The Maternal Health Thematic Fund

Improving maternal health: Surging towards the 2015 deadline

Annual Report 2014

UGANDA 2014

Twenty-seven year old Rose Yangu shows off her bundle of joy that she delivered 24 hours earlier at Panyandoli Health Centre in the UNFPA-supported Kiryandongo Refugee settlement.

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

Cover photo:
© Evelyn Matsamura Kiapi, UNFPA.
Winner MHTF AR 2014 photo competition

Uganda 2014: Twenty-seven-year-old Rose Yangu shows off her bundle of joy that she delivered 24 hours earlier. She has named her baby Eve, meaning "giver of life." Rose Yangu fled the conflict in South Sudan in June 2014 when she was five months pregnant. She travelled on foot all the way from Kajo Keji in the Central Equatoria Region of South Sudan into Uganda. She says she was well received at the Dzaipi reception centre in Uganda and given special attention because of her condition before she was transferred to a health centre. At the advice of a health worker, she attended two more antenatal visits before delivering at Panyandoli Health Centre in the UNFPA-supported Kiryandongo Refugee settlement where she now lives. Today, she advises all pregnant women to deliver their babies at a health centre to ensure a safe birth.

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Acknowledgements

Progress is best achieved through partnerships, and UNFPA wishes to extend its appreciation for its close partnerships with national governments and donors, other UN agencies and civil society organizations, as well as development and private sector partners in supporting the Maternal Health Thematic Fund to contribute to the realization of Millennium Development Goal 5.

We acknowledge, with gratitude, the support that has been generated to strengthen sexual and reproductive health from multiple donors. In particular, we would like to thank the governments of Australia, Austria, 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 also want 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. A special note of appreciation is extended to our many individual donors and to UN Trust Funds and Foundations.

We also would like to extend our sincere appreciation to UN colleagues around the globe in UNAIDS, UNICEF, UN Women, the World Bank Group and the World Health Organization, who in collaboration with UNFPA are making a stronger and healthier partnership possible through the H4+ and through the French and Canadian grants promoting maternal, newborn and child health, known as the Muskoka Initiative. Our thanks also extend to UNFPA colleagues, whose continuous efforts at country and regional levels help support the improvement of maternal health, and who also participated in a photo contest arranged for this publication.

Our collaborating partners play significant roles as champions and technical experts in sexual and reproductive health and reproductive rights issues. Their collaboration and contributions are much valued. These partners include the International Confederation of Midwives, International Federation of Gynecology and Obstetrics, International Society of Obstetric Fistula Surgeons, Columbia University's Averting Maternal Death and Disability Program, Johns Hopkins University, Jhpiego, Guttmacher Institute, University of Aberdeen, 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 and valued partnerships.

Acronyms & Abbreviations

AFD . . . . . Agence Française de Développement (French Development Agency)
AMDD . . . . . Averting Maternal Death and Disability Program (Columbia University)
CARMMA . . . . Campaign on Accelerated Reduction of Maternal Mortality in Africa
CCBRT . . . . . Comprehensive Community Based Rehabilitation in Tanzania
CDC US . . . . . Centers for Disease Control and Prevention
CEFOREP . . . . Centre Régional de Formation et Recherche (Senegal)
DFID . . . . . Department for International Development (United Kingdom)
EmONC . . . . . Emergency Obstetric and Newborn Care (B=Basic; C=Comprehensive)
FIGO . . . . . International Federation of Gynecology and Obstetrics
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 Group 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
MDG . . . . . Millennium Development Goal
MDSR . . . . . Maternal Death Surveillance and Response
MHTF . . . . . Maternal Health Thematic Fund
MMR . . . . . Maternal Mortality Ratio
MNH . . . . . Maternal and Newborn Health
MRMR . . . . . Mano River Midwifery Response
MSF . . . . . Médecins sans Frontières
NGO . . . . . Non-Governmental Organization
RIF . . . . . Results Indicators Framework
RMNH . . . . . Reproductive, Maternal and Newborn Health
RMNCAH . . . . Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA . . . . . Skilled Birth Attendants
SIDA . . . . . Swedish International Development and Cooperation Agency
SRH . . . . . Sexual and Reproductive Health
SoWMy . . . . . State of the World's Midwifery Report
STIs . . . . . Sexually Transmitted Infections
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

UNFPA's Maternal Health Thematic Fund (MHTF) supports critical interventions in countries with high maternal mortality and morbidity to strengthen health systems and ensure that women and adolescent girls have quality maternal health services when they need them.

Thanks to the Fund, more women have access to a skilled birth attendant, and there are more opportunities for preventing obstetric fistula and for reconstructive surgery for fistula survivors to restore their dignity, health and hope. While working to help ensure that no woman dies giving life, the Fund also supports efforts to ensure that a woman's tragic death in childbirth does not go unregistered, un-acted-upon or quietly accepted.

The MHTF works in tandem with our Global Programme to Enhance Reproductive Health Commodity Security to help countries enable women and girls to make fundamental decisions about their own bodies, attain the highest possible standard of sexual and reproductive health and exercise their reproductive rights.

This annual report highlights the Fund's critical contributions in 2014: from the training of 16,000 midwives, to supporting 10,000 surgical fistula repairs, to the finalization of national surveys on emergency obstetric and neonatal care, to South-South collaboration to improve maternal death surveillance and response, to the piloting of activities for first-time young mothers, a new focus area for the Fund.

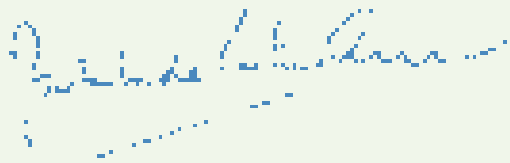
None of this would be possible without the support of our partners, primarily our national and local partners that make this positive change happen for women and girls on the ground. But partnerships at all levels are necessary for success. Key partnerships for the Fund include the UN Secretary-General's Every Woman, Every Child initiative; the H4+ partnership (UNAIDS, UNICEF, UN Women, World Bank Group, WHO and UNFPA), Family Planning 2020 and others.

Let me also take this opportunity to thank all our donors — Germany, Iceland, Luxembourg, Spain, Friends of UNFPA and Sweden, the main donor of the trust fund.

Millennium Development Goal 5 to improve maternal health remains an unfinished agenda, but we have made significant progress. By enabling UNFPA to target financial, material and human resources to countries with the highest needs, the MHTF has contributed to halving maternal mortality levels since 1990. Maternal death has become unacceptable; necessary and effective interventions have been documented; programme implementation is happening on the ground; and the lives of women and newborns are being saved.

As we enter the post-2015 era, the Fund will continue to accelerate positive change through the emerging Sustainable Development Goals, which confirm universal sexual and reproductive health, including maternal health, as a key global target for the health and well-being of individuals and for the sustainable development of nations.

We can end preventable maternal deaths in our lifetime. We know what we need to do. We at UNFPA will continue to intensify action in support of women's and adolescent girls' health and well-being to ensure that no woman is left behind. Working together with our partners, I am confident that we will deliver a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.



Introduction

Following six years of implementation (2008-2013), the Maternal Health Thematic Fund (MHTF) entered its second phase in 2014. A new Business Plan for 2014-17 was developed with a strengthened Results Indicators Framework (Annex 2) linking the outcomes of the MHTF directly to the achievement of UNFPA's Strategic Plan 2014-17.

The year 2014 was characterized by a reinforced focus on critical intervention areas with a strong emphasis on results that included the establishment of baseline data for the MHTF Results Indicators Framework.

Hence, the areas of Midwifery; Emergency Obstetric and Newborn Care (EmONC); Obstetric Fistula; and Maternal Death Surveillance and Response (MDSR) remain essential features of the MHTF focus, ensuring a holistic approach to improved maternal and newborn health.

In addition, as a result of the alignment of the MHTF to UNFPA's Strategic Plan, the MHTF added a new focus area: addressing the needs of first-time young mothers, a particularly vulnerable group in the context of maternal health. First-time young mothers — often still children themselves — face increased vulnerabilities during pregnancy, childbirth and caring for their newborn.

Essential Features of the MHTF

- Midwifery;
- Emergency Obstetric and Newborn Care (EmONC);
- Obstetric Fistula;
- Maternal Death Surveillance and Response (MDSR);
- First-Time Young Mothers.

In lieu of a traditional executive summary, the MHTF Annual Report 2014 will begin with an overview, highlighting the results and achievements of the Fund, progress realized as it has moved into its second phase and the application of strengthened management tools.

Individual chapters in this report highlight activities and results on the ground within each of the four focus areas of Midwifery, EmONC, Obstetric Fistula and MDSR. Each of these chapters starts with an overview of key highlights and results. The financial overview provides details on income and expenditure of the Thematic Fund. Based on the current status of the MHTF, as documented in the report, the concluding chapter looks at challenges and the way forward, including in the context of the post-2015 development agenda; it also discusses the importance of continued MHTF support in assisting countries most in need with specific and critical reproductive health, including maternal and neonatal health interventions, in the changing global environment.

Overall, the MHTF 2014 report shows how MHTF activities and results have not only contributed to accelerating efforts to realize MDG5 but have also demonstrated that targeting high-burden countries with strategic and complementary evidence-based, high-impact interventions backed with sufficient and sustainable financing can make substantive inroads in reducing maternal mortality and morbidity; in building capacity; and in strengthening health systems to meet prioritized health needs. Thus the MHTF is very well positioned to contribute to the global movement for the post-2015 Sustainable Development Goals.

Mother and child in a village in Laos, where health advisors do outreach activities.

Overview 1

Highlights

The Maternal Health Thematic Fund is UNFPA's flagship programme for accelerating improved maternal and newborn health and the only one of its kind in the UN system that focuses on a key area of reproductive health while intensively contributing to strengthening health systems. The MHTF enables a targeted response to maternal mortality and morbidity across several dimensions, using sound evidence and state of the art knowledge while contributing to build the capacity of countries to create a functioning health system.

As a thematic fund, the MHTF allows UNFPA to rapidly channel financial, material and technical resources directly to countries most in need to accelerate the prevention of maternal and newborn deaths and stillbirths through targeted support.

As a provider of technical expertise, the MHTF transfers know-how from country to country, contributing to building national capacity for robust health systems.

As a comprehensive programme, the MHTF conducts activities that directly contribute to the achievement of the goals of the UNFPA Strategic Plan; to the MDG5 targets; and to maintain its strong position to contribute to the global movement for the post-2015 Sustainable Development Goals.

As a funding facility, the MHTF serves as a strategic funding mechanism that allows UNFPA to seek new and additional resources from donors with the specific goal to support improvements in maternal health and newborn health.

And as a partner, the MHTF works closely with governments, civil society organizations, academic institutions, the private sector, UN entities and other maternal health programmes to ensure the 3 Cs — coordinated, complementary and catalytic high-impact responses for improved maternal health.

Results:

In 2014, **42 countries received MHTF funding** for maternal health and/or fistula activities.

In these countries, **MHTF continued to contribute to strengthening health systems, national reproductive health policies and strategies and** including those focused on maternal and newborn health, as well as on planning, partnership, collaboration and the integration and implementation of programmes

New maternal mortality numbers released in 2014 showed **that six countries supported by the MHTF in phases I and II impressively achieved the MDG5 goal** of 75 percent reduction in maternal mortality ahead of the MDG deadline.

MHTF supported over 65 countries in implementing midwifery programmes, some through regional support. Since 2009, MHTF has helped train over 35,000 midwives, of which 16,000 received pre- or in-service training in 2014 alone.

A total of 36 countries have conducted needs assessment for EmONC and are improving their ability to act on this data.

MHTF has supported regional and national development of EmONC monitoring systems covering 27 countries.

A total of 57,000 fistula surgical repairs have been directly supported by the MHTF, including more than 10,000 in 2014, as partnerships and technical advances have enabled many more repairs to be performed.

All 42 MHTF countries have implemented components of Maternal Death Surveillance and Response (MDSR) to learn from and act on maternal deaths in order to prevent similar incidences in the future and to strengthen accountability between the service providers and community.

A new and innovative Results Indicators Framework and other management tools were developed to track progress and follow results in a more effective, accumulative and transparent way.

