skoool™ technology, these modules do not require an Internet connection and can be accessed anywhere at any time via low-cost laptops or netbooks that health workers are trained to operate.

The modules offer case studies to walk users through real-life normal and emergency situations during pregnancy, childbirth and the postpartum period to promote the competent clinical practice necessary to reduce maternal and newborn mortality. Reviewed and endorsed by major professional bodies, including WHO, the International Federation of Gynecology and Obstetrics (FIGO), ICM and the International Council of Nurses (ICN), they represent the highest standard of e-learning today. The modules can be translated into any language and the graphics can be adapted to suit the sociocultural context.

[11] http://www.unfpa.org/webdav/site/global/shared/Symposium%20Joint%20Declaration.pdf"

Eight e-learning modules on key maternal and newborn lifesaving skills and family planning were developed in 2013. These include modules on pre-eclampsia/eclampsia, postpartum haemorrhage, sepsis, post-abortion care, obstructed labour, essential newborn care, family planning for frontline health workers and danger signs in pregnancy. Two pilot training programmes in Bangladesh and Ghana are underway and road maps have been developed to roll out the e-learning implementation.

The Ministry of Health in Ghana has agreed to adopt these global modules, and an initial pilot training was organized at 10 pre-service midwifery schools and two regional hospitals in 2013. In Bangladesh, the preparatory work on localization of the e-modules is well underway, and the e-learning programme ICT4RH (Information Communication Technology for Reproductive Health) will be operational in 2014.

Ongoing global efforts and partnerships to generate evidence base on midwifery

• *Lancet* series on midwifery

In 2013, the first series of scientific papers on midwifery was developed. These will be published by ***The Lancet*** and launched in London in June 2014. The papers discuss the impact of midwifery on improving maternal health and towards the elimination of preventable maternal and newborn deaths.

• Second State of the World's Midwifery Report (SoWMy 2014)

In 2013, midwifery data was collected and analysed and national workshops on midwifery and human resources for maternal and newborn health were organized in 40 countries, further fostering national dialogues around midwifery. This data will be used for the Second State of the World's Midwifery (SoWMy) Report, which includes data from 73 high-maternal mortality countries and is to be launched at the ICM Triennial Congress in Prague in June 2014.

• Midwifery workforce assessments: the High Burden Country Initiative

Further progress was noted in the ongoing workforce assessments done by national governments and the H4+ in seven of the eight countries representing more than 60 per cent of global maternal and newborn deaths. In five of the countries -- Afghanistan, Bangladesh, Ethiopia, Democratic Republic of the Congo and Tanzania -- the reports are nearly completed and ready to be released.

The Bangladesh report has been endorsed by the government and is now being used as part of the national dialogue on human resources and as the country invests in a new three-year direct-entry midwifery training programme.

In Afghanistan, the report has been completed and will be presented at the SoWMy 2014 report launch in Kabul in mid-2014.

An additional assessment was conducted in Mozambique and the first phase — desk review, country situation analysis — was completed in 2013.

Midwifery Programme: key achievements in the first phase of the MHTF

- Midwifery gap analyses/needs assessments have been completed in **33 countries**;
- Results from gap analyses/needs assessments have been used for planning and management of the midwifery health workforce in almost all **33 countries**;
- Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies have been developed or strengthened in **33 countries;**
- Nine innovative, multimedia e-learning modules and its complementary Implementation Guide have been launched and disseminated **in over 30 countries** to support training in essential lifesaving skills;
- National Midwifery Councils (either stand-alone or included in nursing) are present and supported in **28 countries**;
- **Two hundred midwifery training institutions** are currently supported by the Midwifery Programme, with capacity to train **8,000** to **10,000** midwives annually.

CHAPTER FOUR

The Campaign to End Fistula

"*We challenge those charged with developing the post-2015 health and development agenda to place the unmet needs of ultra-poor people at centre stage. Without a resolute effort to emphasize, understand and counter the deeply ingrained structures and processes — operating both within and beyond healthcare systems — that perpetuate invisibility, inferiority and powerlessness, progress towards equity in maternal health will remain elusive. Furthermore, in many parts of the world, continued neglect of the needs of the most marginalized women will also mean failure to achieve MDG5.*"[12]

Obstetric fistula is a devastating medical condition, yet in most cases it is both preventable and treatable, which is why it has all but disappeared from wealthier countries. The persistence of obstetric fistula reflects the failure of health systems to provide accessible and equitable sexual and reproductive health services, including universal access to family planning, skilled birth attendants and referral to emergency obstetric and newborn care when needed.

The condition also persists because of broader human rights violations facing women and girls, such as poverty, gender disparities, lack of schooling, child marriage and early childbearing, all of which impede the well-being and opportunities of women and girls.

What Is Obstetric Fistula?

Obstetric fistula is a severe morbidity occurring when a woman or girl suffers from 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, and the woman suffers a devastating injury, fistula, that renders her incontinent.

What is the Campaign to End Fistula?

The Campaign to End Fistula (CEF) is a global initiative led and coordinated by UNFPA that aims to make obstetric fistula as rare in developing countries as it is in the industrialized world. The Campaign was launched in 2003 with partners to raise awareness of this severely neglected health and human rights tragedy. It brings together hundreds of partner agencies at the global, community and national levels and is present in more than 50 countries across Africa, Asia, the Arab States and Latin America, including all the countries supported by the MHTF. The Campaign focuses on three key areas of intervention: prevention, treatment and social reintegration/follow-up.

[12] Mumtaz Z, Salway S, Bhatti A, and McIntyre L. 2013. "Addressing invisibility, inferiority and powerlessness to achieve gains in maternal health for ultra-poor women." The Lancet. Published online Oct. 2, 2013. http://dx.doi.org/10.1016/S0140-6736(13)61646-3.

A mother in the Democratic Republic of the Congo.

Photo by Abbie Trayler-Smith/H4+

FIGURE 6

Increase in the number of fistula repairs from 2003 to 2013

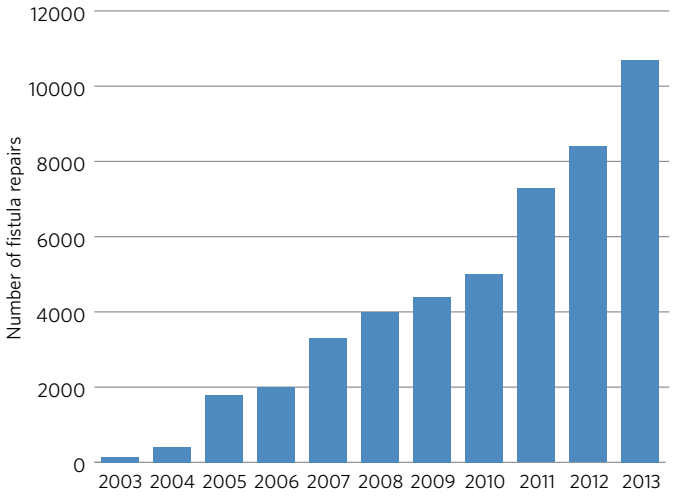
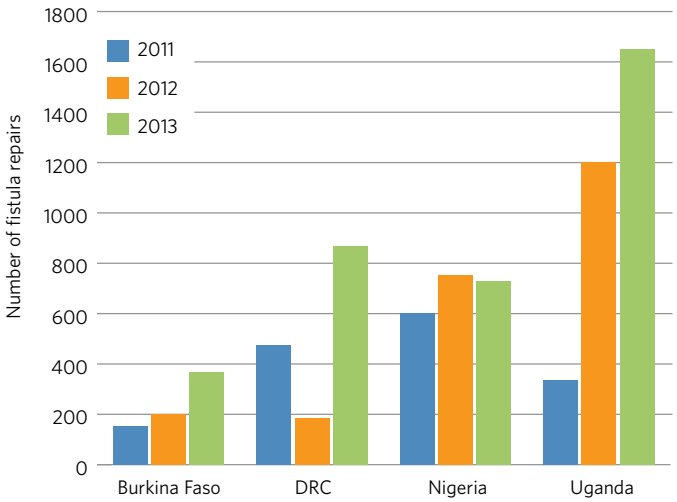


FIGURE 7

Progress in the number of repairs performed in selected countries supported by the Campaign to End Fistula



The average cost of fistula treatment — including surgery, post-operative care and rehabilitation — is around $400. Yet, more than 2 million women and girls cannot receive this care because of a lack of available services by trained obstetric fistula surgeons; when services do exist many women are not aware of them or cannot afford them.

In 2013, the 10th anniversary of the Campaign to End Fistula, UNFPA:

- Supported (directly and/or indirectly) **10,700**[13] women and girls to access life-changing surgical fistula repair and begin to rebuild their lives;
- Doubled the number of repairs supported from **5,000** in 2010 to over **10,000** in 2013;
- Raised awareness, activities and funds through the first International Day to End Obstetric Fistula;
- Increased the number of Campaign to End Fistula partners from 80+ to **91.**

In addition, partners of the Campaign have achieved tremendous results, including:

- **EngenderHealth's** Fistula Care programme has conducted numerous research projects, such as the determinants of post-operative outcomes of surgical fistula treatment, costs of fistula services in Nigeria and Ethiopia, a five-country review of Caesarean section records and a feasibility study on conducting community-based fistula screening processes. This research has improved the much-needed evidence base for fistula prevention and treatment;
- **The Government of Niger** and **Health & Development International (HDI)** have made tremendous strides in the country preventing obstetric fistula and reducing maternal mortality through the Rapid Maternal Mortality and Obstetric Fistula Prevention project, which began in 2008;
- **Fistula Foundation** became part of the "Half the Sky Movement: The Game," a new Facebook feature that highlights issues impacting women in the developing world, including fistula. This platform draws visibility, action and funding for surgical fistula repairs for women and girls around the world;
- The **International Federation of Gynecologists/ Obstetricians (FIGO)**, in collaboration with the **International Society of Obstetric Fistula Surgeons**

[13] Countries were still submitting fistula repair results at the time of this report.

(ISOFS), supported the process of evaluating training and treatment centres and scholarships for doctors and surgeons (from Madagascar, Nepal and elsewhere) to undergo training in fistula surgery and to subsequently link with UNFPA country offices to enhance collaboration and coordination for fistula activities.

Country highlights

Afghanistan: Promoting national leadership and ownership

The government, with UNFPA support, has shown strong leadership in tackling the problem of obstetric fistula with a pro-active approach. Key strategies have involved developing and costing a National Reproductive Health Action Plan that includes fistula (as well as EmONC and family planning/reproductive health commodity security); establishing a national Obstetric Fistula Committee chaired by the deputy minister of healthcare provisions; and distributing 1,000 copies of the Obstetric Fistula Manual (translated into the local language) to graduated midwives.

Burkina Faso: Cultivating strong partnerships to expand access to prevention, treatment and social reintegration

Recognizing the important role that faith-based organizations play in meeting the healthcare needs of populations in Africa and elsewhere, Burkina Faso strengthened partnerships with key faith-based health centres by providing training in prevention, treatment and post-operative care for fistula sufferers. They also developed training modules to reach both health workers and key stakeholders at community level. These collaborative efforts contributed to significant progress in the number of women that were treated for fistula, from 244 in 2012 to 368 in 2013. Further, recognizing the critical importance of post-operative follow-up and socioeconomic support (in the continuum of care for fistula), the country office partnered with an NGO, Fondation RAMA, to help survivors regain their livelihoods, dignity and sense of empowerment and hope.

Burundi: Evidence-based human resources planning for fistula

Making important strides to strengthen their national fistula programme, Burundi planned the necessary human resources for health and drafted a national strategy to fight fistula to address the problem, including sending two female surgeons to the hospital of the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) for training. A tripartite partnership/agreement was made among the Ministry of Health, UNFPA and Médecins sans Frontières (MSF, Belgium) to increase the national capacity of surgeons to repair and treat fistula. They also made a concerted effort to raise awareness and reach out to journalists and use multimedia approaches, as well as building the advocacy abilities of leaders such as parliamentarians, women's groups and the national women's forum to spread the word about preventing and treating obstetric fistula.

Central African Republic: Fighting fistula against all odds

Already battling one of the highest maternal mortality ratios (MMRs) in the world, even before the recent devastating humanitarian crisis erupted in December 2013, the country continues to fight to lower its levels of maternal death and disability, including fistula. Efforts have included ordering fistula repair kits, strengthening the emergency transportation system through moto-ambulances and launching a high-level human rights and maternal mortality reduction initiative with the support of upper levels of governments. Yet conflict and insecurity continue to obstruct some of the gains that might have been achieved, and CAR urgently needs intensified help battling fistula.

Republic of the Congo: Forging innovative partnerships with the private sector

Tapping into the resources of the oil company Total E&P (Exploration & Production), UNFPA Country Office has established an important partnership to strengthen the three-pronged Campaign to End Fistula approach of prevention, treatment and social reintegration/follow-up of fistula survivors. A special focus has been placed on the crucial component of psychosocial rehabilitation and support of survivors, with activities that feature developing a support guide for social workers; establishing a network of fistula survivors at community level; designing a flip chart for health workers; and doing a case study/research (by a psychologist based at the Brazzaville University Hospital Centre) to document fistula patients' experiences and to make recommendations for improving psychosocial care and support for survivors.

Democratic Republic of the Congo: A role model in raising local and national support

As part of the commemoration of the International Day to End Obstetric Fistula, under the leadership of Carine Katumbi Chapwe, the first lady of Katanga Province, in collaboration with the Consulate of South Africa and UNFPA, a fund-raising dinner for fistula was organized The event was presided over by the governor of the province, Moïse Katumbi Chapwe, accompanied by the consul general of South Africa in Lubumbashi, the provincial Ministers of Finance, Environment and Tourism, and Gender delegates, heads of UN agencies, mining industries and other private sector partners.

As the governor appealed for funds, he announced his own personal contribution to cover the costs of 100 fistula cases. The provincial government, represented by the Minister of Finance, committed to funding 200 more cases. The World Food Programme promised to cover all logistical costs during fistula repair campaigns. At the end of the evening, the head of the Decentralized Office of Lubumbashi, Dr. Jeannette Danho, announced that $400,000 had been raised.

Michael Sneed, Vice President, Global Corporate Affairs of Johnson & Johnson (left), presents the 2013 Friends of UNFPA International Award for the Health and Dignity of Women and Girls to Dr. John K. Mulbah at Gotham Hall, for the Health and Dignity of Women and Girls gala.

Liberia: A fistula hero and life-long champion honoured

An independent jury of distinguished experts and Friends of UNFPA honoured Dr. John K. Mulbah, the program manager and Liberian Ministry of Health and lead surgeon of the Liberia Fistula Project, for his work to end obstetric fistula in his country and for his extraordinary efforts to create significant change in the lives of women, men and youth around the world. Dr. Mulbah received the award at Friends of UNFPA's Gala on 10 October 2013 in New York City. He also travelled to Washington, D.C., to meet members of Congress, government officials, donors and NGO colleagues. The award includes a grant to enhance the development work of the UNFPA-supported organizations in Liberia.