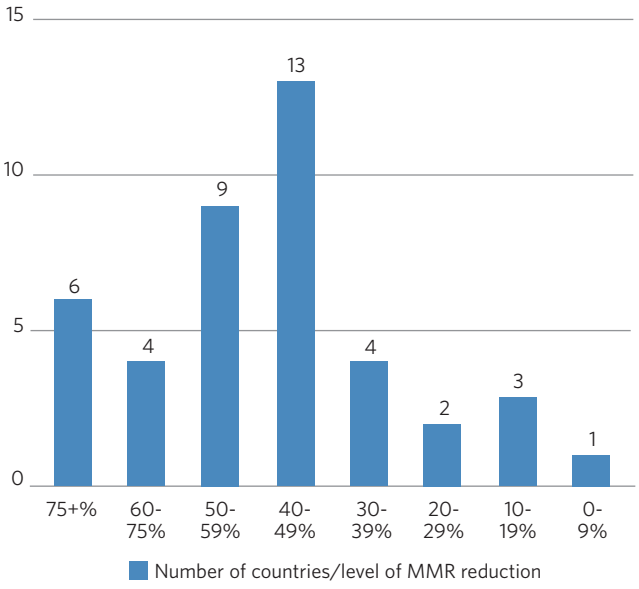
Overview

The world is facing a pivotal moment in global development, as the MDGs, which have demonstrated the power in mobilizing around a clearly defined development agenda, will finish at the end of 2015, and a new era of sustainable development is soon to be unveiled. Hence, 2014 constituted the penultimate year to enhance the gains already realized, accelerate efforts to reach the eight goals and to particularly address those goals lagging the furthest behind. In this context, MDG5, to improve maternal health, aimed for a 75 percent reduction in maternal mortality levels as compared to 1990 (target a); and universal access to reproductive health (target b).

In reviewing MDG5 progress, 2014 saw the release of new data on maternal mortality by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division. The new numbers showed that between 1990 and 2013, the global level of maternal mortality declined by 45 percent to 289,000 maternal deaths annually. Sixty-three percent of these deaths took place in MHTF-supported countries, underscoring that the Fund strategically targets countries most in need.

The estimates also showed that numerous countries have impressively reached MDG5 before the 2015 deadline. Among MHTF-supported countries these included Cambodia, Eritrea, Lao People's Democratic Republic, Nepal, Rwanda and Timor-Leste. Because addressing maternal health is so critical for building functioning health systems, the achievement of the MDG5 places these countries on a path of effectively building a basis for robust, sustainable health systems that address these and other emerging health issues in the future. Other MHTF-supported countries have also achieved significant reductions in their maternal mortality – see Figure 1.

Figure 1. Levels of reduction in maternal mortality among MTHF-supported countries



When quality Maternal and Newborn Health (MNH) services help pregnant women and newborns survive, those services can also prevent many more women who suffer from maternal morbidity, such as obstetric fistula. Moreover, saved women equals saved children — not only infants who survive birth but also siblings who are saved from distress, deprivation and potentially being orphaned. With their mothers alive and healthy, the MHTF has increased the chances of these children staying in good health, going to school, growing and developing, and to enjoy better prospects for the future and that of their family and community.

Furthermore, MHTF's strategic, evidence-based investments in promoting improved MNH at the global level, including strengthening health systems; equipping facilities with skilled birth attendants; training of fistula surgeons; and investing in improved data systems for enhanced monitoring and continuous quality improvement of these services have yielded significantly improved outcomes. This was the case not only in terms of immediate results, but also in lives saved well into the future, effecting positive intergenerational impacts.

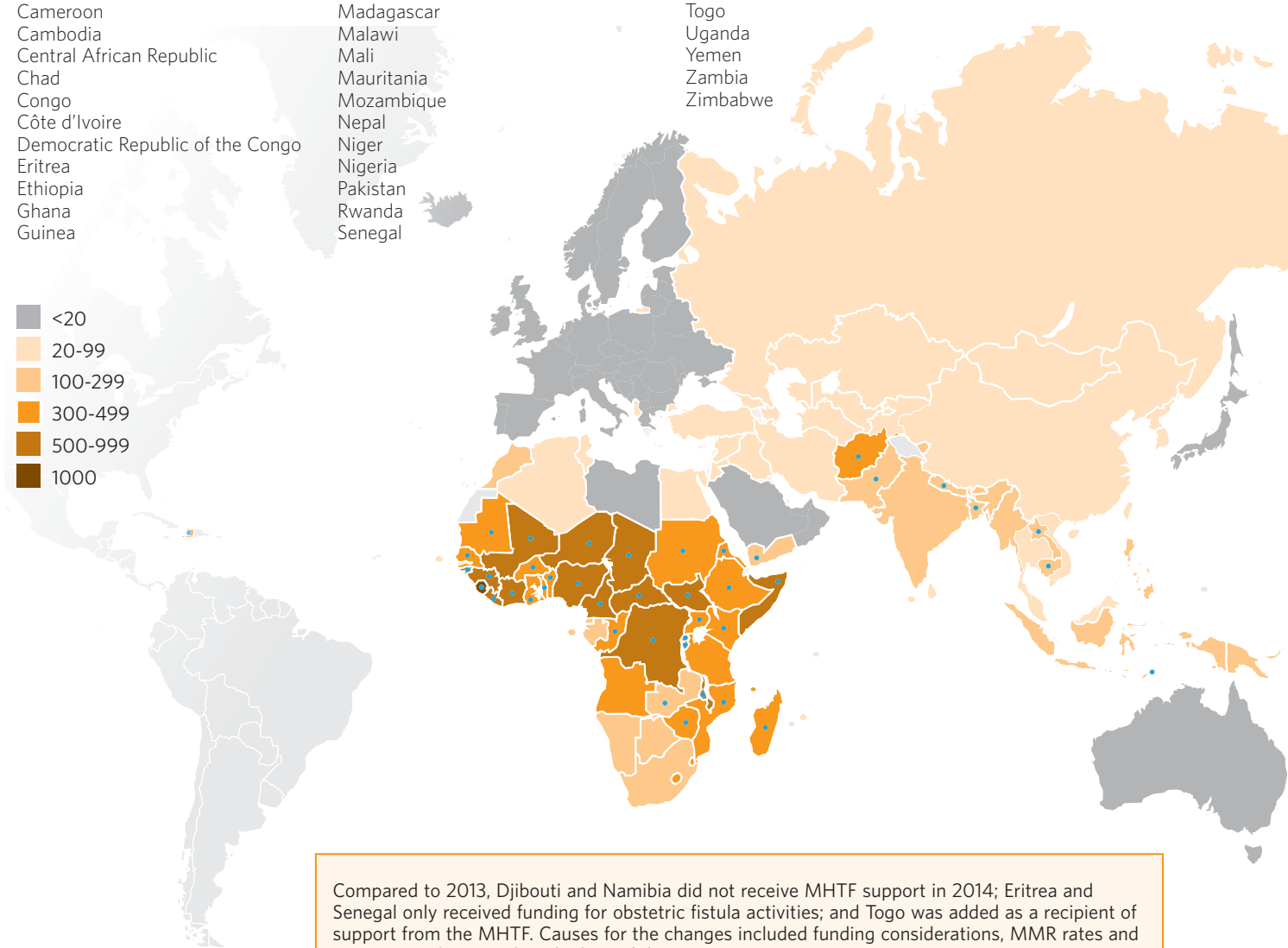
Still, despite significant progress, most countries were not on track to reach MDG5 in 2014. Severe inequalities in health persist among and within countries, leaving the poorest and most vulnerable women and girls without access to quality, lifesaving health services on demand, thus impacting adversely on their health and well-being. Insufficient progress towards MDG5 a and b targets was often a result of inadequate focus on specific interventions and translating such a focus into implementation at scale and equitably to reach all women and girls in need, even those hardest-to-reach.

Moreover, there is often insufficient data to monitor and evaluate the impact of maternal and newborn health programmes to determine whether they are making a difference.

Figure 2. Maternal Mortality Rate 2013 and MHTF countries

MHTF Countries:

Afghanistan
Bangladesh
Benin
Burkina Faso
Burundi
Cameroon
Cambodia
Central African Republic
Chad
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Eritrea
Ethiopia
Ghana
Guinea
Guinea-Bissau
Haiti
Kenya
Lao People's Democratic Republic
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Nepal
Niger
Nigeria
Pakistan
Rwanda
Senegal
Sierra Leone
Somalia
South Sudan
Sudan
Timor-Leste
Togo
Uganda
Yemen
Zambia
Zimbabwe



Compared to 2013, Djibouti and Namibia did not receive MHTF support in 2014; Eritrea and Senegal only received funding for obstetric fistula activities; and Togo was added as a recipient of support from the MHTF. Causes for the changes included funding considerations, MMR rates and priorities in the annual work plans of these countries.

Besides these public health determinants – the wider social, political and economic factors such as gender equality, human rights, education, economics, governance and political stability also affect health and health care conditions.

In 2014, the MHTF entered into a second phase with a new business plan, a new results indicators framework and enhanced management tools all fully aligned with UNFPA's Strategic Plan 2014-17. Based on lessons learned and capitalizing upon achievements from MHTF Phase I, the key activities for MHTF Phase II were identified based on their ability to scale up high-impact interventions and deliver results, i.e., those proven to be effective on maternal and newborn mortality and morbidity and able to be monitored for their impact and equity.

It is the ambition of MHTF Phase II to enhance the reach of high-impact interventions in countries, thus ensuring quality, equality and accountability by building national capacity to both implement and sustain these actions.

MHTF Phase II – The New Business Plan

The extension of the MHTF into a second phase was based on these four considerations:

1. Two independent evaluations—one looking at UNFPA support to maternal health generally, including a detailed analysis of the contribution of the MHTF, and looking at the Campaign to End Fistula—pointed to the catalytic and strategic value of the MHTF;

2. The MHTF has an established system of operations that covers both technical support and extensive partnership that is worth building and expanding further interventions on;

3. The MHTF provides targeted, strategic contributions to critical areas of the UNFPA mandate, specifically UNFPA's 'bulls eye'– achieving universal access to sexual and reproductive health, realizing reproductive rights and reducing maternal mortality to accelerate progress on the ICPD agenda;

4. The unfinished agenda of MDG5 and the need to address the continued unacceptably high MMR in many MHTF countries.

The MHTF is fully aligned with UNFPA's Strategic Plan 2014-17; the overarching goal of MHTF Phase II is the implementation of outcome 1, output 3 of the Strategic Plan integrated results framework, namely "increased national capacity to deliver comprehensive maternal health services."

To support this goal, the MHTF business plan aims to achieve six outcomes for the MHTF:

1. Strengthened national capacity to implement comprehensive midwifery programs;

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

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

4. Enhanced national capacity for maternal death surveillance and response (MDSR);

5. Enhanced attention for pregnant adolescents and adolescent mothers;

6. Strengthened coordination and management of the MHTF.

As for the first five outcomes — related to key intervention areas — **the raison d'être for the MHTF is the added value it can bring as a global programme, particularly supporting countries to escalate efforts to improve maternal and newborn health and reproductive health overall.**

With its strong, strategic partnerships and state of the art technical expertise, the MHTF helps to move the field of maternal health forward at the technical level. This is exemplified, for instance, in the EmONC guidance notes developed in partnership with WHO.

Through global advocacy, the MHTF has helped advance the global agenda and political commitment on maternal health; for instance, when the United Nations General Assembly (UNGA) adopted a resolution in 2014 calling for an intensification of efforts to end obstetric fistula, which was signed by over 150 countries.

At the regional level, through MHTF's support to key strategic initiatives such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), drawing from key priority areas in the African Union Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa (2005) and the Maputo Plan of Action (2005). All together, 44 countries have launched CARMMA with two countries launching in 2014 (Madagascar and Somalia).

By generating and disseminating much-needed data (as a key building block for evidence-informed policies and programming), the MHTF raises awareness and facilitates change; for instance, in 2014 it launched the second State of World Midwifery Report with key data readily available.

And at both the regional and the global level, the MHTF is a vehicle for exchange of best practices, innovative approaches and lessons learned, enabling positive South-South collaboration through key regional meetings of national teams sharing experiences in MDSR and numerous inter-country exchanges to build capacity among fistula surgeons in high-burden countries.

The Results Indicators Framework

To further strengthen the focus on results and drawing on the experience of MHTF Phase 1**, a Results Indicators Framework (RIF) to measure progress towards the outcomes identified in the MHTF Business Plan Phase II was developed and finalized in 2014**. The establishment of baseline data was an important MHTF activity with results noted in Annex 2 of this report.

The **RIF, a critically innovative tool, allows the MHTF to record and report results progressively.** More important, **the RIF helps countries to generate necessary information to both inform and improve programmes effectively, such as monitoring the development of EmONC facilities; following the level of deployment of midwives in facilities; or tracking the number of fistula cases repaired**, to highlight a few instances.

As evident from Chapter Six on Resources and Management, the RIF also allows data to be disaggregated by outcomes rather than by the main intervention areas as previously done. Thus, when it comes to results, scope of activities and expenditure disaggregation, the RIF offers more details than in previous years.

New Management Tools

In 2014, almost all MHTF countries elaborated the 2014 annual work plan in a consolidated manner, i.e., including other sources of funding. This process will be further integrated with the new RIF in 2015, as it is applied to plans to implement interventions in maternal and newborn health. Furthermore, the formats of midyear and annual reports were modified to enable more detailed monitoring and enhanced technical support of the implementation of the planned activities.

In 2014, the MHTF and the GPRHCS integrated their annual report system from country offices, so that countries should only submit one report for these two programmes. In addition, enhanced reporting provided more in-depth analysis and results orientation. Furthermore in 2014, more integration took place among the MHTF, the GPRHCS, United Budget, Results and Accountability Framework (UBRAF/UNAIDS) and the UNFPA-UNICEF Joint Programme for the acceleration of the abandonment of FGM. From 2015, countries will submit only one annual plan for the four UNFPA thematic funds.

Gauri, Nepal. Midwife Swarswati Oli Anm provides antenatal care for Nainai Mati Raidass (20) who is expecting her first child.

Nicolas Axelrod/Ruom for UNFPA, 2014

The Key Intervention Areas of the MHTF

The Midwifery Programme

Skilled birth attendance during pregnancy and childbirth play a critical role in ensuring the health and well-being of a woman and her newborn. Midwives are trained to provide this essential health care from the pre-pregnancy and antenatal periods to postnatal follow up; midwives can accompany women through the pregnancy, identify and manage complications and ensure timely referrals in emergencies. The Midwifery Programme supports countries with high maternal mortality rates in improving the availability of more, better trained midwives; ensures that supportive midwifery workforce policies are in place; and that midwives are deployed in areas where they are most needed.

Improving the quality of midwifery training is a key focus area and includes, among others goals, ensuring that countries use a WHO/International Confederation of Midwives (ICM) competency based curriculum; that midwifery schools are well equipped with training materials, books and models; that midwifery tutors have proficient clinical and teaching skills; and that midwives who are already in the field can improve their skills through in-service trainings.

E-learning modules on all key lifesaving skills and family planning have been developed for global use in collaboration with partners like Intel and Jhpiego and are now being piloted. The MHTF also works with countries to ensure that they have strong midwifery associations and that midwifery is recognized as a profession in its own right.

Supported by the MHTF, UNFPA published the State of the World's Midwifery Report 2014 in collaboration with 30-plus partners using data from the report for global advocacy to enhance national investments in midwifery. This effort is completed with other activities related to the midwifery workforce, in particular assisting countries in assessing and planning for midwifery development. More about the midwifery programme is on page 11.

Emergency Obstetric and Newborn Care (EmONC)

The availability of emergency obstetric and newborn care services linked through well-functioning referral systems that connect communities to health centers and hospitals are a basic necessity for improved maternal health. In 2014, in addition to strengthening the MNH/EmONC services network and quality of care in all supported countries, the MHTF continued its work with partners to develop effective, relevant guidance on how to best assess, develop and monitor MNH services with the full package of EmONC interventions. In MHTF Phase I, a key focus was on supporting countries in conducting EmONC needs assessments, a key step of data collection and analysis.

While this work continues, a new focus in MHTF Phase II is on data: strengthening national capacities in the use of data for planning and programming for MNH services (Data to Action Continuum). More information on EmONC activities is on page 23.

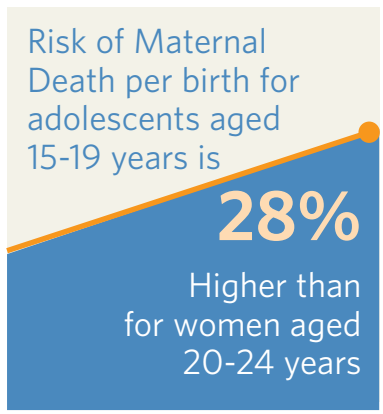
The Campaign to End Fistula

As long as health systems fail to adequately meet the needs and fulfill the human rights of women to the highest attainable standard of maternal health, women will not only risk dying in childbirth, but will also suffer from the devastating condition of obstetric fistula. This condition leaves women incontinent after experiencing prolonged obstructed labour without receiving adequate emergency obstetric care. In most cases, obstetric fistula is both preventable and treatable.

The Campaign to End Fistula brings together hundreds of partners to do just that: prevent new cases of fistula and help the estimated two-million-plus women who suffer from the stigmatizing condition today. In 2014, fistula was once again brought to the attention of world leaders when the UN Secretary-General released his report "Supporting Efforts to End Obstetric Fistula," and the United Nations General Assembly then adopted a resolution on "Intensification of efforts to end obstetric fistula." The campaign brought further attention to the subject through numerous activities on the second International Day to End Obstetric Fistula.

The MHTF continued to directly support thousands of surgical fistula repairs and the exchange of knowledge and experience among both fistula surgeons and fistula survivors. Also in 2014, work continued in UNFPA to further develop, refine and roll out the next generation of fistula kits with expert advice from some of the world's leading doctors connected to the International Society of Fistula Surgeons (ISOFS). More on the Campaign to End Fistula is on page 31.

Maternal Death Surveillance and Response (MDSR)



Based on experience from work done in implementing systematic maternal death reviews, MDSR holds the promise of registering, understanding and acting upon each maternal (and perinatal) death, with the aim to avoid similar future cases at facility and community levels and to provide governments and all stakeholders with an overview of maternal death levels and causes. Therefore the MHTF actively advocates for the introduction of MDSR in countries and provides technical guidance to this end. In 2014, the MHTF worked on the development of new indicators enabling better use of MDSR data for national level reviews. Furthermore, a questionnaire to monitor the MDSR system was developed by WHO and UNFPA to measure progress and facilitate the further implementation of MDSR systems. On an ongoing basis and with significant activities in 2014, the MHTF provides technical assistance to countries on MDSR implementation through the UNFPA regional offices; enables the exchange of experiences on MDSR between countries; and supports the upgrading of national capacities on MDSR. More on MDSR is on page 39.

First-Time Young Mothers – A New MHTF Focus Area

Girls and young women face increased risks of maternal mortality and morbidity from causes that are both biological and sociological in nature. For example, girls and younger women experience pre-eclampsia, eclampsia and prolonged and obstructed labour at higher rates. This requires that healthcare workers, including midwives, be trained to be extra alert to these conditions and to know how to diagnose and treat them. In many countries, girls and young women use existing services at lower rates than older mothers do. This may be due to past experiences (with poor quality services), financial barriers (lower income and less control over income), social barriers (low mobility and restrictions on leaving home), legal barriers (laws requiring consent of adults or spouses) or information barriers (no reliable sources of information on what is available).

The MHTF-supported countries that will work on this outcome will strategically address these barriers by two ways. The first strategy will be to make first-time young mothers (FTYM) a priority focus in national plans to improve their access to quality maternal health services. Interventions include:

- Collection, disaggregation and analysis of national statistics and data for improved understanding of the maternal health situation of the youngest mothers (including 10-14 years old);
- Strengthened policy dialogue and governmental commitment to prioritizing a) investments in the youngest mothers to improve equity of health investments and outcomes and b) ensuring that the youngest mothers and their needs are explicitly addressed in various national policies and strategies that impact their sexual and reproductive health and rights.

The second strategy is to develop innovative, scalable approaches to improving maternal health service use by first-time young mothers through, for instance, outreach programs targeted at this population. Such outreach could include:

- Developing and rolling out a training resource package for appropriate community health worker cadres as exists in Brazil, Ethiopia, India and Pakistan;
- Supporting the development and operationalization of intervention approaches that are particularly relevant to first-time young mothers, such as programmes that promote institutional delivery with targeted incentives, or that improve availability and use of maternity waiting homes. Both approaches are particularly appropriate for high-risk pregnancies, which tend to be more common among younger mothers;
- Programmes that promote targeted postpartum follow-up care including family planning services, or that facilitate longer-term support groups for first-time young mothers with a focus on newborn care, psychosocial care, nutrition etc.

As this is a new outcome area, it was piloted in just a few countries in 2014. In Liberia, UNFPA supported activities to provide safe maternal friendly health services for 260 first-time young mothers in two slum communities in Monrovia. These FTYMs were 13 to 24 years old (40 percent aged 13 to 19, 60 percent aged 20 to 24). Most were already in their second or third trimester at the time of recruitment into the program. While only 56 percent had had 4 antenatal visits (partly due to late entry into the program), 86 percent delivered with the assistance of skilled birth attendants. Fifty-six community health workers provided home-based visitations and safe pregnancy education messages to these young mothers. As a result of the Ebola crisis, which intensified during the second and third quarters of the year, some of the girls and young women (11 percent) had their deliveries attended by trained traditional birth attendants. All of them received postpartum starter kits after delivery. The kits consisted of clothes for both the mother and the newborn and were distributed at health facilities and community meetings. Other country examples include Madagascar, which used mobile strategies and community workers to target young mothers, and Sierra Leone with Teenage Mothers Clubs.

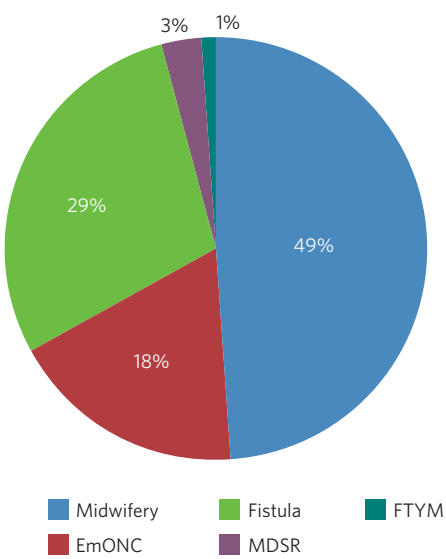
First-Time Young Mothers

With one in three adolescent girls in developing countries married or in a union before age 18, millions of girls become pregnant each year, and 7.3 million of them give birth before age 18. About 70,000 adolescents in developing countries die each year from complications during pregnancy and childbirth, and the risk of maternal death per birth is 28 percent higher for adolescents aged 15–19 years old than for women aged 20–24 years. Adolescent mothers are also at risk of severe reproductive morbidities, including obstetric fistula. Stillbirths and death in the first week of life are 50 percent higher among babies born to mothers younger than 20 years old than among babies born to mothers 20–29 years old. Given these facts, and considerations of equity, Phase II of the MHTF introduced an additional emphasis on adolescent and young mothers. In 2014, this new focus was piloted in a few countries.

Resources

The Maternal Health Trust Fund comprises two multi-donor funding streams: the Thematic Trust Fund for Maternal Health and the Thematic Fund for Obstetric Fistula. Since the programmatic merging of the two entities in 2009, more funds for both thematic areas are being channeled through the Thematic Trust Fund for Maternal Health.

Figure 3. Distribution of MHTF expenditures on key intervention areas.



Sylhet, Bangladesh. Dr. Narin checks on patients at the Fistula corner of the Sylhet Medical College. Lack of awareness about possibilities for treatment of obstetric fistula is widespread, stalling Bangladesh's efforts to eliminate the condition.