Somalia: Prevention through maternity waiting homes

As one of the most difficult and dangerous countries in the world for women and babies, Somalia recognizes the need to address the first two of the 'three delays' that lead to maternal death and morbidity, including obstetric fistula: the delay in making the decision in the community to seek healthcare and the delay in reaching such services.[14] Somalia has therefore created Maternity Waiting Homes, similar to those in Chad, Eritrea, Nigeria and Tanzania. These homes are a key strategy for ensuring safe delivery among fistula survivors in subsequent pregnancies as well, given that future deliveries must be done by an elective Caesarean section to ensure both the mothers' lives and their baby's survival.

South Sudan: National leadership despite humanitarian crisis

This year's fistula treatment campaign was conducted under the theme **Make South Sudan Free of Obstetric Fistula.** It took place from October 28 to November 15 2013 in three sites: Juba, Wau and Rumbek. The campaign was led by the Ministry of Health in collaboration with UNFPA, AMREF and the World Food Programme (WFP). WFP provided food for fistula patients, and

[14] Thaddeus S, Maine D: Too far to walk: maternal mortality in context. Soc Sci Med 1994, 38:1091–1110.

AMREF deployed six surgeons, three anesthetists, six nurses and one coordinator for the operation. Key lessons learned were the importance of good political will and commitment demonstrated by the national MoH and state authorities; strong partnership and teamwork among UNFPA, AMREF, national MoH, WFP, State Ministry of Health and hospital teams; effective coordination by UNFPA International United Nations Volunteers (IUNVs) throughout all states in mobilizing patients, including the vital role of such partners as Médecins sans Frontières transporting some patients; and the important role of media and communications in mobilizing communities.

Uganda: UNFPA achieves record number of fistula repairs globally

To increase access to fistula surgery in 2013, support was provided by UNFPA for the mobilization, transport and subsistence of patients during both routine fistula repair service delivery and surgical camps. As a result, over 1,436 fistula cases were repaired during the year under direct UNFPA backing, compared to 1,300 in 2012. However, this number still falls short of the estimated 1,900 new cases of fistula that require surgery annually in Uganda, reflecting the need to increase capacity to care for more cases next year. Highlights of other key achievements include:

- **Achieving better coordination of the fistula programme** partly through UNFPA support to the activities of the Fistula Technical Working Group (FTWG). This is to assist the MoH in coordination of partners supporting capacity building and fistula treatment service delivery activities in Uganda;

- **Facilitating enhanced national capacity for fistula policy, management and training** through the formal accreditation in 2013 of the Mulago National Referral Hospital by the International Federation of Gynecology and Obstetrics (FIGO) as an obstetric fistula treatment centre. The hospital can now issue internationally recognized certification on fistula surgery, which means that there will be less need for surgeons to train outside Uganda, thus reducing costs.

- **Providing routine fistula repair services at regional referral hospitals**. UNFPA continued to support training of more fistula treatment teams for the 13 regional referral hospitals and the 5 private nonprofit hospitals offering fistula treatment.

Yemen: Establishing teams and networks to strengthen the fistula programme

To strengthen the country's fledgling fistula programme in a fragile and conflict-torn environment, a fistula planning workshop was conducted in five governorates, during which a network was established that included the reproductive health director, community volunteers, fistula focal points and national midwifery association focal points (to mobilize fistula patients by the community volunteers, while fistula focal points screened cases before sending them to the midwifery association for enrolment.) The midwifery association, as a key partner, screens and organizes fistula patients and arranges their transportation and accommodation with their companions in a hostel before referring them to the fistula unit in Sana'a, the capital, for surgery.

Efforts also continue to raise awareness about fistula at community level, to train surgeons and health workers to provide fistula treatment and to increase access to treatment for women and girls suffering from fistula.

Regional highlights

In one of the highest-burden regions for fistula and maternal health in the world, UNFPA facilitated two **regional fistula meetings,** convening them in Senegal and Niger.

Senegal: Accelerating the fight against fistula by mobilizing more resources in West and Central Africa

Forty-six health professionals from Ministries of Health, fistula treatment centres, NGOs, civil society organizations, professional associations and UNFPA fistula focal points from nine countries (Benin, Burkina Faso, Cameroon, Chad, Congo, Guinea, Mauritania, Niger and Senegal) met in Saly, Senegal, from 2 to 4 December 2013 to galvanize the movement to end fistula in the region.

This forum enabled participants to exchange experiences and share good practices; update their country data on fistula, based on the situation analysis conducted by the regional office; identify strategies for revitalizing activities; and develop action plans for advocacy, resource mobilization and reinforcement of fistula treatment and care.

Niger: Strategic direction for obstetric fistula

Niger's decade of fighting against obstetric fistula has borne fruit, a workshop held 8-10 October 2013 in the capital Niamey concluded. Organized by UNFPA, the event gathered together more than 70 health professionals and partners working to end obstetric fistula in several countries. Fistula focal points from UNFPA country offices in the Central African Republic, Chad, the Democratic Republic of the Congo and Mauritania also participated in the workshop to improve South-South cooperation and learn from Niger's extensive experience in addressing obstetric fistula, including establishing a national network of key stakeholders, promoting long-term follow-up care for women and agreeing to pilot a mobile phones scheme to help empower and reintegrate women into their communities.

Fistula patients proudly showing their mobile phones at the National Reference Centre for obstetric fistula in Niamey, Niger.

Credit: UNFPA/Niger.

Global highlights

The first International Day to End Obstetric Fistula

The UN marked the first ***International Day to End Obstetric Fistula*** on 23 May, established from the resolution on Supporting Efforts to End Obstetric Fistula, passed by the UN General Assembly in December 2012. This historic occasion, launched at UN headquarters in New York, with multiple parallel activities by UNFPA country offices, authorities and Campaign to End Fistula partner agencies worldwide, will be observed annually to raise awareness and provide extra support for the prevention, management and eventual elimination of obstetric fistula. One highlight was the powerful testimony of Beriha Reda, a fistula survivor from Ethiopia who now works as a safe-motherhood ambassador for Healing Hands of Joy, a partner in the Campaign to End Fistula.

Reda roused the audience in New York, saying: *"I spent five long days in labour, I was very scared. I suffered from obstetric fistula, and I had to visit several places until they repaired it. It was very painful and very embarrassing because I smelled bad and I was rejected. Now I am helping other women to prevent this awful experience. Please help end fistula."*

UNFPA Executive Director Dr. Babatunde Osotimehin, UN Secretary-General Ban Ki-moon, the president of the World Bank Group and the Special Envoy for the Great Lakes region of Africa, Mary Robinson, marked the day in

UN Secretary-General Ban Ki-moon and UNFPA Executive Director, Dr. Babatunde Osotimehin visiting a fistula ward in Goma, Democratic Republic of the Congo.

Credit: UN Photo/Eskinder Debebe.

the DRC by visiting the fistula ward of the HEAL Africa Hospital in Goma.

The global celebrations enjoyed high coverage in the media, including a CNN feature, 'A Fate Worse Than Death for Scores of African Women,' as well as a UNFPA Comment in *The Lancet*.

Fistula repair kits: Delivering high-quality, critical health supplies faster to those in need

UNFPA led the way in promoting increased access to quality treatment and care by launching two innovative fistula repair kits. Led by the Technical Division, in full collaboration with the Procurement Services Branch in Copenhagen and a group of globally renowned fistula surgeons from the International Society of Obstetric Fistula Surgeons, this initiative ensures that high-quality instruments and specialist materials are available for surgical fistula repairs. In October 2013, Johnson & Johnson announced a donation of sutures (valued at $2.2 million) for the UNFPA fistula kits, enabling the treatment of 15,000 women. This represents a new UNFPA-J&J collaboration for the kits, as well as a fivefold increase of sutures donated globally by the company for such repairs. A new high-quality, specialized fistula operating table, which can be ordered with the repair kits, was also made available in 2013.

Research, data and monitoring and evaluation

UNFPA helped update and expand the first **Global Fistula Care Map** (launched in 2012), led by Direct Relief International, with UNFPA and the Fistula Foundation. The map highlights over 16,000 repairs at 190 health facilities providing fistula repair surgeries in 43 countries. The map is a major step in understanding the landscape of worldwide treatment capacity and service gaps for the condition.

Crucially expanding the evidence base for fistula, **Johns Hopkins University,** with **WHO, UNFPA** and the **MacArthur Foundation,** is conducting a multicountry study to examine post-operative prognosis, improvements in quality of life and social reintegration and rehabilitation of fistula patients after surgery. The

results of the study are intended to help advocacy efforts and to improve the appropriateness, cost-effectiveness and feasibility of programmes and national strategies for the treatment, prevention and rehabilitation of fistula patients and training of fistula surgeons.

At the request of UNFPA, Johns Hopkins is also developing a new formula to estimate the incidence and prevalence of obstetric fistula in countries. This will be a powerful, cost-saving tool to aid governments in obtaining solid data about fistula and in conducting evidence-based planning and programming.

In addition, to mark the 10th anniversary of the Campaign to End Fistula and to envision the way forward, UNFPA organized a panel in the global **Women Deliver Conference** in Kuala Lumpur, Malaysia, in 2013, examining progress and perspectives from the Campaign's decade of work.

Campaign to End Fistula: key achievements in the first phase of the MHTF

- Currently supports approximately **half of all fistula surgical repairs** globally;
- Facilitated training of more than **3,900** healthcare workers, including surgeons, nurses, midwives and community health workers;
- Provided social reintegration services to **8,960** women and girls surgically treated for obstetric fistula.

CHAPTER FIVE

Maternal Death Surveillance and Response

In late 2011, increased demand for accountability at national and subnational levels in countries with high maternal mortality led to significant changes towards the establishment of effective maternal deaths and surveillance systems. The Maternal Death Surveillance and Response (MDSR) system has been developed to respond to the urgent need for continuous and reliable data to be available in real time on maternal mortality, while using such information to strengthen accountability; enhance the quality of maternal health services and avoid future maternal deaths. UNFPA and other agencies, including the United Kingdom's Department for International Development (DFID), the International Federation of Gynecology and Obstetrics (FIGO), the United States' Centers for Disease Control and Prevention (CDC) and WHO have developed a technical guidance to support countries in the implementation of MDSR.[15] UNFPA has also made implementation of MDSR a key output in the Strategic Plan (2014-2017).

Despite the challenges in ensuring strong political commitments to implement MDSR from the outset, and the fact that MHTF support in this area began just in 2012, countries have achieved significant results in 2013. Subnational experience in countries like Burundi and Rwanda will contribute to the development of MDSR systems at national level, especially regarding the 'response' component, which requires an inter-sectoral approach involving several stakeholders beyond the health sector.

Country highlights

Burkina Faso: identifying the main causes of maternal deaths through MDSR

In 2013, further progress was made in MDSR in Burkina Faso, enabling the Ministry of Health to have real time data available for reorienting the implementation of interventions. More than 100 healthcare providers received training in auditing maternal deaths. The system set up functions comparable to the the notifiable diseases surveillance systems, with rapid circulation of the information and answers from the health system. This system enables the Directorate for the Fight Against Diseases (*Direction de la Lutte Contre les Maladies)* of the Ministry to upgrade its information on maternal deaths weekly. The information is then sent to the Directorate for Family Health (*Direction de la Santé de la Famille*) for analysis and preparation of the response, and a weekly newsletter is circulated to those in charge of the system at all levels.

[15] http://apps.who.int/iris/bitstream/10665/87340/1/9789241506083_eng.pdf

◀ Adissa Banse, Chief of Obstetrics, during a prenatal consultation at the CSPS Health and Social Promotion Center of Moaga, Burkina Faso.

Photo by Olivier Girard Photography.

In 2013, 529 maternal deaths were reported by health facilities, compared with 702 in 2012 and 744 in 2011.

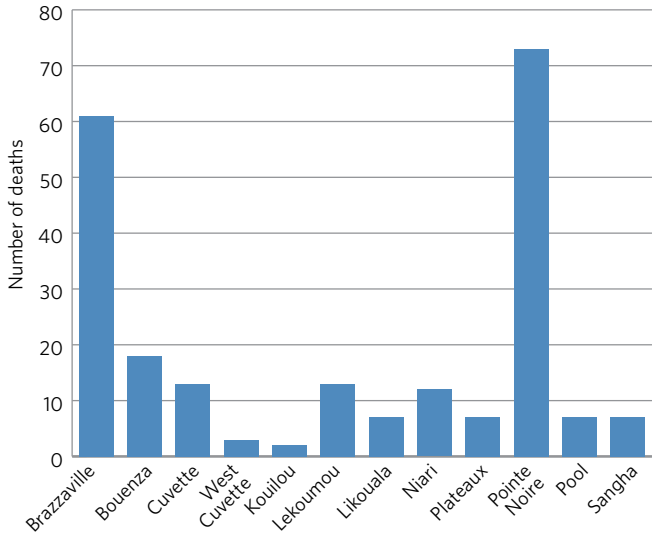
One mandate of the Association of Gynecologists and Obstetricians of Burkina Faso (SOGOB, Société des Gynécologues et Obstétriciens du Burkina Faso) is to support the training of the healthcare staff in reviewing maternal deaths, following the national guidelines for the performance of maternal death audits. This temporary arrangement will end when the targeted staff members to acquire methodological mastery. UNFPA, through the MHTF, supported SOGOB for its training activities in 12 EmONC facilities in 2013.

From 2010 to 2013, 434 cases (427 maternal deaths and 7 cases of "near miss"[16]) were reviewed by the facilities where this tutoring is effective. The main factors identified include:

- Delays in the decision to seek help due to lack of knowledge about pregnancy-related danger signs and, once help was sought, inadequate referral system;
- Inadequate service organization and coordination, especially in the management of obstetric and newborn emergencies, which causes significant delays in care;
- Nonfunctional operating theaters (deficiency in the supply/maintenance of equipment, lack/shortage of qualified staff);
- Inadequate supervision, leading to lack of compliance with standard protocols of care;
- Unavailability of EmONC kits and other emergency drugs in the delivery room, including insufficient blood supplies;
- Lack of communication among health team members.

FIGURE 8

Number of maternal deaths reported per provinces, Republic of the Congo



Source: Congo Ministry of Health, National Observatory for Maternal, Newborn and Child deaths, 2013 report.

Republic of the Congo: a National Observatory of Maternal Deaths

The national observatory of maternal deaths is functional and provincial observatories have also been established. Training sessions on maternal death audits were given to 75 providers from the departments of Plateaux (25) Cuvette (25) and Pointe-Noire (25). The training will continue in 2014.