Nicolas Axelrod/Ruom for UNFPA. 2014

In 2014, the operating budget for maternal health increased by 29 percent as compared to 2013, to USD 24.6 million, while the operating budget for fistula decreased by almost 60 percent as compared to 2013, to USD 0.7 million.

In 2014, almost half (49 percent or USD 5.3 million) of all MHTF expenditure was accounted for by the midwifery programme (see figure 3). The Campaign to End Fistula accounted for 29 percent of MHTF (USD 3.1 million). Costs for EmONC activities amounted to 18 percent (USD 1.9 million) of MHTF expenditures. MDSR took up 3 percent (USD 0.3 million) and activities for first-time young mothers used 1 percent (USD 0.07), remaining relatively small in terms of costs as this is very much a new intervention.

The financial implementation rate — expenditures as compared to allocations — for the MHTF as a whole reached 94 percent in 2014 as compared to 93 percent in 2013, showing a rising trend of implementation despite challenges faced in countries such as humanitarian situations; for instance, the Ebola crisis in 2014. More on Resources and Management is on page 45.

In MHTF countries 183,000 women are dying every year, yet most of these deaths are preventable. This represents both a real tragedy and a golden opportunity to prevent such deaths.

The MHTF: Improving the Lives of Women and Adolescents, Building the Capacity of Functioning Health Systems

While the different key intervention areas of the MHTF are described individually in this report, it is important to underscore how they complement each other and are interlinked, and in practical terms how they could not be implemented separately. Indeed, well-functioning EmONC facilities with good referral systems would not function at all without the availability of skilled birth attendants (SBAs); and SBAs would have nowhere to work if there were no EmONC facilities. EmONC systems need to be continuously improved with the use of good data, as compiled by EmONC needs assessments and monitoring at the systems level, as well as that provided by MDSR – the investigation of each death for future improvement of services. Fistula prevention is a result of well-functioning EmONC services operated by SBAs. But fistula repairs also need to take place within the auspices of a larger health system. This is the case for all MHTF activities: not only do they support improved maternal health for women in need but they also support the strengthening of health systems as such.

As mentioned earlier in this overview, significant progress has been made in reducing maternal and newborn mortality and morbidity and stillbirths. But not enough has been done to reach the MDG 4 and 5 targets, which remain underachieved agendas. In MHTF countries 183,000 women are dying every year, yet most of these deaths are preventable. This represents both a real tragedy and a golden opportunity. Efforts to provide accessible, high quality maternal and newborn health services as well as access to family planning need to be strengthened towards scaling up.

The persistence of high levels of preventable maternal and newborn mortality and morbidity and stillbirths 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. Maternal mortality and morbidity also persists because of broader human rights violations facing women and girls, such as poverty, gender disparities and gender based violence, lack of schooling, child marriage and early childbearing, all of which impede the well-being and opportunities of women and girls.

But improvements in maternal health do not need to await improvements on all these other fronts; countries that have prioritized investments in maternal health have reached the MDG5 target even at low GDP rates. Besides, all of these factors are mutually reinforcing; improved maternal health, while a goal in its own right, is also a step in the right direction for human rights, for gender equality, for better health and schooling of children and for increased opportunities for women and girls.

The MHTF employs a human-rights based approach to save and improve lives of women and their families, particularly those with the greatest needs. Through partnerships and collaboration, the MHTF is part of the global efforts to achieve sexual and reproductive health and reproductive rights and gender equality for all women and girls, men and boys.

Lessons learned from MHTF funded activities at country level allow UNFPA to support effectively SRH/MNH evidence-based activities at global and regional levels, planning and implementing innovative ways of accelerating the ending of preventable maternal and neonatal mortality and stillbirths, and the unfinished MDG's agenda. MHTF supported the development of the Ending Preventable Maternal Mortality Strategy (EPMM) and country consultations to define the proposed 2030 targets for Maternal Mortality Ratio (MMR), and has been a leading voice/champion advocating strongly and systematically at global and national levels for ending preventable maternal morbidity—especially obstetric fistula.

The Midwifery Programme 2

Niger: A UNFPA-supported midwife holds a newborn after having assisted in a safe birth in northern Niger.
© Danielle Engel, UNFPA.

Highlights

The world needs midwives now more than ever. Investments in midwives can help avert two-thirds of maternal and newborn deaths. Midwives deliver more than just babies: they also provide lifesaving reproductive health information and services, including family planning and prevention of malaria and STI transmission of HIV from mother to child.

Countries with high prevalence of maternal deaths generally lack sufficient and adequately skilled midwives. This translates into a huge need for training new midwives and upgrading the midwifery skills of existing frontline health workers. Moreover, it is important to have midwives deployed in remote rural areas where their services are needed most. Doing so requires proper incentives, suitable policies and a supportive health infrastructure.

In addition, midwifery needs to be recognized as a profession in its own right by the health system and its users. Midwives need to be recognized as those who offer empathetic advice and key sexual and reproductive health services; and as those who have the capacity to recognize and act on maternal and newborn health complications to help save lives.

Results:

65 countries strengthened their midwifery services and workforce policies through direct or indirect support from the MHTF:

16,000 midwives
were educated and trained
(pre- and in-service), with the potential of annually assisting more than:

2.8 million safe births.

Bachelor degree programmes in midwifery were launched in Afghanistan, Burkina Faso, Somalia and Zambia.

Over 325 midwifery schools and training institutions were strengthened with books and training materials, with the potential of training more than 20,000 midwives annually.

Over 1,200 midwifery tutors upgraded their skills to provide competency-based education and training.

2,400 midwives upgraded their lifesaving skills using the nine innovative multimedia e-learning modules launched by UNFPA in partnership with Intel and Jhpiego.

The second State of the World Midwifery Report was launched to support policy dialogue, programme planning and advocacy.

A practitioner's handbook, the "Midwifery Programme Guidance," was launched and globally disseminated.

MHTF support was instrumental **in leveraging additional funds for midwifery** in South Sudan and the Sahel.

The Midwifery Programme

The UNFPA midwifery programme works to scale up investments in building a competent, well-trained and well-supported midwifery workforce in low-resource settings.

Launched in 2008, the programme entered its second phase in 2014, with enhanced civil society, H4+ and private sector engagement. Through the Maternal Health Thematic Fund (MHTF), over 65 countries received support for strengthening comprehensive midwifery workforce policies. By the end of 2014, UNFPA had 24 country midwifery advisers providing dedicated technical assistance to national stakeholders on midwifery strengthening.

Over 16,000 midwives received pre- and in-service education and training in 2014; the skills of over 1,200 midwifery tutors were upgraded, and over 325 midwifery schools and training institutions were enhanced with books, equipment and training models through MHTF support.

As a result of the sustained support and advocacy from the MHTF, midwifery is now recognized globally as a key workforce essential for improving maternal, newborn and adolescent health and ensuring access to universal health coverage. This has become evident from the more than 45 national commitments made towards midwifery since 2011, which the MHTF is helping countries achieve.

The MHTF key midwifery programmatic strategies include: Partnerships, Evidence Based Advocacy, Capacity Building and Innovations.

Global Highlights

Partnerships

The collaboration with the International Confederation of Midwives (ICM) entered its second phase in 2014, focused on strengthening midwifery in 22 countries in the Francophone Africa region.

Memorandums of Understanding (MoU) were signed with Amref Health Africa and Jhpiego to collaborate on addressing pre- and in-service education and training of midwives and other health workers and promotion of SRHR as well as family planning and adolescent and youth-friendly services using evidence-based, innovative, low-cost healthcare solutions.

H4+ partners continued to collaborate in 2014 to address social determinants and barriers to access of RMNCAH (Reproductive, Maternal, Neoborn Child and Adolescent Health) services in select countries: Benin, Burkina Faso, Chad, Democratic Republic of the Congo, Guinea, Mali, Sierra Leone, Togo, Zambia and Zimbabwe.

Partnership with Laerdal Global Health (LGH) on the Helping Mothers Survive (HMS) and Helping Babies Breathe (HBB)[1] programme continued to expand in 2014. UNFPA is among the free recipients of the innovative low-cost Mama and Newborn models and training materials obtained under the LGH "Buy One Gift One" free scheme. Forty-two composite sets of these essential training materials have been distributed at UNFPA-organized midwifery

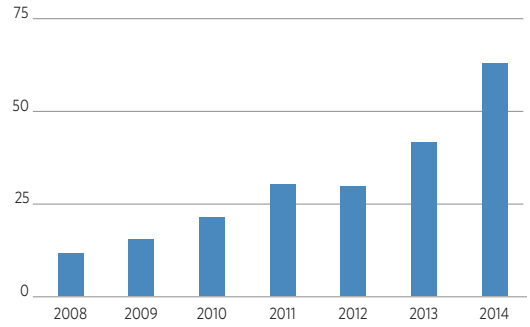
The Midwifery Programme at a Glance:

Objective: To ensure a maximum number of countries have comprehensive midwifery workforce policies based on global ICM and WHO global standards for midwifery education and regulation.

The **UNFPA Midwifery Programme** aims to build national capacities in:

- ICM/WHO competency-based midwifery training curriculum
- Development of strong regulatory mechanisms
- Strengthening and establishing midwifery associations
- Proactive advocacy with governments and stakeholders to encourage investment in quality midwifery services.

Countries supported in midwifery (directly or indirectly)



1 http://www.helpingmotherssurvive.org

trainings and donated to schools in countries in Africa and Asia in 2013 and 2014. By the end of 2014, 1,300 midwives and midwifery trainers had been trained in HMS and HBB using the models in 13 MHTF-supported countries.

Evidence Based Advocacy

Global advocacy proved invaluable to fostering national policy dialogue, generating a supportive environment and national resources for midwifery, and informing the planning of midwifery initiatives.

International Day of the Midwife

The global yearly celebration of the International Day of the Midwife (IDM) on 5 May again helped to draw national attention and visibility to the role of midwives and to encourage policymakers to scale up investments in midwifery. In collaboration with the national midwifery associations and other stakeholders, celebrations were vast, ranging from marches by midwives to debates on mass media and to free family planning, HIV, breast and cervical cancer screening camps, all generating much visibility and political commitment.

In Côte d'Ivoire, midwives provided free in-service trainings on family planning, conducted hundreds of cervical cancer and HIV screenings and led thousands of community sensitizations on SRH and family planning. UNFPA South Sudan distributed and pre-positioned USD 1 million worth of reproductive health kits and supplies in all 10 states. UNFPA Uganda organized a midwifery symposium to critically examine the status of midwifery in the country and developed a one-year roadmap. Madagascar held an "open day" at two health centres, where free family planning services and maternal health consultations were provided. In addition, Midwives in Madagascar provided training in EmONC to 300 new graduate midwives, oriented 1,350 high school and out-of-school youth on prevention of STI/HIV and early pregnancy, and sensitized media professionals on fistula prevention. Ethiopia launched its "Standards of Midwifery Care" and published the evaluation findings of the Accelerated Midwives Programme.

Midwifery Workforce Assessments

The Midwifery Workforce Assessments initiated in 2011 by the H4+ in response to the UN Secretary-General's Global Strategy for Women's and Children's Health, has enabled UNFPA to conduct assessments in Afghanistan, Bangladesh, Democratic Republic of the Congo, Ethiopia, Mozambique and Tanzania. These seek to assess the status of all midwifery workforce cadres (including doctors, nurses, obstetricians and community health workers) in countries with high maternal mortality rates. Similar assessments on a smaller scale were done in Benin, Guinea and Togo.

The assessments identify gaps in service availability, quality and accessibility, and can subsequently support the development and implementation of national costed RMNCH plans tailored to country needs. Bangladesh and Tanzania have published High Burden Country Initiative reports and are using the findings in their decision-making. An operational guidance that allows most countries to replicate this workforce assessment was released in 2014 by UNFPA.

UNFPA and the ICM Triennial Congress 2014

From 1-5 June 2014, over 4,000 delegates from a record 126 countries assembled in Prague, the capital of the Czech Republic, to participate in the 30th Triennial Congress of the ICM. UNFPA participated as a Gold Sponsor, serving as a main exhibitor at the event. The Congress was strategically used to: a) launch the State of the World's Midwifery

COUNTRY HIGHLIGHT

Lao PDR Attendance at the ICM Congress Motivates Midwifery

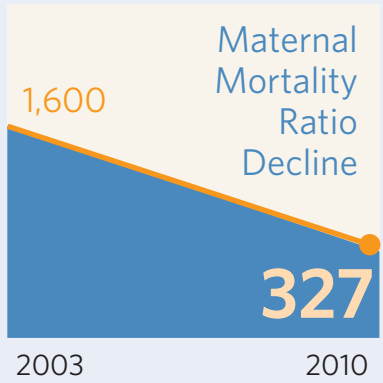
"The motivation that the midwifery focal points received from their participation at the ICM conference in Prague resulted in a number of advocacy activities and policy discussions at the national level. The Government of Laos has subsequently made several commitments to deliver high quality health services with the goal of improving women and children's health. The proposed strategies include: strengthening midwifery training; a plan to ensure equitable care; scale up of tested successful innovations; and provision of services within the community while also maintaining and improving services at facility level."

UNFPA midyear report 2014 from Laos Country Office.

COUNTRY HIGHLIGHT

SoWMy Afghanistan

The Afghan Midwife Association in collaboration with UNFPA, USAID, WHO and the Afghan Ministry of Health produced its own State of Afghanistan Midwifery Report. This report has helped strengthen policy dialogue and identify barriers and opportunities to improve midwifery services in Afghanistan. Significant investments in community midwifery since 2005 have resulted in a precipitous decline in maternal mortality ratio from 1,600 in 2003 to 327 per 100,000 live births in 2010. Afghanistan is among the first countries in the region to develop a cohort of internationally recognized degree-level midwives.

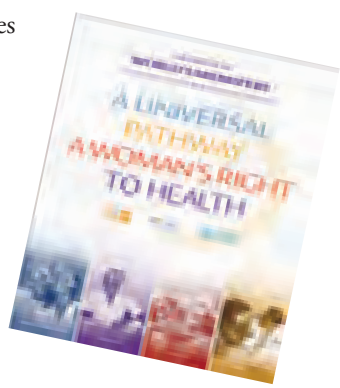


Report; b) disseminate midwifery good practices, comprehensive programme guidance and the e-implementation guidance at a special training; and c) support a side session on midwifery in South Asia. In addition, Pronita Rani Raha, a Bangladesh midwife nominated by UNFPA, won the International Midwife Award 2014 from the ICM and Save the Children.

Launch of the State of the World's Midwifery Report

The Second State of the World's Midwifery Report (SoWMy 2014) was launched on 3 June 2014 by UNFPA, ICM, WHO and approximately 30 global partners (UN, civil society, private sector and donors) at the ICM Triennial Congress in Prague. The report describes the current midwifery situation in 73 low- and middle-income countries, which account for more than 92 percent of global maternal, newborn and child deaths and stillbirths.

In addition, the report provides information on progress since the first SoWMy report in 2011, and makes projections for the midwifery workforce up to 2030. The report is an invaluable resource for policy dialogue with stakeholders and governments and for planning midwifery interventions and supporting negotiations for the post-2015 development agenda.



A successful media campaign was carried out with more than 20 partners (ICM, Jhpiego, Family Care International, WHO, Integrare and Johnson & Johnson, among others). As a result, SoWMy received extensive high-profile global coverage from Time, Reuters, Huffington Post, The Guardian, Voice of America, Bloomberg News, The New York Times, ABC, NPR and many others. Twenty-four national level SoWMy launches took place from June to December 2014 with good help from an impressive advocacy toolkit created by Family Care International.

Dissemination of Midwifery Good Practices

Nine good practices in midwifery[2] documented in 2013 were globally disseminated in 2014. They highlight innovative initiatives in Afghanistan, Bangladesh and Uganda to improve retention and training of midwives; to increase access to midwifery services in Burkina Faso, Ethiopia and South Sudan; and to strengthen midwifery associations in Guyana. The Lancet Midwifery Series[3], launched in June 2014, are

2 http://www.unfpa.org/resources/good-practices-strengthening-midwifery-services-avert-maternal-and-newborn-deaths
3 See: http://midwiferyaction.org/ and http://www.thelancet.com/series/midwifery

COUNTRY HIGHLIGHT

E-Learning in Ghana

Since the launch of the pilot in Ghana in 2013, Jhpiego through its flagship Maternal and Child Health Integrated Program (MCHIP) has trained over 31 trainers and approximately 800 midwives in e-learning at six schools. To further strengthen this initiative, in June 2014 the Ministry of Health with support from UNFPA Ghana launched a national e-learning steering and technical committee to develop a harmonized strategic vision of the national midwifery e-learning programme. Alexander Yaw Arpal, director of human resources at the Ministry of Health, noted that the modules would transform how training is provided to frontline healthcare workers by improving access and reinforcing correct clinical decision-making skills. Preliminary results from the Ghana e-learning feasibility study conducted by the USAID MCHIP programme revealed that the modules are feasible, acceptable and user-friendly. Plans are underway to scale up training in midwifery schools. See media brief at *http://www.ghanaweb.com/GhanaHomePage/health/artikel.php?ID=357180*

major international research papers that discuss the impact of midwifery (quality of care, improvements in SRH, scale up and deployment) in eliminating preventable maternal and neonatal deaths and the potential for improving outcomes for women and newborns through collaboration of health-care professionals working along the continuum of care.

The latest evidence generated by the State of the World's Midwifery (SoWMy) Report 2014, midwifery workforce assessments, the Lancet Midwifery series and the Emergency Obstetric and Newborn Care Needs Assessments supported by MHTF have proven highly effective in supporting policy dialogues and advocating for governments to prioritize investments in midwifery.

Capacity Building

A comprehensive "Midwifery Programme Guidance,"[4] developed by UNFPA and the ICM in 2013, was formally released and globally disseminated by UNFPA in 2014 in Arabic, English, French and Spanish. The guide is a user-friendly technical tool for midwives and midwifery programme managers, partner agencies[4] and Ministries of Health that can help develop, scale up and strengthen midwifery programmes at the national level. It explains key midwifery concepts and global standards; outlines a step-by-step approach in strengthening midwifery; and complements and references major available tools, protocols and guidelines on midwifery developed by UNFPA, WHO, Jhpiego and others. UNFPA oriented approximately 70 midwives and programme managers from 30 MHTF-supported countries on using this tool. Since then, the guide has been extensively used by UNFPA country teams to strengthen and increase midwifery interventions and to conduct advocacy and fund-raising efforts.

Innovative Approaches

In 2014, UNFPA, in collaboration with Jhpiego, WHO and Intel, developed an "eLearning Implementation Guide"

4 http://www.unfpa.org/resources/midwifery-programme-guidance

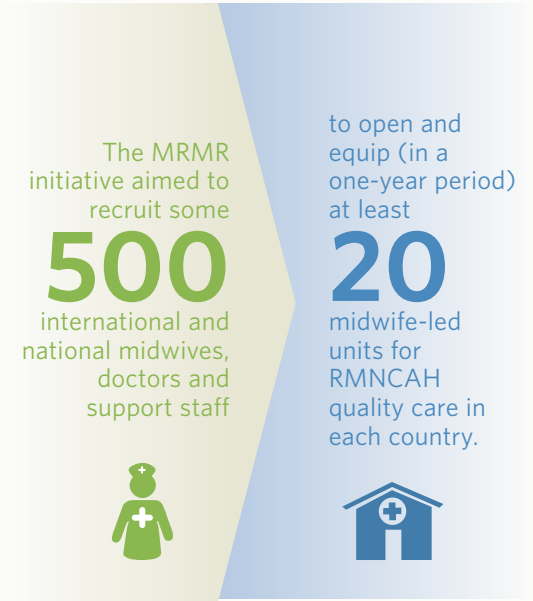
Midwifery in Crisis Situations:

UNFPA Midwifery Response to the Ebola Crisis in West Africa*

To address the Ebola outbreak in West Africa, which killed more than 11,000 people in 2014 – mainly in Liberia, Guinea and Sierra Leone (including over 500 health workers and midwives), UNFPA and the governments of Guinea, Liberia and Sierra Leone and other partners developed and initiated the Mano River Midwifery Response (MRMR) to restore resilient health systems for RMNCAH and prepare for the post-Ebola period.

The MRMR initiative aimed to recruit some 500 international and national midwives, doctors and support staff to open and equip (in a one-year period) at least 20 midwife-led units for RMNCAH quality care in each country. The response will also develop community-based interventions, including mobile clinics, outreach activities, education, family planning, clean delivery kits, maternal healthcare and gender-based violence.

In 2014, using a situational analysis, strategic facilities were selected in the most-affected districts, some international staff in collaboration with UN Volunteers and the Economic Community of West African States were recruited; and national and retired midwives were redeployed. UNFPA Sierra Leone, Liberia and Guinea supported the case-management teams of the Ministries of Health in contact tracing and provided on-the-spot training on case management and infection prevention and control. UNFPA also disseminated information and supplies to midwifery schools and healthcare providers and communities, including personal protective gear like medical gloves, disinfectants and heavy duty aprons, as well as hand-washing equipment and emergency reproductive health kits.



Specific examples include:

Sierra Leone: Midwifery tutors helped to train students and graduate midwives in Infection Prevention and Control (IPC) and to define strategies to combat the effect of Ebola on SRH services. A midwifery mapping exercise has helped to deploy midwives to areas in which RMNCAH workforce was depleted.

Liberia: UNFPA supported the government of Liberia to train, orient and deploy its first batch of 33 retired midwives to remote settings for the provision of RMNCAH care and services.

Guinea: Midwives and community health workers were trained in the mobile phone application that helped support contact tracing, particularly in areas with high rates of Ebola transmission, which helped speed the government's response to the Ebola outbreak.

**Note: Part of the MHTF and H4+ funding provided to the affected countries was redirected to address the crisis.*

and a promotional video[5] to assist in the operationalization and promotion of the nine e-modules developed in 2013 for midwives and other frontline health workers on all lifesaving skills. The module on "Danger Signs in Pregnancy" was translated into French and Spanish. In 2014, some 2,400 midwives were trained through the e-modules produced by UNFPA, Jhpiego and Intel.

Regional Highlights

Key capacity gaps in, for example, competency based education; building mentorship skills; trainings in skills lab management; and leadership skills were addressed through a series of regional workshops. Major advocacy was also conducted at regional levels to further enhance midwifery commitments.

The UNFPA Arab States Regional Office organized the second Regional Midwifery Conference with the government of Saudi Arabia in Riyadh. The conference brought together representatives of Ministries of Health and midwifery experts from 17 Arab countries and other global experts and focused on adoption of regional strategies and actions to advance ICM competency based midwifery education. A *Statement*[6] issued by the Ministry of Health at the end of the conference affirmed the critical role of midwives in saving lives of mothers and newborns and declared midwifery education an urgent priority for the region.

UNFPA Latin America and Caribbean Regional Office (LACRO) launched a comprehensive midwifery report titled "Strengthening Midwifery in Latin America and the Caribbean (2014)" at the ICM Americas Regional Conference in June 2014. The report highlights the midwifery situation of 18 high-burden maternal mortality countries of the region[7].

The regional office scaled up Competency Based Education (CBE) Training in the Caribbean. By December 2014, six countries had trained 61 midwifery educators/clinical instructors and 12 master trainers in competency-based teaching, learning and assessment strategies. Lessons learned from the trainings were used to implement a second training for 19 midwifery faculty members in Argentina, Ecuador, Paraguay, Peru and Uruguay. Evaluations suggest the needs for CBE are being rapidly met in Latin America and the Caribbean.

LACRO further developed models (prototypes) of midwifery regulation in 2014 and has created a Midwifery Regulation Commission by the Latin American Federation of Midwives. Another successful initiative by the region has been the Young Midwifery Leaders Programme (YML) in seven Latin American countries (Argentina, Brazil, Chile, Ecuador, Paraguay, Peru and Uruguay), which aims to develop competency-based education and training skills, strengthen networks and provide leadership support to young midwifery trainers.