The 2011, 2012 and 2013 reports on maternal deaths are being used to monitor and compare trends in maternal deaths in between Demographic Health Surveys. This surveillance, coupled with the performance audits on maternal deaths, facilitates awareness-raising among the providers about their role in the reduction of maternal deaths. In 2013, 223 maternal deaths were analyzed by the national observatory, or 34 per cent of the maternal deaths expected in Congo for 2013 (Figure 8).

An analysis of the maternal deaths in healthcare institutions shows that the women often present socioeconomic vulnerability, including 54 per cent being single, 62 per cent with limited or no formal education; and 80 per cent unemployed. The Ministry of Health will focus on supporting the reference hospitals of the two major towns in which most of the population is concentrated. These hospitals receive referrals from the whole country, which may explain why the largest number of deaths is recorded in Brazzaville and Pointe-Noire. A workshop is being organized for 2014 to create a national consensus on how to move forward on MDSR system development.

[16] A near miss is commonly understood as a severe life-threatening obstetric complication necessitating an urgent medical intervention in order to prevent the likely death of the mother (WHO, *Beyond the Numbers*, 2004).

Niger: mandatory weekly reporting of maternal deaths in all health facilities

An MDSR system was adopted by the Ministry of Public Health (MSP, or Ministère de la Santé Publique) of Niger as a national strategy for the reduction of preventable maternal deaths. In 2013, the MHTF contributed to the training of 20 of the 102 healthcare workers, comprising gynaecologists, general-medicine physicians capable of basic surgery, midwives, nurses and epidemiologists trained in auditing, surveillance and response on maternal deaths. All these trained professionals are directly involved in maternity activities at the primary level (Centre de Santé Integre, or CSI) and at the reference level (maternities of district and regional hospitals). They are also in charge of epidemiological surveillance and health statistics within the districts and regional public health directorships.

A national multidisciplinary committee for the review, surveillance and response following maternal deaths was set up in the Ministry of Public Health. Weekly reporting of maternal deaths became mandatory for all health structures from the bottom (CSI) to the top level (tertiary maternities of national reference). These efforts enabled the reporting of 289 cases of maternal deaths by health facilities in 2013. The initiative of financing the strengthening of the Ministry's capacities on MDSR was retained as a good practice in 2013, and taken into account in the 2014 annual plans of action for all 42 health districts and reference maternities in Niger's eight healthcare regions.

Rwanda: training providers and integrating MDSR into the WHO Integrated Disease Surveillance and Response system (IDSR)

With UNFPA support, 160 health providers were trained on how to conduct verbal autopsy for maternal and child deaths in Nyamasheke and Karongi Districts. As a result, they are now able to conduct audits of maternal, neonatal and infant deaths, and each health facility has at least two health providers skilled in verbal autopsy.

A workshop on MDSR oriented 50 people on the new MDSR technical guidance highlighted above. Participants were managers, health professionals, healthcare planners from all hospitals involved in maternal death audit and eight policy makers working in maternal and newborn health. The goals were to differentiate between maternal death reviews (MDR) and MDSR, and to acquire knowledge and gain competency on the key messages included in the new guidance.

At the end of the workshop, recommendations were formulated, including immediate reporting to the Ministry of Health of maternal deaths at health facilities and community level; revision to the audit form and procedures to capture more relevant information; and implementation of recommendations made by the audit report. Other key decisions included making the National Maternal Death Committee functional and integrating MDSR into the WHO Integrated Disease Surveillance and Response system (IDSR).

Zambia: a national MDSR meeting and review of MDSR guidelines

The Zambian Ministry of Community Development and Mother and Child Health provided support for a national MDSR meeting, attended by 100 participants from all 10 provinces, to gradually shift maternal death reviews to MDSR. Some of the main conclusions from the meeting included making maternal death declaration mandatory and notifiable; reviewing MDSR reporting tools; and guiding districts in their shift from maternal deaths review to MDSR.

The UNFPA Zambia Country Office supported the review of MDSR guidelines and reporting tools. It also supported orientation of 40 trainers of trainers in MDSR at provincial level to ensure that MDSR is institutionalised at national scale.

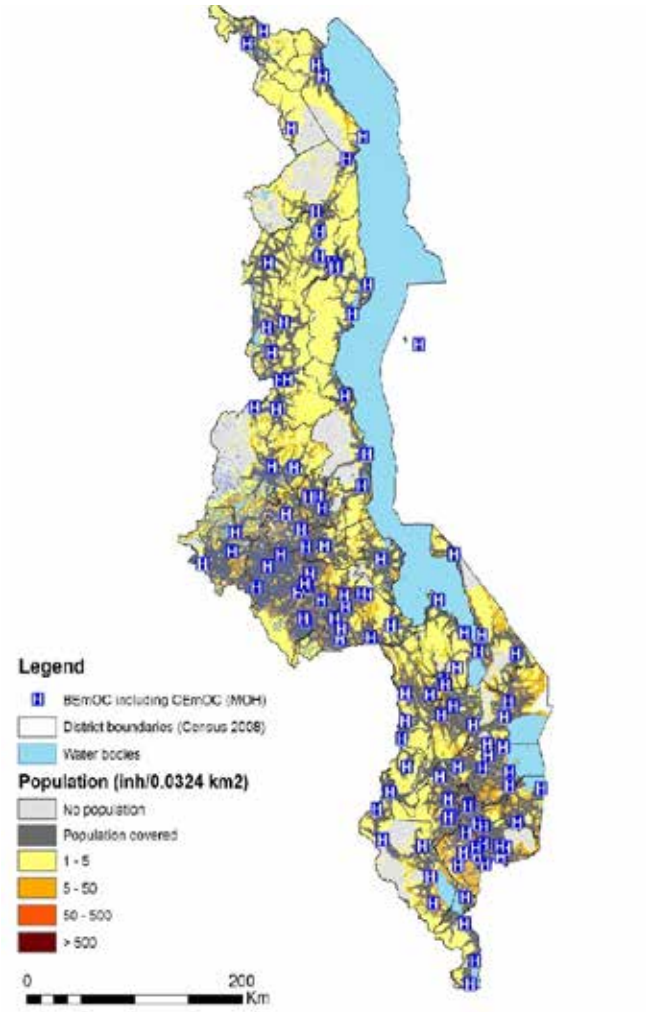
Case study: Moving from Maternal Death Review (MDR) to Maternal Death Surveillance and Response (MDSR) in Malawi[17]

Background and objectives

Maternal mortality ratio in Malawi slowly declined from 984 (MDHS 2004) to 675 (MDHS 2010), but total fertility rate remains high, with almost no change over the same period, from 6 (MDHS 2004) to 5.7 births per woman (MDHS 2010). According to the latest UN estimates,[18] the lifetime risk of maternal mortality in Malawi is 1 in 34.

[17] This case study summarizes the main findings of the situation analysis presented in: *Technical Assistance to Support the Review of MDR* and *Facilitate MDSR in Malawi*, by Florence Mirembe and Jolly Beyeza-Kashesya. Makerere University College of Health Sciences, Kampala, Uganda.

[18] Trends in Maternal mortality: 1990 to 2013. WHO, UNICEF, UNFPA and the World Bank estimates. Available at http://unfpa.org/public/home/publications/pid/17448



Disclaimer: the boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. All reasonable precautions have been taken by WHO to produce this map. However, this map is being distributed without warranty of any kind, either express or implied regarding its content. The responsibility for its interpretation and use lies with the user. In no event shall the World Health Organization be liable for damages arising from its use.

Malawi has a total population of 15.4 million, of which 84 per cent is rural.[19] The government provides 60 per cent of the healthcare services, while the Christian Health Association of Malawi (CHAM) and other NGOs provide the remainder (approximately 37 per cent).

Fifty-three comprehensive EmONC (C-EmONC) and 120 basic EmONC (B-EmONC) facilities address emergency obstetric and newborn care. Coverage of EmONC services (geographic distribution) reaches the minimum acceptable level, according to WHO standards, but only a few EmONC facilities are fully functional (no deficit in signal functions and able to efficiently deal with obstetric and newborn emergency situations).

The WHO map to the left shows the distribution of the population that must travel more than one hour to reach a B-EmONC facility (including C-EmONC).

Malawi started the process of maternal death reviews in 2003, and maternal death notification was introduced in 2009, using WHO guidelines[20] to design and implement maternal death review both at facility (audit/review) and community levels (verbal autopsy). However, maternal mortality has only slightly decreased in Malawi over this time.

In 2011 the country, following its participation in meetings held under the umbrella of the Secretary-General's Every Woman Every Child initiative, decided to move from maternal death reviews to surveillance and response. The first step in this important change was to conduct a situation analysis, to adapt MDSR guidelines to country context and to enable the implementation of MDSR.

Situation analysis: methods

With technical assistance supported by UNFPA regional office, an in-depth analysis of the specific country context and current MDR situation was conducted in 2013. This included in-person interviews with key Ministry of Health senior officials and main stakeholders at WHO, UNFPA, USAID and UNICEF's country offices. Representatives from the National Committee on Confidential Enquiry on Maternal Deaths (NCCEMD), established in 2012 with support from UNFPA, provided active support to the study from its inception. As part of the analysis, two districts were selected and visited to meet with members of the local MDR committees and conduct in-person interviews. In addition, the team reviewed audited MDR forms from several districts, as well as current notification and maternal death reporting forms. The situation analysis was supported by MHTF funds.

[19] 2013 World Statistics Pocketbook Country Profile: Malawi. Available at http://unstats.un.org/

[20] Beyond the numbers: reviewing maternal deaths and complications to make pregnancy safer. WHO, 2004.

Key Findings

The analysis showed that the main components of maternal death surveillance are in place in the country, and notification of maternal death at facility level is done within 72 hours. However, in most cases, the staff involved did not have sufficient skills to adequately manage obstetric complications.

The district-level MDR committees conduct the audit once a month, but members reported that they did not receive formal training for maternal death audit/review. At subnational level ('zonal' level in Malawi), where information from the audits is submitted by district committees, the audit forms are reviewed every three months and submitted to the national level. However, this review is not accompanied by an adequate summary report to guide action and response at the national level. Not surprisingly, district committees reported a lack of supervision and feedback when audit reports were submitted to the Ministry. At national level, there is no analysis of MDR data or a national annual report.

At community level, verbal autopsies are hardly being done countrywide; currently, two NGOs are conducting verbal autopsies in collaboration with the MoH.

Challenges and recommendations

Despite the important issues highlighted in the current MDR process (in particular, inadequate training for the audit process), the main challenge for the implementation of the MDSR system in Malawi is the analysis of information submitted at zonal and national level, and the capacity to organize a more efficient and effective response to this information.

There is an urgent need to move from MDR to MDSR, and policy makers beyond the MoH senior officers should be involved. Community leaders should also be mobilized in support of MDSR, to make community level audit possible, while the MDSR system itself should be strengthened to improve NCCEMD involvement and train district maternal death review committees.

Technical support is available to mentor the MDSR implementation in Malawi, based on the MDSR technical implementation guidelines; and the MHTF will continue to support support the country's effort to build an efficient MDSR system that can contribute to the elimination of preventable maternal deaths.

Regional highlights

Regional workshop on MDSR

In collaboration with WHO and UNICEF, UNFPA's East and Southern Africa Regional Office (ESARO), organized a four-day workshop in Johannesburg from 12 to 17 May with 14 countries participating.[21]

This was a follow-up to three orientation workshops on MDSR hosted by WHO, UNFPA and partners in 2012 (held in Burkina Faso, Tanzania and Zimbabwe), and enabled participating countries to review and/or update MDSR action plans for 2013/2014.

The main objective was to facilitate regional learning and foster a common understanding and agreement on the strategic actions to implement MDSR. After country experiences and MDSR global policy presentations, and practical analysis of bottlenecks for MDSR and how they can be overcome, participants identified key areas for strategic actions: integration of maternal death notification in the WHO Integrated Disease Surveillance and Response system; effective response mechanism on notification; and MDSR monitoring, dissemination and communication of actions and results. These will be translated into action plans in 2014 in each country for further support by UNFPA.

[21] Fourteen countries (Angola, Burundi, Comoros, DRC, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Sudan, Uganda, Zimbabwe and Zambia) participated in the workshop with a mix of UN program officers, regional institutions (East African Community, Intergovernmental Authority on Development and Southern Africa Development Community) and implementing partners (Makerere University School of Public Health) http://esaro.unfpa.org/public/op/preview/news/pid/14147).

Maternal Death Surveillance and Response: key achievements in the first phase of the MHTF

- Since the start of its involvement in late 2011, the MHTF has contributed to the institution of mandatory notification of maternal deaths in **30 countries**;
- The MHTF has supported the adoption of surveillance and response (MDSR) as a framework for the elimination of maternal deaths in **18 countries**, with an additional **11 countries** expected to adopt the system in 2014.

CHAPTER SIX

Advocacy and Demand-Creation for Maternal and Newborn Health

Improving maternal and newborn health in the context of sexual and reproductive health requires concerted efforts and actions to address the neglected needs of women around the world. These efforts and actions must take into account the policy and advocacy arena, at national and international level, to foster a supportive political environment that is committed both to saving women's lives, improving their reproductive health and enhancing their well-being more generally. In 2013, the MHTF, in collaboration with its partners, has realized significant results while also developing transformative initiatives that strengthen the quality of services and enhance demand-creation for comprehensive sexual and reproductive health services that reach marginalized groups.

Country Highlights

Several countries developed and implemented advocacy and communications initiatives in 2013. The MHTF team, in partnership with communications focal points at regional and national level, contributed to the collection of stories and dissemination of videos and reports about results achieved on the ground. This helped raise visibility and increase support to maternal and newborn health priorities in the context of sexual and reproductive health.

Media placement was sought throughout the year, and media coverage of reproductive health issues significantly increased, especially in West Africa (Burkina Faso, Cameroon, Côte d'Ivoire, Liberia, Mauritania, Niger, Nigeria, Senegal) and East and Southern Africa (Ethiopia and Mozambique). These stories were used for advocacy purposes, to mobilize political will and increase resources for sustained commitment to reproductive health.

In addition, the MHTF, through UNFPA country offices, has actively promoted advocacy and policy dialogues with national institutions, to foster a supportive environment for sexual and reproductive health policies.

Communication strategies to support informed decisions and practices

Mozambique: Changing traditional practices

In cooperation with UNTV and with support from the MHTF, a video was produced in 2013 highlighting the risks that poor women and adolescent girls face when delivering their babies at home. The long version of this video is part of the 21st Century series of UNTV and was placed for broadcasting by some 60 TV channels worldwide and on the Internet.[22]

Fostering policy dialogue and capacity development at country level

Guyana: revising legislations for midwifery practice and developing a national sexual and reproductive health policy

In Guyana, the MHTF supported an EmONC needs assessment whose findings were subsequently used to identify key

[22] http://www.unmultimedia.org/tv/21stcentury/detail/2659992210001.html

A mother and her newborn baby girl, her sixth child, in Sepon District, Lao People's Democratic Republic.