Phase 2 (2014-17) of the UNFPA/ICM programme enhanced its efforts to support the **Francophone West and Central Africa region**. The programme seeks to address the gross shortage of competent midwives in the region. In October 2014, a gap analysis workshop was held on Comoros for five French-speaking countries (Comoros, Djibouti, Madagascar, Morocco and Tunisia). The workshop used the SoWMy2014 report and The Lancet Series on midwifery, as well as the Maternal Death Surveillance and Response (MDSR) as an evidence-based foundation to develop action plans to address the deficits in midwifery education, association and regulation.

Mentorship and teaching skills in **the Eastern and Southern Africa Region** were strengthened through a five-day regional workshop held in Nairobi, Kenya, in collaboration with Amref Health Africa in October 2014 on Mentorship and Teaching Skills Training. This benefited 30 midwifery clinical trainers from seven Anglophone countries (Ethiopia, Kenya, Malawi, South Sudan, Tanzania, Uganda and Zambia). Participants gained skills and knowledge on latest evidence-based mentorship and teaching models and wrote follow-up implementation action plans. As part of the plans, South Sudan trained 20 midwifery tutors in mentorship and teaching skills in 2014. Most countries are rolling out similar trainings in 2015.

Asia Pacific Region in collaboration with MHTF and the Indian Academy of Nursing and Women's Empowerment Studies helped build the capacity of 23 midwifery tutors,

5 The video can be accessed at: http://www.unfpa.org/resources/e-learning-modules-midwives

6 See: http://arabstates.unfpa.org/webdav/site/as/shared/ASRO%20website/Publication/Publication%20Pic/Regional%20Midwifery%20Conference%20Statement%20English.pdf

7 Countries included in the report are: Bahamas, Barbados, Bolivia, Guyana, Trinidad & Tobago, Haiti, Dominica, Jamaica, St. Kitts, St. Lucia, Suriname, Argentina, Chile, Ecuador, Paraguay, Peru, Suriname and Uruguay

principals, directors and deans of universities and UNFPA midwifery managers from seven Asian countries (Afghanistan, Bangladesh, Bhutan, India, Myanmar, Nepal and Timor-Leste) on 'Effectively setting up and utilizing a skills lab.' After the workshop Bhutan, Myanmar and Timor-Leste set up their skills labs in 2014 themselves, and action plans are being implemented in Afghanistan, Bangladesh, India and Nepal.

Country Highlights

Midwifery Education

The government of **Bangladesh** increased the number of professionally trained midwives in its three-year direct entry diploma programme, from 525 midwives in 20 training sites in 2012 to 800 midwives in 31 training sites in 2014. Another 1,300 midwives were trained under the six-month post basic midwifery programme in 10 training sites, of which six are funded by UNFPA and four by WHO. Upon graduation, the newly trained midwifery specialists would receive remote postings[8] to help address the big need for skilled health workers in such areas.

MHTF supported numerous countries in 2014 reviewing their national midwifery curriculum to ensure they are aligned with global ICM/WHO standards. These include **Burundi, Chad, Lao PDR, Madagascar, Niger, Uganda and Zambia.**

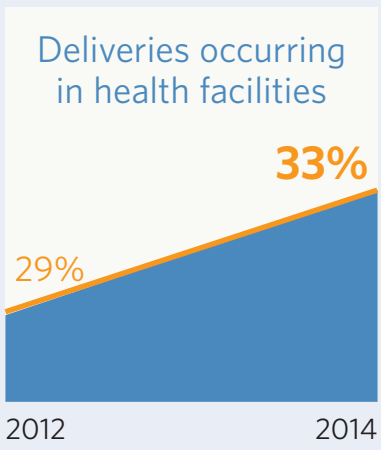
Bachelors in midwifery programmes were launched in **Afghanistan, Burkina Faso, Somalia and Zambia** in 2014 and a master's degree in midwifery was launched in **Madagascar**, giving hope to thousands of midwives for new career paths. **Pakistan** graduated its first group of 21 bachelor degree students in midwifery from the Aga Khan University in 2014, of which 18 were sponsored by UNFPA. UNFPA also supported the initiation of the first master of science programme in midwifery in Pakistan.

The national midwifery training school in **Burundi** graduated its first class of 46 midwives with special emphasis in contraceptive technology and EmONC in 2014. Two skills labs were fully equipped with training materials and over 37 midwifery training sites were accredited. The MoH of **Cambodia** has opened two new healthcare facilities to provide clinical skills training to more student midwives. UNFPA **Niger** facilitated the training of over 63 midwifery teachers in B-EmONC and effective teaching skills and fully equipped new skills laboratories in two midwifery schools. In **Chad**, 45 midwifery teachers and clinical instructors were trained in basic supervision and EmONC skills, and another

COUNTRY HIGHLIGHT

Uganda Sends Midwives to Underserved Areas

UNFPA and partners have supported the government of Uganda to increase access to a skilled midwifery workforce by providing bursaries for training midwives who serve in underserved rural districts since 2010. In 2014, 80 students completed training, bringing the total number of sponsored students to 308. Each graduated midwife enlisted on this initiative is required to work in specific districts for at least three years. A 2013 Human Resources for Health Audit report of the MoH indicated that vacant midwifery positions in health facilities had decreased to 1,043 from 1,961. Uganda has also seen a steady increase in the proportion of deliveries occurring in health facilities in UNFPA-focused districts from 29 percent in 2012 to 33 percent in 2014. This rise has been aided by UNFPA's continuous support to health systems' strengthening, the pre- and in-service training of midwives and the procurement of teaching and learning equipment and reproductive health supplies.



8 http://www.unfpa.org/news/student-midwives-prepare-save-lives-rural-bangladesh

30 midwifery trainers were taught education psychology and supervision.

Midwifery education programmes were positively evaluated in a number of countries, including **Bangladesh** and **Ethiopia**. The resulting action plans will help to guide focused interventions to strengthen midwifery education. The Accelerated Midwifery Programme in Ethiopia has already helped the country achieve the target of 8,635 midwives ahead of schedule.

South-South Collaboration

To address the acute shortage of midwives and midwifery trainers and mentors across the country, UNFPA **South Sudan** has been supporting the government in numerous strategies that include South-South collaboration with **Uganda** and **Tanzania** and an internal scholarship programme with the Catholic Health Sciences Institute (a privately managed entity supported by MHTF). Since the start of this initiative in 2011, over 34 midwives have graduated from schools in Uganda and the Catholic Health Sciences Institute and deployed to under-resourced settings nationwide. Further, 15 national tutor /mentors were trained in Tanzania and deployed at health sciences institutes in the country.

Ghana has seen a rapid increase in the number and distribution of midwifery schools, now totalling 28 and an all-time high of 4,185 registered midwives in 2014. E-learning is also being strongly promoted in the country. **DRC** graduated 43 midwives, increasing the number of graduated midwives from 4,675 in 2012 to 5,628 in 2014. The new midwifery school in **Haiti**, rebuilt in 2013 after the devastating 2010 earthquake, graduated its first group of 39 midwives in June 2014.

The **Lao PDR** government implemented supportive supervision for skilled birth attendants in seven nursing and midwifery schools, and supervisory tools were developed to facilitate monitoring. In 2014, the national **Nepal** Auxiliary Nurse Midwives' curriculum, with all ICM global competencies, was adopted after extensive review.

UNFPA **Somalia** helped establish an additional midwifery school in south-central Somalia, and 25 midwifery students have since been enrolled. The number of midwifery schools now being supported by UNFPA Somalia increased from eight to 11 in 2014. Midwives in **Guinea-Bissau** organized a two-day symposium to better integrate family planning into maternal health activities. Through music, theater, dance and radio spots, family planning information and messages reached the community of Biombo, which has a high prevalence of teenage pregnancy. Mobile strategies will be employed to send such messages to other remote areas.

Midwifery Association Strengthening

The midwife associations in all MHTF-supported countries played a leading role in the celebration of the International Day of the Midwife (see Global Highlights) and in the national launches and dissemination of the findings of the 2014 State of the World's Midwifery report.

The **Bangladesh Midwifery Society** became a member of the ICM in 2014. It was launched in 2010 with 24 members, and as of 2014 had 1,400 members and a new website. **Lao PDR** drafted a constitution to establish the first Lao Association of Midwives. The Midwives Association of **South Sudan** supported the first nationwide nurses and midwives conference with over 390 participants.

The Midwives Association and the Ministry of Population in **Madagascar** successfully engaged more than 50 traditional leaders in a discussion on the rights of children, young people and women, family planning and SRH. The **Chadian Association of Midwives** strengthened the capacity of 10 health centers to provide 24/7 B-EmONC services through the provision of delivery beds, drugs, ambulances and other commodities. In 2014, midwives in these facilities performed over 4,832 deliveries with zero maternal deaths. The **Zambian Midwifery Association** launched and disseminated its strategic plan at its annual general meeting. The 107 members were also oriented on 'Respectful Maternity Care,' which has helped improve quality of care.

UNFPA in collaboration with the Association of Midwives and the Ministry of Public Health of **Niger** completed and disseminated the first national midwifery report. Recommendations (together with the SoWMy findings) were used to develop a comprehensive midwifery action plan that is currently being carried out.

2014, Dinajpur, Bangladesh. Selina Akter, a second-year midwifery student, plays the role of a mother as students practise postnatal care at the Dinajpur Nursing Institute. The institute is currently training 22 second-year and 25 first-year students in midwifery, the first batch of a three-year course that started two years ago.

Midwifery Regulation Enhancing

The **DRC** government developed and validated a ministerial decree enforcing midwifery as an autonomous profession.

The **Bangladesh Nursing Council** (BNC), with UNFPA and WHO, has established a task force to support the endorsement of the Midwifery Act by the Ministry of Health and Family Welfare. Once this is achieved, the BNC name will be changed to the Bangladesh Nursing & Midwifery Council. In **Nepal,** efforts are underway with the Nursing Council to develop education standards and revise the current Nursing Act to include "midwives" as a separate cadre of health professionals.

UNFPA **Pakistan** is working with the Pakistan Nursing Council (PNC) to strengthen its midwifery program. An assessment of the PNC Nursing Examination Boards has prompted the introduction of 'Objective Structured Clinical Examination' (OSCE) for all midwifery teachers. Technical assistance provided by UNFPA helped support the **Cambodia Midwives Council** to develop a guidance document to address public complaints.

More Midwifery Initiatives

Female Genital Mutilation Prevention and Care by Midwives

UNFPA, in the context of the UNFPA-UNICEF Joint Programme on FGM/C and the UNFPA Midwifery Programme will launch a global initiative in 2015 to develop capacities and skills of midwives and other frontline health workers to resist social and economic pressure to perform FGM (Female Genital Mutilation), improve care for girls and women with FGM and to enlist midwives to champion FGM prevention and care. Preliminary work on an e-learning module draft and a draft advocacy toolkit was completed in 2014.

In 2014, midwives were engaged in numerous initiatives as part of ongoing campaigns to end FGM and fistula. For example, midwives from Mauritania and Djibouti signed national declarations for the abandonment of FGM, while midwives in Guinea-Bissau supported integration of FGM into the Peer Educators' Manual on Reproductive Health; Ethiopia, Gambia, Guinea-Bissau, Senegal, Somalia, Sudan and Turkey have integrated FGM into their midwifery pre-service training curricula; over 9,000 midwives were trained in counseling strategies and management of FGM complications (including 5,200 in Sudan, 160 in Turkey and 140 in Somalia, among others). In Sudan alone, 18 new midwifery healthcare facilities became part of the UNICEF Saleema Initiative to promote collective abandonment of the practice at the community level. Ethiopia developed a "women health extension workers" programme to support communications on FGM prevention, and collaborated with the Afar Pastoralist Development Association to train traditional birth attendants on consequences of FGM.

Leverage Impact

UNFPA has helped countries leverage additional national and global resources through documented successes on the ground and national stakeholder engagement. Examples include: After the 2011 commitment made by the prime minister of Bangladesh to train 3,000 midwives by 2015 towards the UN Secretary-General's Every Woman Every Child strategy, the Ministry of Finance finally approved the creation of 3,000 posts for midwives starting from fiscal year 2014-2015 with 600 posts coming on each year until the end of fiscal year 2018-2019.