Photo by UNFPA Lao/Chien-Chi Chang/Magnum Photo.

Mozambique has experienced remarkable economic growth since the end of its 20-year civil war, but not all of its citizens are participating in the country's new opportunities. In Mozambique's remote areas, many women and adolescent girls deliver their babies at home with no access to medical care. When complications arise, they risk developing obstetric fistula, which occurs during prolonged, obstructed labour without medical attention. Those affected suffer from constant pain and chronic incontinence and are often shunned by their husbands, families and communities.

Ilsa Guambe, 15, was married when she was just 13 years old and dropped out of school. She became a mother at the age of 15, and then developed fistula.

Over 2,000 new cases are reported annually in Mozambique. Through the Campaign to End Fistula, the MHTF is training doctors in the country to treat fistula patients, many of them, like Ilsa, still in their teens. But many women affected by fistula never receive medical help and end up being ostracized by their communities and even their own families. After successful surgery, however, they can resume a full life and, in most cases, bear children.

Fifteen-year-old Ilsa Guambe cradles her baby outside her home in Mozambique.

Credit: Guy Hubbard.

bottlenecks in the system. One identified bottleneck was the lack of authorisation for midwives to perform certain basic and emergency functions during delivery, which could only be addressed by revising the legislation and the midwifery training curriculum. In 2013 the Ministry of Health, in collaboration with UNFPA, hosted a five-day workshop to review the scope of practice for midwives, aligning it with International Confederation of Midwives (ICM) standards, and revising the midwifery training curriculum. Fifteen participants representing various regions, nursing schools and health organisations participated in the workshop, and successfully reviewed and revised the scope of practice and midwifery training curriculum.

A further key issue emerged from the EmONC assessment, i.e., the lack of a comprehensive Sexual and Reproductive Health (SRH) policy, which includes family planning and adolescent sexual and reproductive health. The MoH, with support from UNFPA, has since taken the lead for the development of a SRH Policy, which is intended to establish the technical, administrative, financial and political commitments for the delivery of comprehensive SRH services and commodities at the national level.

A strategic plan is being developed to outline the activities and actions required to realize the policy commitments. A Technical Committee on Sexual and Reproductive Health has also been established, to oversee the policy's formulation and to provide guidance, input and support for its development.

Lao People's Democratic Republic: delivering the Maternal, Neonatal and Child Health service package

In Lao PDR, the Reproductive Health Policy has been in place since 2005, but UNFPA has contributed to the current Health Sector Reform agenda by providing technical inputs to the discussions and formulation of policies, particularly on MDGs 4 and 5. As a result, the first phase of the Health Sector Reform focuses on delivering the Maternal, Neonatal and Child Health (MNCH) service package, which is an opportunity to strengthen the system as a whole. Five priority areas have been identified to improve the health system: i) human resources for health; ii) health financing: iii) governance, organisation and management; iv) health service delivery; and v) health information system. In addition, with technical support from UNFPA, the Ministry of Health has developed a National EmONC Action Plan based on the results of the needs assessment conducted in the previous year with the support of the MHTF. Implementation based on priority areas recommended in the plan has already begun.

Malawi: revising the National Population Policy in line with international development frameworks for sexual and reproductive health

Following on the technical and financial support provided for the revision of the National Population Policy in 2012, the MHTF, through UNFPA country office, engaged various stakeholders in six successive advocacy meetings on the national population policy. The policy was subsequently finalized in line with guidelines of international development frameworks such as the ICPD Beyond 2014, the MDGs and the Maputo Plan of Action for sexual and reproductive health and rights. The policy was approved by the parliament and launched on 25 March 2013, and has provided a conducive environment for prioritization, coordination and implementation of country population programmes, including in the area of sexual and reproductive health.

Regional and Global Highlights

The Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality in Africa (CARMMA)

The African Union Commission (AUC), UNFPA and other partners convened a high-level event on the Campaign on Accelerated Reduction on Maternal, Newborn and Child Mortality in Africa (CARMMA)[23] during the African Union Summit in May 2013.

The event, hosted by Thomas Boni Yayi, President of Benin, as the chairperson of the Africa Union, in partnership with AUC and UNFPA, was a side event at the 20th ordinary session of the AU Assembly of heads of state and government.

The event was attended by 51 African country representatives, among whom were 32 heads of state/government; the chairperson of the AUC; the UN Secretary-General; heads of UN agencies such as UNAIDS, UN Women, IOM and UNIDO; donor country representatives, including Australia, Canada, China, France, Japan and the United States; and a large number of Ministers of Health and Finance from high-burden countries currently covered by UNFPA programmes.

In addition to celebrating progress on maternal and child health on the continent—which has witnessed a 41 per cent reduction in maternal deaths between 1990 and 2010—the event offered African leaders a forum in which to share experiences and discuss opportunities to further advance maternal and child health and meet agreed-upon development goals. Heads of state at the event made new commitments to accelerate the reduction of maternal mortality and morbidity in the continent. These include:

- a request for developing a continental structure to monitor and follow up on progress and facilitate the sharing of best practices among member states;
- a request to the African Development Bank, in collaboration with the AUC and UNFPA, to develop a framework for establishing a mechanism to source, pool and manage resources to support maternal, newborn and child health, including through the promotion of intercontinental cooperation on best practices.[24]

From a communications perspective, the event produced:

- Consistent messaging throughout all event-related materials;
- Strong media presence and visibility at all levels, with significant pickup of press materials by first-tier media, such as the South African Mail and Guardian;
- Coordinated outreach;
- Synergy with global initiatives and priorities in the sexual and reproductive health area.

The MHTF continues to contribute to CARMMA with financial and programmatic support, while promoting an increasing involvement and leadership of national authorities in CARMMA countries.

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[23] CARMMA: http://www.carmma.org/

[24] African Heads of State and Government of the AU's communiqué. Available at http://www.who.int/pmnch/media/news/2013/20130121_au_summit/en/index5.html

CHAPTER SEVEN

Resources and Management

The work of the Maternal Health Thematic Fund is financed primarily by two multidonor thematic trust funds: the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula. However, the bulk of donor funding for obstetric fistula is now provided under the broader maternal health umbrella.

Thematic Trust Fund For Maternal Health (ZZT06)

Contributions revenues and payments received in 2013

Table 3 illustrates total contributions revenues* (amount expected to be received) and contributions payments (cash received) for maternal health during 2013. Out of the total contributions revenues of $59.3 million, there was an uncollected contributions receivable of $47.6 million as of 31 December 2013.

Contributions payments received in 2013 amounted to $13.5 million, of which $10.5 million came from Sweden and was received during the fourth quarter of 2013; those funds will therefore be used for the implementation of programmes in 2014. As can be seen in Table 3, this contribution payment from the government of Sweden is only the first installment of a multiyear agreement for the second phase of the MHTF.

TABLE 3. Total contributions revenues and contributions payments received for maternal health (ZZT06) in 2013

Donors	Contributions revenues* (USD)	Contributions payments received (USD)
Austria	67,935	67,935
Friends of UNFPA	5,966	5,966
Germany	1,324,503	1,326,260
Intel Corporation	25,000	25,000
Laerdal Foundation	47,080	47,080
Luxembourg	1,546,811	1,546,811
Sweden	56,241,427	10,516,690

* With the adoption of the International Public Sector Accounting Standards (IPSAS), UNFPA recognizes revenue when a binding agreement is signed by a donor, and not when cash or its equivalent is received. By recognizing revenue this way, UNFPA is better equipped to understand its revenue inflows and expenses, therefore improving cash-flow management, programme planning and prediction of cash-flow needs. This is an important achievement and represents a major step in improving the quality and transparency of financial information provided to donors and partners.

Operating budget

The effective working budget for maternal health in 2013 was $19.1 million (Table 4). The 2013 operating budget represents contributions payments received in the fourth quarter of the previous year ($5.0 million), rollover funds from 2012 ($11.2 million) and contributions payments received during the first three quarters of 2013 ($3.0 million). The contributions payments received around the fourth quarter of 2013 include payments from the

◀ A scence from Ethiopia.

Photo by Deyan Berhane

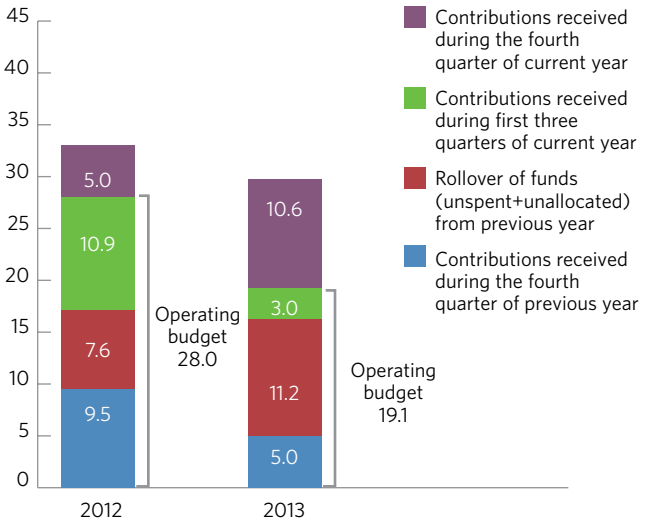
governments of Sweden ($10.5 million) and Austria (0.68 million), received in December 2013. These contributions, received during the fourth quarter of 2013, will be part of the operating budget for 2014 and are not included in the table below. In addition, a small percentage of the 2012 operating budget was withheld by the MHTF to meet financial contingencies in 2013.

TABLE 4. Operating budget for maternal health activities in 2013

Donors	Contributions payments received (USD)
Carryover from 2012	16,169,570
Friends of UNFPA	5,966
Germany	1,326,260
Intel Corporation	25,000
Laerdal Foundation	47,080
Luxembourg	1,546,811
TOTAL 2013	**19,120,687**

Figure 9 illustrates how the operating budget for each year is established, and how it continues to rely heavily on contributions received in the fourth quarter of each year for the next year's planning process.

FIGURE 9
Operating budget for maternal health in 2012 and 2013 (in US$ millions)



Expenditures

Expenditures for maternal health in 2013 totalled $17.27 million, compared to $19.33 million in 2012. During 2013, country and regional programmes, including spending by international NGOs (INGOs) and institutions supporting country-level programme activities, accounted for 90.8 per cent ($15.68 million) of the total; the remaining 9.2 per cent ($1.59 million) represents spending on global programmes. This compares to 88 per cent ($16.98 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level in 2012, and 12 per cent ($2.35 million) for global programmes. Figure 8 shows the percentage of funds spent regionally and globally, including by implementing partners, in 2012 and 2013.

As noted above, $17.27 million was spent in 2013 to achieve expected results in maternal health, against a total allocation of $18.39 million (Table 5). This translates into a financial implementation rate of 94 per cent, compared to 91 per cent in 2012 and 88 per cent in 2011, and shows a rising trend of implementation—which is encouraging, despite the several challenges faced in countries with suboptimal governance or facing humanitarian situations. Figure 9 shows the operating budgets, allocations and expenditures for maternal health in 2012 and 2013.

Support to country, regional and global programmes

In 2013, funds totalling $18.39 million were allocated to country, regional and global programmes in maternal health, compared to $21.17 million in 2012. Of the 2013 total, 88.7 per cent ($16.32 million) went to regional and country programmes, including INGOs and institutions supporting programme activities at the country level, compared to 88 per cent ($18.65 million) in 2012. The percentage allocated to global programmes was 11.3 per cent ($2.07 million), compared to 12 per cent ($2.52 million) in 2012. In regions, the greatest share of resources for maternal health—55.4 per cent ($10.20 million)—went to sub-Saharan Africa; Asia and the Pacific received 6.4 per cent ($1.18 million); Latin America and the Caribbean received 5.6 per cent ($1.03 million); and the Arab States received 4.6 per cent ($0.84 million). The MHTF has also contributed to increasing the human resource capacity of UNFPA at all levels, especially at country level (Figure 12).

FIGURE 10

Share of expenditures for maternal health by region and globally in 2012 and in 2013

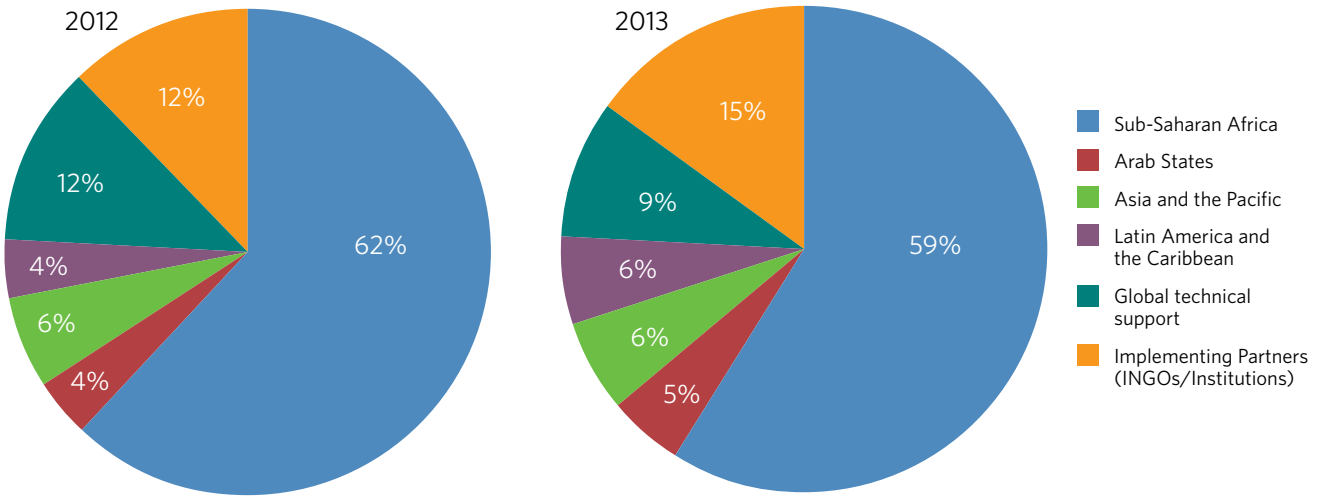


FIGURE 11

Operating budget, allocations and expenditures for maternal health in 2012 and 2013

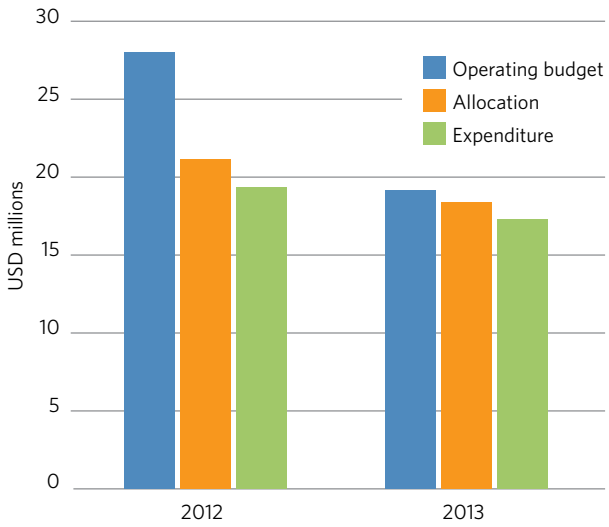


Table 5 shows approved allocations of maternal health funds, expenditures and the financial implementation rate by region, by country and globally in 2012 and 2013.

A scene from Uganda.

Credit: UNFPA/Evelyn Kiapi

TABLE 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2012 and 2013

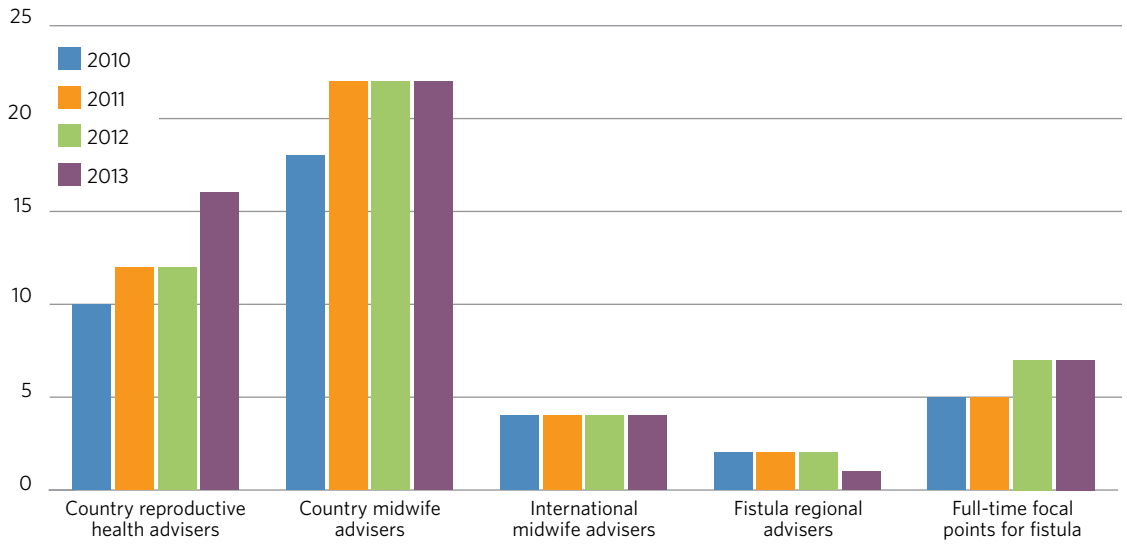
Regional office/country office/ global technical support/ partners	2012			2013		
	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)
Sub-Saharan Africa						
Subregional Office/Johannesburg	303,000	278,905	92	350,000	324,957	93
Subregional Office/Dakar	250,000	246,207	99	210,000	178,241	85
Benin	600,000	637,962	106	420,000	380,034	90
Burkina Faso	500,000	497,677	100	500,000	489,403	98
Burundi	550,000	526,458	96	385,000	479,500	125
Cameroon	50,000	47,101	94	25,000	25,320	101
Central African Republic	50,000	47,241	94	350,000	295,314	84
Chad	1,151,180	1,004,445	87	960,000	990,432	103
Congo	50,000	41,893	84	25,000	33,112	132
Côte D'Ivoire	725,000	662,885	91	420,495	442,017	105
Democratic Republic of the Congo	1,500,000	1,505,550	100	1,020,000	938,653	92
Eritrea	43,000	16,326	38	12,500	11,537	92
Ethiopia	1,500,000	1,427,329	95	750,000	812,933	108
Ghana	465,000	456,154	98	270,000	409,398	152
Guinea	65,000	52,079	80	37,500	47,429	126
Guinea-Bissau	50,000	48,400	97	25,000	3,316	13
Kenya	25,000	23,998	96	25,000	9,000	36
Liberia	300,000	304,046	101	210,000	204,320	97
Madagascar	725,000	556,494	77	595,000	710,569	119
Malawi	600,000	478,243	80	420,000	418,181	100
Mali	178,773	101,455	57	120,000	103,252	86
Mauritania	38,500	6,755	18	25,000	24,807	99
Mozambique	200,000	198,210	99	140,000	132,390,	95
Namibia	43,200	38,954	90	50,000	40,474	81
Niger	400,000	392,985	98	280,000	293,001	105
Nigeria	400,000	389,523	97	400,000	361,695	90
Rwanda	150,000	144,697	96	150,000	132,897	89
Senegal	92,373	75,040	81	200,000	170,469	85
Sierra Leone	500,000	469,148	94	500,000	557,676	112
South Sudan	630,000	596,982	95	700,000	680,360	97
Uganda	330,000	325,398	99	350,000	322,956	92
Zambia	350,000	311,613	89	245,000	195,770	80
Zimbabwe				25,000	19,106	76
Sub-Saharan Africa total	**12,815,026**	**11,910,156**	**93**	**10,195,495**	**10,238,520**	**100**
Arab States						
Djibouti	160,000	150,623	94	90,000	87,531	97
Republic of Yemen	75,000	56,306	75	25,000	24,612	98
Somalia				300,000	280,203	93
Sudan	500,000	475,199	95	425,000	421,614	99
Arab States total	**735,000**	**682,127**	**93**	**840,000**	**813,960**	**97**

TABLE 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2012 and 2013 (continued)

Regional office/country office/ global technical support/ partners	2012 Approved allocation (US$)	2012 Expenditure (US$)	2012 Implementation rate (%)	2013 Approved allocation (US$)	2013 Expenditure (US$)	2013 Implementation rate (%)
Asia and the Pacific						
Asia and the Pacific Regional Office						
Afghanistan	481,480	317,291	66	500,000	444,048	89
Bangladesh	189,300	189,828	100	120,000	53,060	44
Cambodia	250,000	198,819	80	100,000	87,494	87
Timor-Leste	106,000	60,717	57	100,000	55,449	55
Lao People's Democratic Republic	200,000	181,535	91	200,000	218,426	109
Nepal	128,827	108,396	84	100,000	82,990	83
Pakistan	175,000	174,586	100	62,500	34,256	55
Asia and the Pacific total	**1,530,607**	**1,231,172**	**80**	**1,182,500**	**975,723**	**83**
Latin America and the Caribbean						
Latin America and the Caribbean Regional Office	75,000	71,105	95	87,500	87,376	100
Subregional Office Kingston				0	7006*	
Guyana	300,000	273,456	91	0	446*	
Haiti	661,235	527,707	80	940,751	918,807	98
Latin America and the Caribbean total	**1,036,235**	**872,268**	**84**	**1,028,251**	**1,013,634**	**99**
Global technical support						
Global technical support, including implementing partners	4,809,650	4,403,712	92	4,900,467	3,977,798	81.2
Information and External Relations Division	151,689	144,807	95	150,000	186,240	124
Media and Communications Branch	94,160	87,576	93	100,000	66,788	67
Global technical support total	**5,055,499**	**4,636,095**	**92**	**5,150,467**	**4,230,826**	**82**
GRAND TOTAL	**21,172,367**	**19,331,818**	**91**	**18,396,713**	**17,272,664**	**94**

* carryover from 2012 or previous years

FIGURE 12
Staff positions in UNFPA country offices supported by the MHTF



Thematic Trust Fund for Obstetric Fistula (ZZT03)

Contributions revenue and contributions payments received in 2013

The contributions revenue for obstetric fistula in 2013 totalled $0.8 million. The relatively modest revenue for 2013 can be explained by 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. In fact, the revenue through the overall MHTF has increased significantly, to $59.3 million in 2013, also benefitting work on obstetric fistula. Private sector donors provide direct support to UNFPA country offices instead of through the MHTF.

The dedicated fistula funding window has been maintained to raise awareness of the needs of the women already affected by obstetric fistula — for specialized professional medical services and acceleration of holistic treatment, rehabilitation and reintegration programmes. In addition, 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 — for example, a donation for a fistula surgery to change a woman's life.

In 2013, dedicated contributions payments towards eradication of obstetric fistula were received from Iceland, Luxembourg, Poland and private donors, totalling $0.9 million.

TABLE 6. Total contributions revenues and contributions payments received for the Thematic Fund for Obstetric Fistula (ZZT03) in 2013

Donors	Contributions revenues (USD)	Contributions payments received (USD)
Friends of UNFPA	24,270	24,270
Iceland		55,000*
Iceland	103,158	103,158
Luxembourg	678,426	678,426
Poland	42,840	42,840
TOTAL 2013	**848,693**	**903,694**

* This amount from Iceland is not included in the 2013 contributions revenues list because it was recognized in 2012, the year the agreement was signed.

Operating budget

The effective working budget for the Thematic Fund for Obstetric Fistula in 2013 was $1.72 million, slightly less than the 2012 operating budget of $1.82 million (Table 7). As the case for last year, this reflects the trend that donors are providing funding for obstetric fistula through the Thematic Fund for Maternal Health (ZZT06). In fact, the Campaign to End Fistula has experienced a steady increase in programmatic activities in 2013 under the MHTF umbrella.

The budget for 2013 reflects contributions payments received during the fourth quarter of 2012 ($0.05 million), rollover funds ($0.81 million) and contributions payments received during the first three quarters of 2013 ($0.86 million). Rollover funds ($0.81 million) include unspent balances from 2012 allocations to regions and countries (the financial implementation rate for 2012 was 83 per cent).

Figure 13 (page 49) shows how the operating budgets for 2012 and 2013 have been established. These budgets provide the basis for the fistula programme's planning and implementation.

Expenditures

Expenditures from the Thematic Fund for Obstetric Fistula in 2013 totalled $1.48 million, compared to $1.34 million in 2012. During 2013, country and regional programmes, including spending by INGOs and institutions supporting country-level programme activities, accounted

TABLE 7. Operating budget for the Thematic Fund for Obstetric Fistula (ZZT03) for 2013

Donors	Contributions payments received (USD)
Carryover from 2012	862,928
Friends of UNFPA	24,270
Iceland*	55,000
Iceland*	103,158
Luxembourg	678,426
TOTAL 2013	**1,723,781**

* The two payments from Iceland are reported individually since the first one ($55,000) was registered as revenue in 2012, the year the agreement was signed (see table above on contributions revenues).

for 69.4 per cent ($1.03 million) of the total; global programmes accounted for 30.6 per cent ($0.45 million) of the total. This compares with 65 per cent ($0.88 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level in 2012, and 35 per cent ($0.46 million) for global programmes. Figure 14 shows the percentage of funds spent by region and globally, including by implementing partners, in 2012 and 2013.

As noted above, $1.48 million was spent to achieve the goals for obstetric fistula activities in 2013, against a total allocation of $1.72 million. This translates into a financial implementation rate of 86 per cent, higher than in 2012 (83 per cent). Figure 15 shows operating budgets, allocations and expenditures for obstetric fistula in 2012 and 2013.

Support to country, regional and global programmes

In 2013, allocations to country, regional and global programmes for obstetric fistula totalled $1.72 million, compared to $1.61 million in 2012. Regional and country programmes, including INGOs and institutions supporting country-level activities, represented

FIGURE 13
Operating budgets for obstetric fistula in 2012 and 2013 (US$ millions)

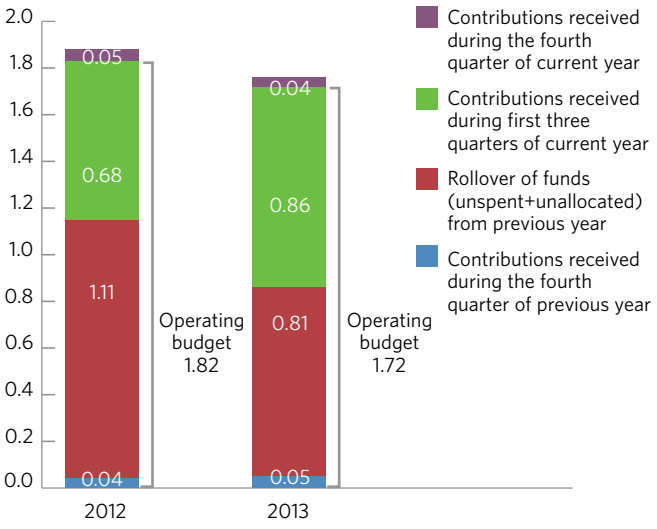


FIGURE 15
Operating budgets, allocations and expenditures for obstetric fistula in 2012 and 2013 (US$ millions)

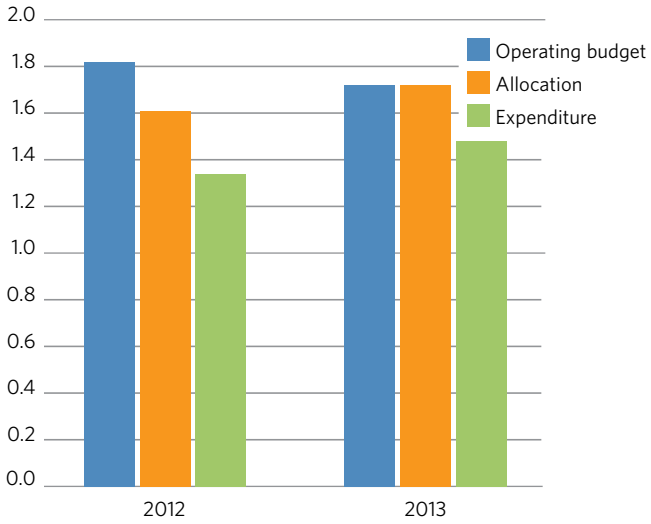


FIGURE 14
Share of expenditures for obstetric fistula by region and globally in 2012 and 2013