UNFPA South Sudan implemented three projects funded by the Department of Foreign Affairs, Trade and Development Canada (DFATD): the Strengthening Midwifery Services Project (CAD 19.4m); the Deploying Midwives in South Sudan, which demonstrated results and huge nationwide impact and will therefore receive additional funding in 2015 (CAD 13.7m); and the "EmONC and MMR survey" (CAD 3M). The timeframe of all three projects extends beyond 2014. UNFPA commenced negotiations with DFATD for a second phase of the Strengthening Midwifery Services in 2014 with an estimated cost of CAD 50 million.

Global advocacy for advancing the midwifery programme has given rise to the USD 200 million World Bank/ UNFPA Sahel Demographic Dividend and Women's Empowerment project, which aims to accelerate the demographic transition (i.e., reduced fertility and child mortality) and trigger demographic dividends into broader economic gains (such as reducing gender inequality) in the Sahel region. The USD 30 million midwifery component of this project would help create two regional midwifery hubs to train competent midwifery tutors, strengthen national midwifery schools and improve deployment of midwives in rural settings. Countries to benefit from this initiative are Burkina Faso, Chad, Côte d'Ivoire, Mali, Mauritania and Niger.

In conclusion, while much progress has been made and UNFPA has helped train over 60,000 midwives (35,000 through MHTF alone) since 2009, this is not sufficient. Using the latest evidence base from the State of the World's Midwifery Report and the midwifery workforce assessments, UNFPA will continue to exercise its global leadership role in collaborating with partners to strongly advocate for mainstreaming midwifery in national human resources for health policies and to ensure that there are adequate numbers and well-distributed posts for midwives. UNFPA will adopt strategic initiatives, like e-learning, to scale up the lifesaving skills and capacities of the health workers with midwifery skills and support countries in developing, implementing and monitoring costed midwifery workforce plans and strategies aligned with ICM global standards.

Going forward, in order to meet the new SDG goals of ending preventable maternal and newborn mortality and achieving universal access to SRH services, strengthening midwifery skills and capacities will need continued focus and enhanced global and national level investments and commitments.

In doing all this, UNFPA remains deeply committed and well positioned to make strategic and targeted investments in human resources for health, such as midwifery.

2014: An obstetric emergency has called for a Caesarean section at an EmONC facility in Sacré-Coeur de Milôt, Haiti.

© Joan Lysias, UNFPA.

Photo submitted for MHTF AR 2014 photo contest. Haiti

Emergency Obstetric and Newborn Care

3

Highlights

Midwives and obstetricians need to work within a functioning health system so they can provide timely and accurate emergency obstetric and newborn care (EmONC). This entails the establishment of functioning health systems; from community to referral hospitals that include: (1) basic EmONC (B-EmONC) services to handle most of the nonsurgical complications at the peripheral level, close to the population; and (2) comprehensive EmONC (C-EmONC) services with efficient referral mechanisms. Skilled birth attendants (SBAs: midwives, doctors and obstetricians or equivalent) need to be effectively deployed to ensure a correct accessibility to women in all communities, including the poor and those living in remote areas. This makes basic and comprehensive EmONC a very cost-effective, high-impact intervention.

EmONC needs assessments show that in MHTF countries, important gaps exists in EmONC services coverage, with the best around 60 percent, based on international standards. The main gap is the lack of SBAs in B-EmONC services. To improve this situation, a full overview of the network of EmONC services — strengths and weaknesses — is a first step. Once data are available they need to be acted on within the **Data to Action Continuum** to improve service availability for women in need.

Results:

Two EmONC Needs Assessments surveys were completed in 2014 — for Congo Brazzaville and Mozambique — which brings the total of national EmONC NA surveys conducted with MHTF support to 36.

As part of the increased attention to the **data to action process** in Phase II of the MHTF, eight national EmONC Needs Assessment surveys' reports have been analysed to:

- Contribute to the **development of national plans** for maternal and newborn health;
- Provide inputs to an additional chapter for the **'EmONC Needs Assessment Facilitation guide'** under development in collaboration with the Averting Maternal Death and Disability group at Columbia University (AMDD).

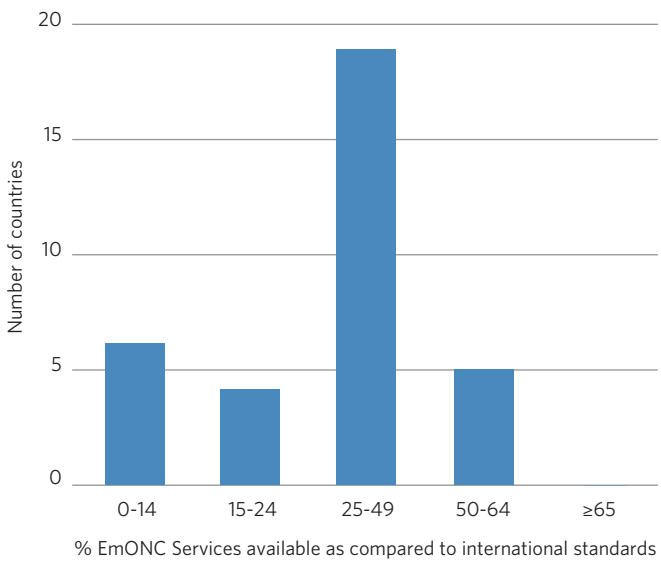
A maternal and newborn health services monitoring mechanism has been designed and started in 2014 to be implemented at national level in a few countries (Cambodia, Haiti and Togo) to assist MoH in developing and strengthening a **better network of EmONC services.**

Emergency Obstetric and Newborn Care

In high-prevalence maternal mortality countries, the EmONC needs of women and newborns are generally not satisfied. The availability of four B-EmONC facilities and one C-EmONC facility per 500,000 inhabitants is considered a minimum standard.

The Countdown to 2015, an international movement to monitor and support country progress towards the health-related MDGs in its latest 2014 report, "Fulfilling the Health Agenda for Women and Children," found that none of the 75 countdown countries has achieved the EmONC minimum standards. According to the 36 MHTF-supported EmONC needs assessment (NA) conducted by the AMDD programme, referral systems are still too weak in many countries. Therefore, UNFPA and AMDD collaborated on highlighting the critical importance of establishing a sufficient network of EmONC services to meet the needs of women and to help accelerate action towards reaching MDGs 4 and 5.

Figure 4. Availability of EmONC Services in MHTF Countries



Useful needs assessments require consideration of both the hardware (e.g., infrastructure, human resources and medicines) and the software (e.g., management, accountability mechanisms and relationships) components of health systems, the second being more difficult to capture through health facility surveys.

Collecting data is not enough if data are not used for action: there is a need for a Data to Action Continuum, which is developed in four phases: 1) EmONC needs assessment findings, 2) recommendations from the needs assessment, 3) action plan, and 4) implementation, including monitoring. This four-step approach has been adopted as a key indicator in the UNFPA's Strategic Plan 2014-17.

Global Highlights

In MHTF Phase I, the focus was primarily on conducting EmONC needs assessments. MHTF Phase II is giving much more attention to the data-to-action process as outlined in the previous section, with four steps: findings, recommendations, action plans and implementation.

To promote this four-step approach, a workshop was jointly organized in New York by AMDD and UNFPA, with the participation of UN Women, WHO and Save the Children. The meeting's purpose was to ensure that the processes and recommendations of the EmONC needs assessments effectively facilitate a smooth data-to-implementation process in countries. The meeting took an in-depth look at the recommendations from eight EmONC NA surveys (Bangladesh, Burundi, Côte d'Ivoire, Congo, Ghana, Malawi, Niger and Togo).

Participants concluded that special attention should be given to ensure that all recommendations from EmONC NAs are relevant and actionable to develop plans to effectively contribute to the creation of national maternal and newborn health plans.

At the workshop, it was also agreed that the EmONC indicators need to be used in a logical way to clarify availability, use and quality of care. The workshop highlighted a new focus on evaluating the ability of services to perform the critical EmONC signal functions. Participants proposed to add more indicators to better describe newborn care.

In December 2014, AMDD and UNFPA organized a second, much larger workshop that was attended by UNICEF, USAID, CDC, the Bill and Melinda Gates Foundation, WHO, FHI 360, the Population Council, University of Southampton, Heidelberg University, Jhpiego, Save the Children, CEFOREP (Senegal) and ICDDR,B (Bangladesh).

The objective was to consult with partners on potential revisions of the EmONC needs assessment tool and processes to reflect the four-step approach needed to improve EmONC. To do so, participants examined emerging developments in maternal and newborn health metrics, such as indicators for quality of care, newborn health and routine delivery care in the broad sexual and reproductive health and HIV contexts. In addition, they focused on approaches to tracking and using data for decision-making and implementation.

Key conclusions of the meeting:

- The partners emphasized the added value of the EmONC NA tool, which goes far beyond the EmONC services and remains the most comprehensive survey on maternal and newborn health services existing in the world today.
- Consensus was reached among partners to strengthen collaboration on EmONC needs assessments, reduce overlaps and ensure provision of relevant, usable and actionable data in countries. The collaboration will be initiated in countries with ongoing or forthcoming EmONC needs assessments.
- New indicators on emergency newborn care and routine services delivery will be tested in the ongoing and forthcoming needs assessments. The results will be shared to support global indicator discussions.
- The national EmONC and MDSR mapping tool should be developed to plan, manage, report and advocate for maternal and newborn health amid reproductive health.

These workshops and successful EmONC NA surveys have served as inputs to a new EmONC guidance. A new chapter in the EmONC Needs Assessment Facilitation

REGIONAL HIGHLIGHTS

Regional-National Collaboration: Congo Brazzaville Acts on EmONC NA

Congo is in a transitional phase in becoming a middle-income country, but it still faces a high maternal mortality ratio of 410 deaths per 100,000 live births, making it unlikely that the country will reach MDG5 in 2015. Together with UNFPA's **West and Central African regional office**, the MHTF technical team provided support to the UNFPA country office of Congo to support the government's efforts to improve the situation.

In 2014, the government completed an EmONC NA survey. After a difficult start due to the lack of updated facilities census, the EmONC assessment data collection began in November 2013. The findings were discussed in March 2014, and the final version of the report was validated in a national meeting in April 2014.

Despite that 94 percent of pregnant women deliver in facilities, an estimated 690 women die every year. The findings of the survey provide a clear explanation for this situation: a huge deficit in B-EmONC facilities, with no province meeting the minimum international standard of five EmONC facilities per 500,000 inhabitants. In addition, the high case-fatality rate of 8.7 percent is more than eight times the acceptable WHO-defined international standard.

This underscores the problem of inadequate competencies among birth attendants to manage obstetric and neonatal emergencies. Other findings pointed out the need to improve the quality of care in the urban areas of Brazzaville and Pointe-Noire, where two-thirds of deliveries occur, and the challenge of addressing the needs of the poorest (and the Pygmies) in the countryside. Another necessary focus is to strengthen the referral system by improving links between B-EmONC and C-EmONC.

The government of Congo is concerned about the situation and ready to allocate USD 20 million to maternal health. In response to a request from the government, the UNFPA country office advised that improvements be made to pre-service training for midwives, that a mentorship program in selected EmONC facilities be implemented and that a network among B-EmONC facilities be developed.

This work is a concrete illustration of the catalytic effect of the MHTF. The initial financial and technical support is used to design an evidence-based strategy strengthening the efforts of the government to reduce maternal mortality with high-impact interventions. It also illustrates how links are developed between the individual phases of the Data to Action Continuum process as well as the role of the UNFPA regional offices in implementing this approach in countries.

See also Table 1 for further data from the EmONC survey.

guide will be created on the subject of developing recommendations, with a first draft to be tested in Malawi and Zambia. An additional guidance document on EmONC services monitoring will start to be developed by a technical group in 2015.

Country Highlights

EmONC Needs Assessments Done in Two More Countries

In 2014, two countries completed an EmONC needs assessment, **Congo (Brazzaville)** (see box under Regional Highlights) and **Mozambique**. Implementing the survey was the governments' decision, with the former as well as local key partners providing the budget to conduct the survey, usually ranging from USD 500,000 to USD 900,000 depending on the size of the country. MHTF supports technical assistance to ensure that the methodology is well defined and implemented and that the quality of data collection and analysis is high. This assistance has been provided by AMDD or regional institutes. Table 1 presents some key data findings from the surveys.