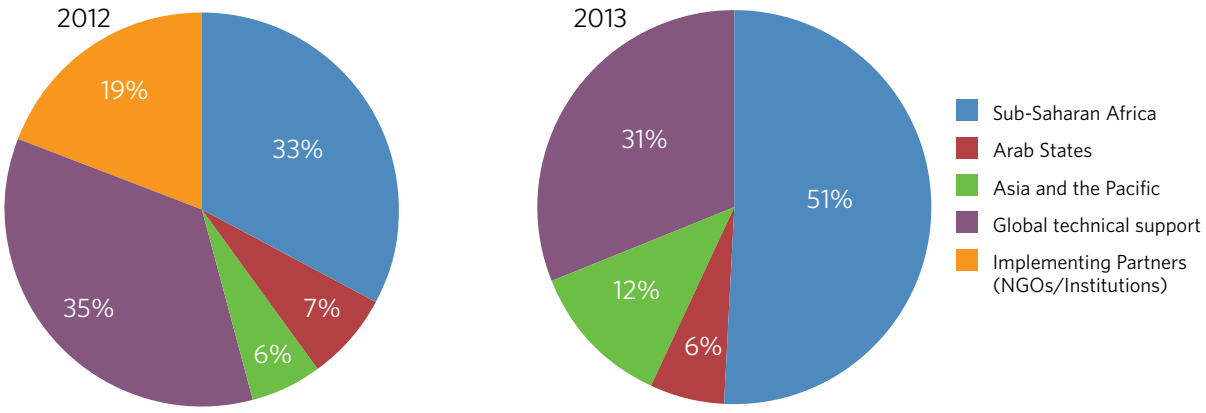


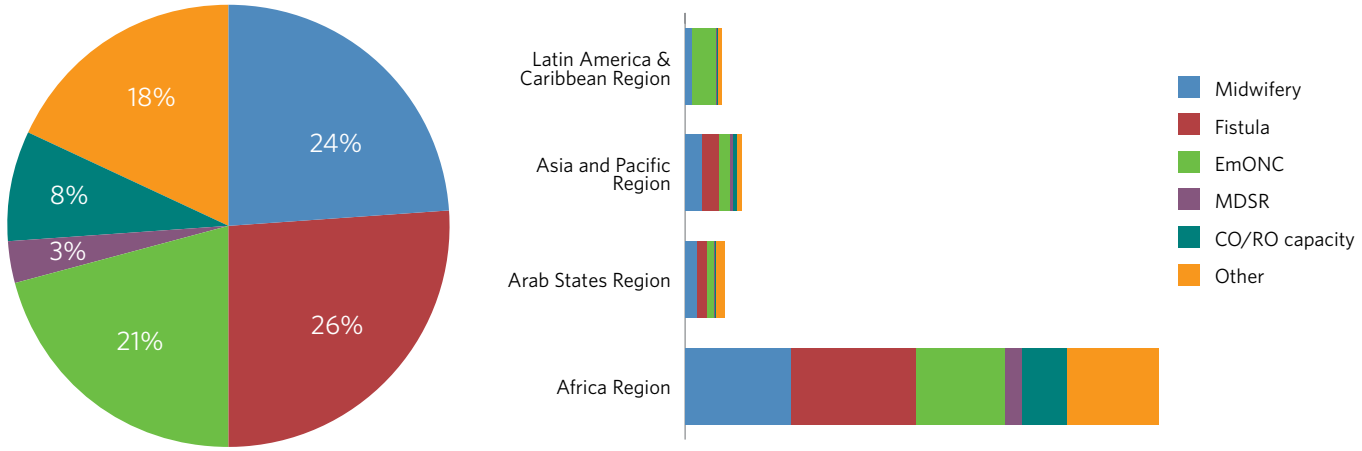
TABLE 8. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2012 and 2013

Regional office/ country office/ global technical support/ partners	2012			2013		
	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)	Approved allocation (US$)	Expenditure (US$)	Implementation rate (%)
Sub-Saharan Africa						
Benin					1,716	
Cameroon	50,000	46,018	92	75,000	73,787	98
Central African Republic	50,000	49,672	99		0	
Congo	50,000	44,639	89	75,000	54,236	72
Côte D'Ivoire		236		79,505	76,709	96
Democratic Republic of the Congo				280,000	234,617	84
Eritrea				37,500	10,160	27
Ghana		9,979				
Guinea	50,000	38,305	77	112,500	103,144	92
Guinea-Bissau	50,000	49,528	99	75,000	65,749	88
Kenya	75,000	75,817	101	75,000	60,057	80
Liberia					213*	
Mauritania	75,000	42,939	57	75,000	74,121	99
Nigeria		5,268				
Senegal	94,340	86,389	92		130*	
Sub-Saharan Africa total	**494,340**	**448,790**	**91**	**884,505**	**754,638**	**85**
Arab States						
Republic of Yemen				75,000	66,236	88
Somalia	100,000	92,737	93		27,619	
Arab States total	**100,000**	**92,737**	**93**	**75,000**	**93,855**	**125**
Asia and the Pacific						
Pakistan	75,000	79,827	106	187,500	180,573	96
Asia and the Pacific total	**75,000**	**79,827**	**106**	**187,500**	**180,573**	**96**
Global technical support						
Global technical support, including implementing partners	942,876	717,445	76	576,776	455,490	79
Global technical support total	942,876	717,445	76	576,776	455,490	79
GRAND TOTAL	**1,612,216**	**1,338,799**	**83**	**1,723,781**	**1,484,556**	**86**

* carry over from 2012 or previous years

FIGURE 16

Approximate distribution of MHTF resources in 2013 globally and by region



66.6 per cent ($1.15 million) of the total in 2013, compared to 68 per cent ($1.09 million) in 2012; global programmes represented 33.4 per cent ($0.57 million) of the total in 2013, compared to 32 per cent ($0.52 million) in 2012.

By region, sub-Saharan Africa received the most support, 51.3 per cent ($0.88 million), followed by Asia and the Pacific at 10.9 per cent ($0.19 million) and the Arab States at 4.4 per cent ($0.08 million). Table 8 shows approved allocations, expenditures and the financial implementation rate by region, by country and globally in 2012 and 2013.

Linking results to financing

Recognizing the importance of estimating the distribution of MHTF resources in order to link results achieved to financing, Figure 16 provides an approximate estimate of how MHTF resources were distributed globally and by region in 2013.

About one-quarter of expenditures (approximately $4.5 million) went to support fistula, and another quarter (approximately $4.2 million) to support midwifery programming. Around 21 per cent (about $3.8 million) was used to support Emergency Obstetric and Newborn Care, 3 per cent (about $0.6 million) to support development and implementation of MDSR, and around 8 per cent (about $1.4 million) to strengthen the capacity of priority country and regional offices. The remainder was used mainly to strengthen national capacity in areas such as overall planning and programming (including technical assistance missions), data collection and management, quality assurance activities, and lifesaving medicines for safe deliveries.

This estimation involved a detailed analysis of each country's work plan for 2013 and avoids double-counting specific synergistic activities that cross more than one output (e.g., training midwives to perform the key medical interventions required in EmONC facilities). In addition, even if reporting is required at three levels (country, regional and global), it is important to consider that many activities at the country and regional levels are intrinsically linked and relate to several health system blocks. Nevertheless, the MHTF continues to provide broad categories or areas of investment in the area of maternal health, including emergency obstetric and newborn care, midwifery, fistula, maternal death surveillance and response, and other important areas of work (such as staffing for operations and strengthening of country and regional offices).

Most important, the MHTF has contributed to significant results with relatively modest resources spanning more than 40 high maternal mortality countries.

CHAPTER EIGHT

Challenges and Way Forward for the Second Phase of the MHTF

Designed in 2007 to contribute to the reduction of maternal and newborn mortality and morbidity in the world's most vulnerable countries, the MHTF has witnessed some important changes since it began in 2008. The international aid environment has changed, with a progressive shift from vertical projects to more programmatic approaches as well as an increased emphasis on capacity development and national ownership and execution. Furthermore, in the context of limited aid budgets, donor support is increasingly determined by effective and efficient use of aid funds, with expectations of tangible results and demonstrable long-term impact. These developments highlight challenges and opportunities for the MHTF.

Addressing the challenges

Significant progress has been made since 1990 to improve maternal and newborn health, reduce maternal mortality and increase universal access to reproductive health. However, Millennium Development Goal 5 (MDG5) still remains the furthest of the goals from reaching its target, with an estimated 289,000 women dying in 2013 from complications in pregnancy and childbirth. Moreover, major efforts are still required to achieve universal access to reproductive health.[25, 26]

Several challenges continue to hamper progress towards reaching this goal, including the need for strong health systems that are fair, accountable and adequately resourced -- human, financial and material resources. Notwithstanding the increases in funding for MDG5, investments need to be scaled up, domestically and internationally; at the same time, more effective use of resources is required to maximize the impact of all investments.[27] The evidence is strikingly obvious: universal coverage through a comprehensive package of reproductive health services, including for newborns, would prevent 59 per cent of maternal deaths and 73 per cent of newborn deaths worldwide.[28]

At the same time, ensuring that such a package of services is fully integrated and readily available at one location will also contribute to the realization of MDG5. In addition, there is a need to confront and address inequality, which is a substantive issue across many countries and a significant blockage, particularly for the most vulnerable and marginalized to access reproductive health services. The quality of services continues to remain a challenge, impacting adversely on reproductive health outcomes as well as acting as a barrier to those who want to access services.

[25] The Millennium Development Goals Report. United Nations, 2013; UNDP; UNFPA; UNICEF; UN Women; WHO. Available at http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf
[26] http://unfpa.org/public/home/publications/pid/17448
[27] http://www.globalhealth2035.org/
[28] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60582-1/abstract

◀ Women wait at the CSPS Health and Social Promotion Center of Moaga, Burkina Faso, for prenatal services.

Photo by Olivier Girard Photography.

It is in this context that the MHTF operates and confronts numerous issues in the countries it supports, particularly such matters as:

- Critical shortages of health providers in relation to needs;
- Weak or insufficiently resourced health systems with low coverage of cost-effective interventions;
- Infrastructure and system deficiencies affecting service quality and delivery, including procurement of essential lifesaving commodities, training materials and other supplies;
- Inadequate scale-up of targeted interventions designed to address specific causes and conditions leading to maternal and newborn deaths across countries;
- Lack of or insufficient health information and management systems, which adversely impact adequate responses to address causes of deaths and monitoring processes and result in weak accountability mechanisms;
- Social instability, conflicts or humanitarian crises;
- Vulnerable or marginalized populations are not well targeted or fully reached;
- Inadequate engagement of constituents beyond the health sectors.

To address these challenges in a concrete, effective manner, while building on past gains and on the recommendations from the midterm evaluation, the MHTF will:

- Strengthen its role as a catalytic tool to facilitate the implementation of evidence-based maternal health interventions in programme countries;
- Mobilize required technical and financial resources to support country offices and programme countries in following up on these interventions until completion;
- Provide assistance for pilot interventions on selected core maternal health issues, such as the development of appropriate support strategies to better target populations with high vulnerability to poor maternal health;
- Develop multiyear country strategic plans for the use of MHTF funds, focused on key maternal health issues;
- Assist government counterparts at country level in defining the population groups most at risk in maternal health and their particular needs; and ensure that MHTF interventions focus on those groups in the effort to strengthen maternal health systems;
- Adopt a more comprehensive approach to health system strengthening, taking into account the key bottlenecks to maternal health and other sexual and reproductive health services;
- Ensure that barriers to access and use of maternal health services (skilled attendance at birth, EmONC), are considered in national strategies or plans and that MHTF-supported initiatives help address these barriers;
- Ensure that MHTF-supported maternal health-related interventions encompass mechanisms to maintain the quality of outputs.

The updated Business Plan sharpens the focus of the MHTF, as the information below outlines how the Fund will move the recommendations of the midterm review forward.

Moving forward

In the MHTF's second phase, covering the period 2014-2017, the Fund positions itself within the context of UNFPA's Strategic Plan vision and goals as follows:

> "Achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights, and gender equality."

Contributing to this goal, Outcome 1 (of four) in the Strategic Plan is "*increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive*

and meet human rights standards for quality of care and equity in access."

The goal of the second phase of the MHTF is **to improve maternal health**, in the overall context of "*increased national capacity to deliver integrated sexual and reproductive health services*," as outlined in the UNFPA's Strategic Plan.

To support this goal, the MHTF will focus on the following target areas:

1. Continue to strengthen national capacity to implement comprehensive midwifery programs;

2. Continue to strengthen national capacity for emergency obstetric and newborn care (EmONC), including quality integrated maternal health services;

3. Continue to strengthen national capacity for prevention, treatment and social reintegration for women and girls with obstetric fistula;

4. Continue to strengthen national capacity for maternal death surveillance and response;

5. Reach out to first-time young mothers to improve their access to quality maternal health services, focusing on delivery in health facilities.

To support each target, the MHTF will prioritize strategic activities for **advocacy and policy**; **capacity development; knowledge management**; and **service delivery**. Special attention will be paid to **first-time young mothers** and their need to deliver in health facilities with skilled attendants, using this as an opportunity to provide them with pregnancy counselling, information on contraception and supportive measures when a pregnancy is unplanned.

Cross-cutting principles

The three principles of **equality**, **quality** and **accountability** will be applied across the key areas of work, as outlined in the new MHTF Business Plan.

Equality

To move towards equality in the health outcomes of pregnancy and childbirth requires focused interventions targeting those most at risk for adverse maternal health outcomes, such as adolescent girls. Globally, there is tremendous momentum on adolescents and the strongest recognition to date as to the importance of prioritizing this population. UNFPA is one of the leading institutions in this global momentum, and the MHTF is an excellent vehicle for building on this leadership to serve the needs of adolescent/young mothers.

Adolescent girls (particularly girls under the age of 15) face higher risks of maternal mortality and morbidity, including obstetric fistula, than women 20 to 24 years of age, and they also represent a large portion of the population in many countries. In its second phase, the MHTF will invest in this population, reaching out to first-time adolescent/young mothers to increase their access and use of comprehensive reproductive health services.

Another important group to target to achieve equality in maternal health outcomes is women who lack access to care. These are often poor, rural women living in remote, underserved areas, women from districts with low-wealth quintiles and low education levels, and women from known marginalized and vulnerable groups, according to specific country contexts.

To address these issues, the MHTF will work with Ministries of Health and partners to:

- Identify vulnerable women and girls;

- Increase access to and use of quality maternal health services by adolescent/young mothers through:
  - Targeted outreach by community-based health workers and midwives for identification of pregnant adolescent/young mothers;
  - Special clinic privileges or hours to ensure an early start to antenatal care;
  - Developing a birthing plan, including planning for a facility delivery;
  - Training of community health workers on symptoms more common among pregnant adolescents (such as pre-eclampsia, eclampsia, prolonged and obstructed labour, preterm delivery, low birth weight, respiratory distress syndrome and stillbirths);
  - Facility- and community-based support groups for adolescent/youth mothers led by nurses or commu-

nity health workers/midwives (focused on breastfeeding, birth spacing, family planning, STIs, nutrition including micronutrients, mental health and psychosocial care, proper infant care).

- Enhance focus on maternal health of adolescent/youth mothers, as well as other vulnerable women, in various sectoral policies (especially health, education and social ministries) to improve their access to quality maternal health services.

Early investments in the sexual and reproductive health of adolescent girls can improve lifelong reproductive health trajectories, and have long-term and wide-reaching development benefits not only for women but also for their children and their families.

Quality

The target areas identified in the new Business Plan will all contribute to increasing quality of care. The MHTF will strengthen the availability of quality services, including:

- Prevention, treatment, social reintegration services and follow up of women and girls with obstetric fistula;
- Nutrition of pregnant women and adolescent girls, first-time young pregnant women in particular (in collaboration with the World Food Programme);
- Post-abortion care and abortion services where it is not against the law;
- Innovative e-learning modules for midwives and community health workers;
- Improved access to reproductive health commodities (in collaboration with the Global Programme to Enhance Reproductive Health Commodity Security);
- Involvement of communities to strengthen quality of services provided.

In addition, while in the **first phase** of the MHTF a key priority was to conduct EmONC needs assessments, in the **second phase**, to meet the EmONC needs thus identified, the MHTF will:

- Focus on supporting countries to implement and monitor implementation of costed national and/or subnational level action plans in which EmONC services are prioritized and meet the minimum international standards for quality, accessibility and utilization of integrated sexual and reproductive health services;
- Continue to invest on scaling up the capacities and skills of the health workforce, midwives in particular, and assist countries in the management of a competent and skilled health workforce (planning, recruitment, status, retention, continuous education and supportive supervision) able to provide quality health services.

Accountability

During the **first phase**, the MHTF supported the strategic shift from maternal deaths reviews to maternal death surveillance and response (MDSR). In its **second phase**, the MHTF seeks to support countries to establish, implement and strengthen MDSR systems as outlined in the national health plan.

The MHTF will:

- Continue to foster advocacy and policy development for the mandatory notification of maternal deaths;
- Promote the inclusion of MDSR in national costed sexual and reproductive health plans (as part of national health plans), with the active participation of the Ministry of Health as well as local and community participation;
- Support national needs assessment (review of existing system, gaps and opportunities);
- Provide technical support to all four MDSR components: compulsory notification, deaths reviews and analysis, monitored response following deaths' analysis, and annual national report;
- Provide technical support to trainings and structuring of an MDSR system at the district and national levels, including monitoring and evaluation.

Partnerships

The MHTF will further strengthen its capacity to forge strategic and **technical partnerships** at global, regional

Midwifery Programme

The Midwifery Programme contributes to the three principles of equality, quality and accountability. It supports the expansion of the midwifery workforce as well as upgrading skills (including through e-training modules), which will expand access to quality prenatal and delivery care services, thus improving both **equality** and **quality**. In addition, an integral part of the e-learning modules, conceived with the Intel Corporation, is a health data-tracking system that enables the programme to contribute to strengthening **accountability** mechanisms.

Emergency Obstetric and Newborn Care

By supporting countries to meet the needs identified in the EmONC surveys, the Fund also addresses the needs of vulnerable groups, including first-time young mothers and underserved women, thus contributing to increased equality. Embedded in this intervention is also improving the **quality** of EmONC services, which becomes an integral part of these activities. In addition, national plans will include the issue of **accountability** to ensure that progress is made on the commitments. Health information and health data-tracking systems will be used for monitoring improvements in services and to strengthen accountability mechanisms.

The Campaign to End Fistula

Obstetric fistula is a condition that inherently affects the most vulnerable groups, including adolescent and young girls who are not fully developed physically to give birth, and women who do not have access to skilled delivery care. Therefore, interventions to prevent and treat obstetric fistula will increase **equality** in health outcomes of pregnancy and delivery. Through training of fistula surgeons, the Campaign to End Fistula works to improve access to **quality** fistula treatment services and promotes a high level of **accountability**, keeping track of every fistula center, every operation and every fistula surgeon that is trained. As the work is done in collaboration with national partners, accountability is also applied at the national level.

Maternal Death Surveillance and Response

Maternal Death Surveillance and Response is first and foremost an **accountability** intervention. Through the MDSR system every maternal death is counted, providing an assessment of the true magnitude of maternal mortality and the impact of interventions to reduce it. Furthermore, a strong MDSR system can be used as a basis for targeted improvements in quality of care: when causes for maternal deaths are identified, the response ('R' in 'MDSR') is to improve the quality of services and address the underlying issues to prevent future deaths. An efficient response to the causes of all maternal deaths will also improve equality in the health outcomes of pregnancy and delivery.

Adolescent/Young Mothers

Adolescent/young mothers face higher risks of reproductive morbidity and mortality and also represent a large share of the overall population in many countries. Therefore, to achieve **equality** of outcomes in reproductive health, interventions to reach them should be prioritized. This also provides the opportunity for the MHTF to support targeted, innovative interventions/strategies for the delivery of **quality** services. Furthermore, ensuring that first time adolescent/young mothers have access to quality services at first contact tends to be an important predictive factor for continued, lifelong service utilization (even intergenerationally). By targeting and prioritizing adolescent/young mothers, the MHTF is better aligned with and **accountable** for UNFPA's overall strategic direction toward the progressive realization of universal access to sexual and reproductive health services.

and national levels. These networks are essential to scale up advocacy activities to end obstetric fistula, uphold the importance of EmONC and MDSR in the reduction of preventable maternal deaths, and to support the importance of the midwifery workforce in the international health arena. The role of the regional institutions will also progressively increase. For example, the Institute for Research in Health Sciences (IRSS) in West Africa and the International Centre for Diarrhoeal Research, Bangladesh (ICDDR,B) are now providing technical support to AMDD by ensuring adequate monitoring following EmONC surveys. The involvement of regional institutions fosters regional and national ownership and contributes to long-term sustainability of the activities supported by the MHTF.

Coordination and Management of the MHTF

The MHTF will significantly modify its **management framework** to better take into consideration the requirements of partners, reinforcing the added value of its support to the countries and in line with the accountability requirements of UNFPA (i.e., the 2014-17 Strategic Plan and Business Model). At country level, it will encourage implementation of more strategic and less numerous activities and **harmonization of the planning process** in countries that receive additional funding, whether from UNFPA or other partners, such as the H4+ funds managed by UN agencies. The goal is to achieve a single timetable and an integrated planning and reporting tool with indicators measuring the performance of the teams and the capacity to deliver on the stated outcomes.

Key strategies

- Strengthen information system, programme results monitoring and reporting on all priority areas of intervention through capacity building and data generation at country level, and ensure an integrated results monitoring system of the implementation of the Fund's activities to better analyze progress in each area of work at country and global level;

- Improve results-based programme management and coordination at all levels and focus on accountability from formulation to implementation of activities, while ensuring timely provision of technical, operational and programmatic support;

- Harmonize and align country level programme results to both national priorities and to UNFPA strategic plan indicators, creating an integrated system in which all elements fully coordinate to support results-based management.

In its 2014-2017 Business Plan, the MHTF emphasizes its strong commitment to work with countries and partners and to transform itself by increasing its contribution to and accelerating progress towards the reduction of preventable maternal and newborn mortality and morbidity. Steady and predictable donor financing will enable strategic in-country investments in areas with high potential for impact and increased sustainability of the activities supported by the Fund. The new Business Plan strengthens the MHTF as it draws from previous experiences, results and evaluations while adapting to a changing environment.

All these steps translate into an effective and efficient programme better tailored to be responsive and performance driven, thus enabling a substantial and sustained impact on reproductive, maternal and newborn health.

Annex 1. Partners in the Campaign to End Fistula

1. Aden Hospital (Yemen)
2. African Medical & Research Foundation
3. American College of Nurse-Midwives
4. Babbar Ruga Fistula Hospital (Nigeria)
5. Bangladesh Medical Association
6. Bill & Melinda Gates Institute for Population & Reproductive Health
7. Bugando Medical Center (Tanzania)
8. CARE
9. Comprehensive Community Based Rehabilitation (Tanzania)
10. Centers for Disease Control and Prevention (CDC)
11. Centre Mère-Enfant (Chad)
12. Centre National de Référence en Fistule Obstétricale (Niger)
13. Centre National de Santé de la Reproduction & du Traitement des Fistules (Chad)
14. Columbia University's Averting Maternal Death and Disability Program (AMDD)
15. Cure International Hospital of Kabul (Afghanistan)
16. Direct Relief International
17. Dr. Abbo's National Fistula & Urogynaecology Center (Sudan)
18. East Central and Southern Africa Association of Obstetrical and Gynecological Societies
19. EngenderHealth
20. Equilibres & Populations
21. Eritrea Women's Project
22. Family Care International
23. Fistula e.V
24. Fistula Foundation
25. Fistula Foundation (Nigeria)
26. Friends of UNFPA
27. Geneva Foundation for Medical Education & Research
28. Girls' Globe
29. Governess Films
30. Gynocare Fistula Center (Kenya)
31. Hamlin Fistula (Ethiopia)
32. Healing Hands of Joy (Ethiopia)
33. Health & Development International
34. Health Poverty Action (Sierra Leone)
35. Hope Again Fistula Support Organization (Uganda)
36. Human Rights Watch
37. Institut de Formation et de Recherche en Urologie et Santé de la Famille (IFRU-SF) (Senegal)
38. International Confederation of Midwives
39. International Continence Society
40. International Federation of Gynecology & Obstetrics (FIGO)
41. International Forum of Research Donors
42. International Nepal Fellowship
43. International Planned Parenthood Federation
44. International Society of Obstetric Fistula Surgeons (ISOFS)
45. International Urogynecological Association (IUGA)
46. International Women's Health Coalition
47. Islamic Development Bank
48. Johnson & Johnson
49. Johns Hopkins Bloomberg School of Public Health
50. Kupona Foundation
51. Lake Tanganyika Floating Health Clinic
52. Ligue d'Initiative et de Recherche Active Pour la Santé et l'Education de la Femme (LIRASEF), Cameroon
53. London School of Hygiene & Tropical Medicine
54. Maputo Central Hospital (Mozambique)
55. Médecins du Monde
56. Médecins Sans Frontières
57. Mercy Ships
58. Moi University (Kenya)
59. Monze Hospital (Zambia)
60. Mulago Hospital/Medical School (Uganda)
61. National Obstetric Fistula Centre, Abakiliki (Nigeria)
62. Obstetrical and Gynecological Society of Bangladesh
63. One by One
64. Operation Fistula
65. Pakistan National Forum on Women's Health
66. Pan African Urology Surgeon's Association (PAUSA)
67. Population Media Center
68. Psychology Beyond Borders
69. Regional Prevention of Maternal Mortality Network (Ghana)
70. Royal College of Obstetricians & Gynaecologists (RCOG)
71. Sana'a Hospital (Yemen)
72. Selian Fistula Project (Tanzania)
73. Société Africaine des Gynécologues-Obstétriciens (SAGO)
74. Société Internationale d'Urologie
75. Solidarité Femmes Africaines (SOLFA)
76. The Association for the Re-orientation and Rehabilitation of Women for Development (TERREWODE) (Uganda)
77. Uganda Childbirth Injury Fund
78. United Nations Population Fund (UNFPA)
79. United States Agency for International Development
80. University of Aberdeen
81. University Teaching Hospital of Yaoundé (Cameroon)
82. Virgin Unite
83. White Ribbon Alliance
84. Women & Health Alliance International (WAHA)
85. Women's Health Organization International
86. Women's Hope International
87. Women's Missionary Society of the African Methodist Episcopal Church
88. World Health Organization
89. World Vision
90. Worldwide Fistula Fund
91. Zonta International

Annex 2. Consolidated results framework for 2013

	MDG5.a AND MDG5.b INDICATORS					
Countries with 5 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**a) Maternal mortality ratio (number of maternal deaths per 100,000 live birth)***	**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	84	94	85.8/60.5	32.6	14
Burkina Faso (M, F)	300	68	130	94.3/33.7	24.5	21.9
Burundi (M, F)	800	33.6	65	98.9/33.4	32.4	21.9
Cambodia (M, F)	250	74.1	48	89.1/59.4	16.9	50.5
Côte d'Ivoire (M, F)	614	59.4	129	84.8 /44.2	27.1	14
Djibouti (M, F)***	-	-	-	-	-	-
Ethiopia (M, F)	350	10	50	88/81	10	66
Ghana (M, F)	350	68.4	69.7	96.4/86.6	27.4	34.7
Haiti (M, F)	350	37	66	91/68.8	35	31
Madagascar (M, F)	478	44.3	163	86.7/51.1	17.8	33.3
Malawi (M, F)	675	71	152	94.7/45.5	26	42
South Sudan (M, F)	730**	14.6	353	40.3/17.3	24	4.5
Sudan (M, F)	730**	23.1	49	74.3/47.1	28.9	9
Uganda (M, F)	310	57.4	146	93.3/47.6	34.3	30
Zambia (M, F)	440	46.5	151.1	93.7/60.3	26.6	40.8
Zimbabwe***	-	-	-	-	-	-

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 EmONC, 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 EmONC	Costed national development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care and EmONC
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
No	✓	✓	✓	✓
–	–	–	–	–
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
No	✓	✓	✓	No
✓	✓	–	✓	✓
✓	✓	✓	✓	✓
No	✓	✓	✓	In progress
✓	✓	✓	✓	✓
✓	✓	No	✓	✓
✓	✓	✓	✓	✓
–	–	–	–	–

Annex 2. Consolidated results framework for 2013 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 5 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies (number or %)**	**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	21	✓	✓	✓
Burkina Faso (M, F)	4	–	✓	✓	✓
Burundi (M, F)	1	–	✓	–	✓
Cambodia (M, F)	5	685	Partial	✓	✓
Côte d'Ivoire (M, F)	4	545	✓	✓	✓
Djibouti (M, F)	–	–	–	–	–
Ethiopia (M, F)	31	6300	✓	✓	Partial
Ghana (M, F)	30	–	✓	✓	✓
Haiti (M, F)	1	80	✓	–	–
Madagascar (M, F)	6	150	Partial	Partial	Partial
Malawi (M, F)	–	–	✓	✓	✓
South Sudan (M, F)	3	17	No	No	In progress
Sudan (M, F)	1	1200	No	✓	✓
Uganda (M, F)	54	–	Partial	✓	✓
Zambia (M, F)	15	300	✓	✓	✓
Zimbabwe***	–	–	–	–	–

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
✓	-	8	6	-	105	105
✓	-	69	14	1	368	-
✓	-	-	1	1	450	183
✓	2	-	1	-	2	-
✓	-	155	7	5	251	64
-	-	-	-	-	-	-
No	-	120	15	15	3500	-
✓	-	-	9	-	114	48
✓	-	-	-	-	-	-
✓	-	12	17	-	485	42
✓	-	13	8	3	254	-
✓	3	-	-	-	200	-
✓	-	60	4	4	569	-
✓	24	68	20	20	1850	< 20%
✓	1	-	5	0	271	0
-	-	-	-	-	-	-

(continued)

Annex 2. Consolidated results framework for 2013 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)							
Countries with 5 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**Availability of basic EmONC: national number of facilities**	**Availability of comprehen-sive EmONC: national number of facilities**	**Geographic distribution: proportion of subnational areas with the required number of emergency obstetric and newborn care facilities (reported as proportion or %)**	**Proportion of all births in EmONC facilities, %**	**Met need for EmONC, %**	**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)	-	-	-	-	-	-	23	5.4
Burkina Faso (M, F)	4	21	-	-	14.2	0.5	28	-
Burundi (M, F)	-	-	-	-	-	-	-	4.3
Cambodia (M, F)	96	36	17/24	23	35	0.2	-	3.2
Côte d'Ivoire (M, F)	17	11	0	2	39	3	1.5	1.9
Djibouti (M, F)	-	-	-	-	-	-	-	-
Ethiopia (M, F)	-	175	100	58	-	<1	7	5
Ghana (M, F)	-	-	-	-	-	-	-	-
Haiti (M, F)	8	6	0/10	-	6	-	-	-
Madagascar (M, F)	-	-	-	-	-	-	Intrapartum: 121/1000; Early neonatal deaths: 186/1000	-
Malawi (M, F)	120	53	-	73	24	2	33	3.4
South Sudan (M, F)	10	18	-	-	-	-	-	-
Sudan (M, F)	-	-	6/18 (in the 9 states supported by UNFPA)	21	-	-	-	7
Uganda (M, F)	-	-	-	-	-	-	23	>5
Zambia (M, F)	200	56	-	-	-	-	34	3
Zimbabwe***	-	-	-	-	-	-	-	-

*Source: Country data. If not available,the latest MDG indicators were used (available at: http://unstats.un.org/UNSD/MDG/SeriesDetail.aspx?srid=570&crid=
** UN data available for Sudan only
***No data provided for 2013
§ Annual number of births to women 15 to 19 years of age per 1,000 women in that age group
(-): no data available

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$**
✓	✓	✓	–	–
✓	✓	No	–	–
✓	Partial	–	19	–
✓	✓	✓	–	–
✓	No	No	4.6	–
–	–	–	–	–
✓	✓	✓	24	–
✓	No	In progress	–	–
No	No	No	–	–
Partial	Partial	Partial	–	–
✓	✓	✓	–	–
No	No	No	–	–
✓	Partial	No	–	–
✓	Partial	No	–	15%-12 USD per capita
✓	Partial	Partial	11	–
–	–	–	–	–

Annex 2. Consolidated results framework for 2013 *(continued)*

	MDG5.a AND MDG5.b INDICATORS					
Countries with 4 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/ or fistula activities**	**a) Maternal mortality ratio (number of maternal deaths per 100,000 live birth)***	**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**
Afghanistan (M, F)	460	38.6	90	47.9/14.6	-	21.8
Bangladesh (M, F)	240	31.7	128	54.6/25.5	13.5	61.2
Cameroon (M, F)	690	63.6	127	84.7/62	23.5	23.4
Central African Republic (F)	890	53.8	229	68.3/38.1	19.1**	19
Chad (M, F)	1084	28.4	203.4	62.8/23.1	28.3	4.8
Congo (F)	560	94	147	93/74.7	18	44.7
Democratic Republic of the Congo (M, F)	540	85	135	87.3/43.8	25	5.4
Eritrea (F)	240	28.3	85.2	70.3/40.9	28.5	8
Guinea (F)	610	46.1	146	88.4/50.3	21.9	5.6
Guinea-Bissau (F)	790	44	249	92.6/70	6	14.2
Kenya (F)	360	43.8	106.3	91.5/47.1	25.6	45.5
Lao People's Democratic Republic (M, F)	357	20.3	94	54	20	50
Liberia (M, F)	770	73	177.3	79.3/66	35.7	19
Mali (M, F)	368	58.6	165	74	-	10
Mauritania (F)	626	65	88	75.4/16.4	31	10
Mozambique (M, F)	408	54.3	167	90.6/53.1	28.5	11.3
Namibia (M, F)***	-	-	-	-	-	-
Nepal (M, F)	170	46	81	85/50.1	27	49.7
Niger (M, F)	590	29	206.6	83/33	16.1	12
Nigeria (M, F)	630	49	89	66.2/56.6	19.4	17.5
Pakistan (M, F)	260	52	8	70.3/28.4	20	35
Rwanda (M, F)	340	69	41	98/35.4	20.8	51.6
Senegal (F)	370	65.1	88	93.3/50	29	16
Sierra Leone (M, F)	890	61.3	122	97/74.7	27.4	15.6
Somalia (F)	1044	38	123	26.1/6.3	15	1.5
Timor-Leste (M, F)	300	30	51	86/55	31	22
Yemen (M, F)	200	35.7	80	69	24	27.7

* Source: Country data. If not available,the latest MDG indicators were used (available at: http://unstats.un.org/UNSD/MDG/SeriesDetail.aspx?srid=570&crid=

** Country data from 1995

***No data provided for 2013

§ annual number of births to women 15 to 19 years of age per 1,000 women in that age group

(-): no data available

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 EmONC, 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 EmONC**	**Costed national development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care and EmONC**
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	Under development; to be completed in 2014	Under development; to be completed in 2014
–	–	–	✓	✓
✓	✓	✓	✓	✓
In progress	In progress	–	In progress	Being revised
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	Partial	Partial
In progress	✓	✓	✓	✓
–	–	–	–	–
In progress	✓	✓	✓	✓
No	✓	✓	✓	✓
✓	✓	Partial (midwifery)	✓	✓
–	–	Partial	✓	✓
✓	✓	No	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	Partial	Partial	Partial
Partial	–	No	✓	✓
–	In progress	Partial	Expected for 2015	Expected for 2015

Annex 2. Consolidated results framework for 2013 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 4 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies (number or %)**	**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	800	✓	–	–
Bangladesh (M, F)	40	200	–	–	–
Cameroon (M, F)	10	–	–	–	–
Central African Republic (F)	–	30	✓	✓	✓
Chad (M, F)	Validating revised curricula	265	✓	✓	✓
Congo (F)	2	88	✓	In progress	✓
Democratic Republic of the Congo (M, F)	8	2090	✓	✓	✓
Eritrea (F)	1	100	✓	✓	✓
Guinea (F)	3	–	✓	✓	✓
Guinea-Bissau (F)	1	–	–	✓	✓
Kenya (F)	–	2800	✓	✓	✓
Lao People's Democratic Republic (M, F)	9	214	Partial	In progress	✓
Liberia (M, F)	4	101	✓	✓	✓
Mali (M, F)	–	298	✓	✓	✓
Mauritania (F)	5	49	✓	✓	✓
Mozambique (M, F)	–	–	–	–	–
Namibia (M, F)***	–	–	–	–	–
Nepal (M, F)	–	–	✓	–	–
Niger (M, F)	5	118	✓	✓	✓
Nigeria (M, F)	–	2750	✓	Partial	✓
Pakistan (M, F)	–	–	✓	–	✓
Rwanda (M, F)	8	191	✓	✓	✓
Senegal (F)	100%	706	✓	✓	✓
Sierra Leone (M, F)	2	95	✓	–	Partial
Somalia (F)	10	200	✓	✓	✓
Timor-Leste (M, F)	1	65	✓	Partial	Partial
Yemen (M, F)	21	782	–	–	–

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
-	5	3	4	-	200	0
✓	12	24	14	10	308	39
-	-	-	1	1	55	47
✓	-	-	2	-	-	21
✓	-	15	4	3	276	276
✓	4	30	2	2	40	56
No	8	14	27	0	868	9
No	3	9	-	-	128	-
No	-	15	4	3	60	0
✓	9	27	3	-	31	-
✓	-	-	12	4	200	-
No	-	-	-	-	-	-
✓	-	75	3	1	60	34
✓	-	46	7	-	282	121
✓	-	-	4	1	50	10
✓	-	14	4	-	377	-
-	-	-	-	-	-	-
No	2	-	2	-	13	-
No	5	-	7	4	345	25
✓	-	-	15	15	6000	-
No	94	-	15	5	431	69
✓	16	126	11	0	1282	-
✓	-	20	3	2	100	35
✓	1	-	2	2	211	188
✓	-	-	3	-	120	10
No	-	-	1	0	3	-
-	4	24	2	1	58	7

Annex 2. Consolidated results framework for 2013 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)			
Countries with 4 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**Availability of basic EmONC: national number of facilities**	**Availability of comprehensive EmONC: national number of facilities**	**Geographic distribution: proportion of subnational areas with the required number of EmONC facilities (reported as proportion or %)**	**Proportion of all births in EmONC facilities, %**
Afghanistan (M, F)	–	–	–	–
Bangladesh (M, F)	114	105	–	18.7
Cameroon (M, F)	61	32	1/10	–
Central African Republic (F)	–	–	–	–
Chad (M, F)	35	20	12/23	4.6
Congo (F)	1	9	1/12	50
Democratic Republic of the Congo (M, F)	5 (Kinshasa, Bas Congo and Bandundu provinces)	4 (Kinshasa, Bas Congo and Bandundu provinces)	–	25
Eritrea (F)	32	12	100%	34
Guinea (F)	3	7	–	–
Guinea-Bissau (F)	–	7	–	44
Kenya (F)	–	–	–	42
Lao People's Democratic Republic (M, F)	20	5	1/17	50
Liberia (M, F)	–	–	–	–
Mali (M, F)	81	61	–	55
Mauritania (F)	5	7	1/13	–
Mozambique (M, F)	35	33	28.9%	19
Namibia (M, F)***	–	–	–	–
Nepal (M, F)	153	123	–	28
Niger (M, F)	83	38	1/8	29
Nigeria (M, F)	–	–	–	–
Pakistan (M, F)	–	–	–	–
Rwanda (M, F)	442	44	30/30	–
Senegal (F)	46	11	1/14	80
Sierra Leone (M, F)	5	8	–	55.9
Somalia (F)	21 (Somaliland and Puntland)	22 (Somaliland and Puntland)	–	25 (Somaliland)
Timor-Leste (M, F)	10	5	100%	–
Yemen (M, F)	466	61	17/23	–

UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)				MHTF OUTPUT 6 COUNTRY INDICATORS		
Met need for EmONC, %	Direct obstetric case fatality rate, %	Neonatal mortality (intrapartum and very early neonatal deaths), per 1000	Proportion of births with Caesarean sections as a proportion of all births, %	Mandatory notification and surveillance of maternal deaths	Routine practice of maternal death audits/reviews	Confidential enquiries system for maternal deaths in place
-	-	-	-	In Progress	In progress	In progress
24.4	3	2.1	11.6	Partial	Partial	No
-	-	-	4	✓	No	No
-	-	-	-	✓	-	-
4.3	12.4	-	0.3	✓	✓	No
19.8	5.2	20.9	3.5	✓	✓	-
2.4	1.6	4	7.6	No	✓	✓
-	44	-	-	✓	✓	✓
-	7	33	2	✓	✓	✓
-	3	-	7	✓	-	-
-	-	-	5	✓	✓	-
13.9	13	4.4	2.6	✓	✓	✓
31.3	-	19.6	7.3	✓	Partial	No
7.7	3.8	35	-	✓	No	No
19.8	2	-	2.5	No	No	No
13	2.6	7	3	✓	✓	✓
-	-	-	-	-	-	-
19	0.17	33	5.9	No	Partial	No
19.6	1.6	24	2	✓	✓	No
-	-	-	-	✓	Partial	Partial
-	-	55	-	-	✓	-
-	-	-	-	✓	✓	✓
-	< 1	35	5	✓	✓	No
-	-	-	1.9	✓	✓	Partial
30 (Somaliland)	0.9 (Somaliland)	17	0.7 (Somaliland)	-	-	-
2.9	-	-	-	✓	Partial	No
10	<2	-	-	-	-	-

Annex 2. Consolidated results framework for 2013 *(continued)*

	MHTF OUTPUT 7 COUNTRY INDICATORS	
Countries with 4 years of implementation **(M) and (F) indicate MHTF funding for midwifery and/or fistula activities**	**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)	–	–
Bangladesh (M, F)	–	–
Cameroon (M, F)	5	–
Central African Republic (F)	–	–
Chad (M, F)	5.6	–
Congo (F)	–	–
Democratic Republic of the Congo (M, F)	–	–
Eritrea (F)	–	–
Guinea (F)	–	–
Guinea-Bissau (F)	–	–
Kenya (F)	–	–
Lao People's Democratic Republic (M, F)	–	–
Liberia (M, F)	10.6	–
Mali (M, F)	36.6	–
Mauritania (F)	4.6	–
Mozambique (M, F)	7	–
Namibia (M, F)***	–	–
Nepal (M, F)	6	36.2 USD million
Niger (M, F)	6.28	–
Nigeria (M, F)	5.7	–
Pakistan (M, F)	–	–
Rwanda (M, F)	–	–
Senegal (F)	8.04	–
Sierra Leone (M, F)	9.7	–
Somalia (F)	–	–
Timor-Leste (M, F)	–	–
Yemen (M, F)	5	35.9 USD million

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

In the five years since its inception, the Maternal Health Thematic Fund, which includes UNFPA's Midwifery Programme and the Campaign to End Fistula, has invested heavily in strengthening health systems and providing technical support for maternal and newborn health in all the supported countries.

Overall results during the first phase of the MHTF (2008-2013)

Emergency Obstetric and Newborn Care (EmONC)

- ✓ The MHTF has supported EmONC needs assessments and post-assessment implementation guidance and interventions in **34 countries**;
- ✓ Recommendations derived from EmONC needs assessments have been used for evidence-based planning and implementation of maternal and newborn health services in **15 countries**, and district-by-district scale-up plans are currently being developed in **19 countries**.

The Midwifery Programme

- ✓ Midwifery gap analyses/needs assessments have been completed in **33 countries**;
- ✓ Results from gap analyses/needs assessments have been used for planning and management of the midwifery health workforce in almost all **33 countries**;
- ✓ Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies have been developed or strengthened in **33 countries**;
- ✓ Nine innovative, multimedia e-learning modules and a complementary Implementation Guide have been launched and disseminated in **over 30 countries** to support training in essential lifesaving skills;
- ✓ National Midwifery Councils (either stand-alone or included in nursing) are present and supported in **28 countries**;
- ✓ **Two hundred midwifery training institutions** are currently supported by the Midwifery Programme, with capacity to train **8,000** to **10,000** midwives annually.

The Campaign to End Fistula

- ✓ Currently supports approximately **half of all fistula surgical repairs** globally;
- ✓ Facilitated training of more than **3,900** healthcare workers, including surgeons, nurses, midwives and community health workers;
- ✓ Provided social reintegration services to **8,960** women and girls surgically treated for obstetric fistula.

Maternal Death Surveillance and Response

- ✓ Since the start of its involvement in late 2011, the MHTF has contributed to the institution of mandatory notification of maternal deaths in **30 countries**, and the adoption of surveillance and response as a framework for the elimination of preventable maternal deaths in **18 countries**.

During its second phase the MHTF will continue to strengthen national capacity to improve maternal and newborn health, with a focus on equality, quality and accountability of the interventions, to ensure a substantial and sustained impact on reproductive, maternal and newborn health.

No woman should die giving life.

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