Main Findings of the Needs Assessments— Mozambique

In 2012, for the second time, the Mozambican National Directorate of Public Health of the Ministry of Health launched a national EmONC services needs assessment. The survey was based on six modules or questionnaires and extended to all health facilities that provide childbirth services in the country. The final report was validated in 2014, comparing 2012 data with 2007-08 data.

For a country of 23.6 million inhabitants, the recommended minimum number of EmONC services was 236, including at least 47 C-EmONC services. The survey showed 28.9 percent (68/236) coverage of the recommended minimum of B-EmONC services and 70.2 percent (33/47) coverage of the recommended C-EmONC services. However, availability varies across provinces: the Maputo Province has only a single C-EmONC facility, and the most densely populated provinces (Nampula and Zambézia) have critical shortages. None of the 11 provinces reaches the international standard in terms of EmONC coverage.

Table 1. Sample indicators for EmONC in MHTF-supported countries

EmONC indicators	Republic of Congo (Brazzaville)	Mozambique
Population	4,085,422	23,569,908
Maternal Mortality Ratio	410/100,000 lb [240-720]	300/100,000 lb [300-780]
Total numbers of facilities assessed	240 (census)	947 (census)
Availability of Basic EmONC facilities	1	35
Expected B-EmONC according to minimum international standards	33	188
Availability of Comprehensive EmONC (C EmONC) facilities	9	33
Expected C-EmONC according to minimum international standards	9	47
Provinces with sufficient EmONC facilities	0 / 12	0 / 11
Proportion of all births in EmONC facilities	21%	19%
Met need for EmONC	5.6 %	13%
Direct obstetric fatality case rate	8.7%	2.4%
Intrapartum and very early neonatal death rate	11.72 / 1,000 births	15/1,000 births in EmONC facilities; 7/1,000 births in all health facilities
Caesarean sections as a proportion of all birth (normal range 5%-15%)	1.4% in EmONC facilities 3.5% in all facilities	2.6% in EmONC facilities; 3.0% in all health facilities

The survey data documented an institutional delivery rate of 72 percent. However, only 13 percent of the expected number of obstetric complications (15 percent of all births) were treated in EmONC facilities.

Two EmONC indicators measure aspects of quality of care: the direct obstetric case fatality rate (to be below 1 percent) and the rate of intrapartum and early neonatal death rate. A rate of 2.4 maternal deaths for every 100 women with complications was found in EmONC facilities, with postpartum sepsis (7 percent) and uterine rupture (5 percent) being the most frequent causes of maternal death. It should be noted, however, that the maternal-case fatality rate calculated in 2007 was significantly higher (5.2 percent), suggesting progress.

The survey demonstrated the need to develop more B-EmONC and C-EmONC services. Health professionals need to be upgraded with skills and an enabling environment to perform the missing signal functions. Preservice education of midwives should be strengthened. The large gap in health workers who can provide anaesthesia, Caesarean deliveries and blood transfusions for mothers and newborns must be addressed by training trainers at teaching institutions as well as deploying the qualified staff effectively. The MHTF will contribute to the implementation of these recommendations.

Strengthening EmONC Monitoring

Burkina Faso has started monitoring maternal and newborn health services in two districts and is preparing to scale up. The country has validated a national procedure to organize a national EmONC services monitoring system to better manage the maternal and newborn programme. This is a strategic approach to strengthen Ministry of Health's leadership and ease a quick scaling up.

Dr. Mohan Chandra Regmi, associate professor of obstetrics and gynaecology, visits patients at the BP Koirala Institute of Health Science.

Nicolas Axelrod/Ruom for UNFPA. 2014, Dharan, Nepal.

In **Haiti**, the MHTF supported upgrading three MNH facilities with B-EmONC services. The facilities have been showcased for advocacy purposes. They report accurate data on a regular basis to MoH, a good example of what can be expected from EmONC services in every country: good data are critical to document the activities conducted by the professional teams and to enable managers to deal with results and better address weaknesses in service availability and quality of care. By showing results, data

COUNTRY HIGHLIGHT

Mentorship to Strengthen EmONC in Burundi

Since 2013, Burundi has been developing an eight-day B-EmONC training for providers followed by supportive supervision at facilities where they work. Using the relationship of trust established to selected mentors, 218 providers have improved their capacity in EmONC management. Mentors also participate in data collection on site in the facilities to monitor progress in EmONC coverage and quality of care.

As a result, in the 19 targeted facilities, the number of facility deliveries increased from 11,318 in 2013 to 12,227 in 2014. The number of direct obstetric complications managed increased from 2,900 cases in 2013 to 3,004 in 2014. In the same period of time, the number of maternal deaths decreased from 71 in 2013 to 45 in 2014 and early newborn deaths from 233 in 2013 to 183 in 2014. The program was extended to the hospitals in four additional provinces in 2014.

Table 2. Obstetrical activities in 3 Basic EmONC facilities in Haiti in 2015

Year 2014	Facility					
	Béthanie		Jean Denis		Petite Place Cazeau	
Catchment area	31,884		42,170		41,787	
Type	Public / Private		Public		Public / Private	
Location	urban		rural		urban	
In zone expected number of births	429		664		439	
Number of in zone expected obstetric complication (15% of expected births)	64		100		66	
Number of midwives + nurses effectively working in the facility	3+4		2+4		4+5	
Deficit in the seven B-EmONC signal functions	none		none		none	
Number of deliveries according to the zone of origin	In Zone	Outside Zone	In Zone	Outside Zone	In Zone	Outside Zone
	825	362	512	342	733	355
Total number of deliveries in B-EmONC facility	1,186		854		1,088	
Complication management	handled	referred	handled	referred	handled	referred
Dystocia	1	13	18	17	5	64
Pre-eclampsia/eclampsia	7	13	58	27	9	14
Puerperal fever	0	0	0	0	0	0
Complication of abortion	0	0	11	7	0	0
Haemorrhage	6	3	19	19	46	11
Others	18	9	192	44	26	177
Total # of complications managed	70		412		372	
# maternal death	0		0		0	
# life births	1,188		836		1,081	
# stillbirths	12		18		14	
# neonatal deaths	3		1		0	
Direct obstetric fatality rate	0		0		0	

allow for decision-makers to invest effectively on EmONC development of services and skilled birth attendants.

The data from the B-EmONC facilities show that they are measuring the interventions and coverage for their catchment area and also reporting on interventions and outcomes for women coming from neighboring areas. The high number of outzone patients who seek services underscores the reputation of the B-EmONC services in the considered area.

The supported B-EmONC services have different profiles, ranging from private to public, rural to urban, all with satisfactory results. Figures from 2014 show that the number of women reaching these facilities is largely above expectations, both for in- and out of zone women; and all obstetric complications were handled and/or referred with no maternal deaths. The significant number of obstetric complications fully handled within the B-EmONC facilities is demonstrating the capacity of midwives to efficiently manage maternal and newborn emergencies.

This level of activity and quality of care requires skilled birth attendants who are organized to deliver maternal

COUNTRY HIGHLIGHT

Referral System in Togo

Togo has successfully instituted a plan to upgrade EmONC facilities to offer all signal functions around the clock. In addition, a referral system has been established in each region. This creates an EmONC facilities network where links between B-EmONC and C-EmONC facilities are described according to available means of transport, costs and time (red = difficult; orange = needs improvement; green = all right).

As evident from the map of the Maritime region, the EmONC network is vulnerable. Links are red or orange. The action plan would have to address and improve this situation. To facilitate access, Togo has decided that the referral should be made to the most accessible C-EmONC facility even if it belongs to a different district or region.

Having prioritized the EmONC network to meet the minimum international standards, Togo elaborated an action plan with built-in monitoring to manage its implementation on a continuing basis. This approach has reduced signal functions deficits, in particular for newborn and vacuum extraction. Based on these positive indications, the UNFPA Country Office has begun to provide technical support to Guinea and Benin to initiate the same model in these different settings.

health services around the clock. The human-resource factor is essential and underlines the need for strong links between the education of competent midwives and their deployment in an efficient working environment. Making this happen is a key factor for maternal mortality reduction. Demonstrating that reducing effectively maternal and neonatal mortality in such maternity wards is possible in Haiti, and will encourage the government and partners to invest in MNH services to increase access to quality care MNH services.

In conclusion, a key factor to reducing maternal mortality is the availability of EmONC services. These services depend on the distribution of skilled staff in a national network of facilities that are organized to manage emergency situations. In almost all countries with high maternal mortality rate, this EmONC network still needs to be extended with fairer geographical distribution.

The specific contributions of the MHTF is to support the development of such an EmONC network and provide technical assistance in conducting EmONC needs assessments and monitoring, B-EmONC facilities developed as training centers and integration of care within the EmONC facilities. This will be the MHTF focus for EmONC development in the future.

The Campaign to End Fistula

4

Highlights

When women and girls have inadequate access to health care during pregnancy and childbirth, they risk not only losing their lives and/or their babies, but also suffering from the debilitating and stigmatizing condition of incontinence caused by fistula. And many of the factors contributing to the fistula in the first place also hinder proper treatment: lack of qualified providers and facilities; lack of awareness of treatment and support services; and an inability to pay for the services.

However, with treatment and support for social reintegration, most of the more than two million women and girls living with the condition could return to a normal life and reclaim their dignity and hope. With both prevention and treatment, fistula could become as rare in developing countries as it is in wealthier countries. This is the aim of the MHTF and the Campaign to End Fistula, which is led by UNFPA.

The Campaign to End Fistula brings together hundreds of partners working in more than 50 countries across the developing world on prevention, treatment and social reintegration.

Results:

More than
10,000
surgical fistula repairs
were directly supported by UNFPA
and thousands more were supported by Campaign partners.

Awareness, activities and funds were raised at the global and local levels during the second International Day to End Obstetric Fistula.

Following the release of a UN Secretary-General report on the subject, the **UN General Assembly passed a resolution** in December 2014 **calling for the "Intensification of efforts to end obstetric fistula" in all countries where women are affected.**

Work on the developing the **next generation of fistula kits** was begun with expert advice from the world's leading fistula surgeons.

Uganda, 2015: A fistula survivor at a Fistula Ward, Soroti Referral Hospital

The Campaign to End Fistula at a Glance

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. The average cost of fistula treatment — including surgery, post-operative care and rehabilitation — is around USD 400 for each patient. Yet, more than two million women and girls cannot receive this treatment because of a lack of services by obstetric fistula surgeons. When services do exist, many women are not aware of them or cannot afford or access them.

The average cost of fistula treatment — including surgery, post-operative care and rehabilitation — is around USD 400.

Obstetric fistula is a severe morbidity that can occur 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 that renders her incontinent.

As is the case with maternal mortality, obstetric fistula is most often both preventable and treatable. Therefore, the persistence of the condition—primarily among the poorest and most vulnerable women and girls worldwide—reflects severe inequalities and inadequate access to sexual and reproductive health services, including universal access to family planning, skilled birth attendants and referral to emergency obstetric and newborn care when needed.

Global Highlights

At the global level, the field of obstetric fistula was moved forward through a new international agreement, global advocacy and sharing of best practices to advance the subject at the technical level.

Report of the United Nations Secretary-General: Supporting Efforts to End Obstetric Fistula

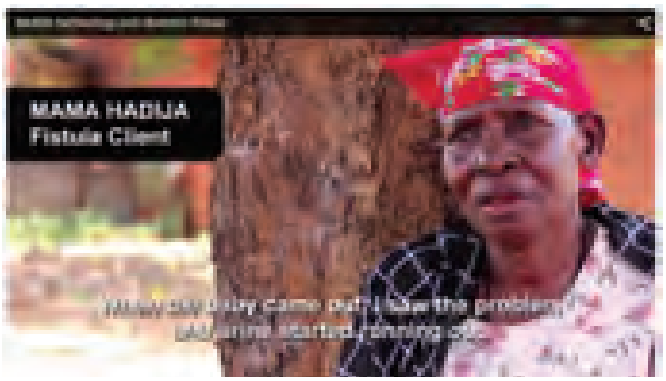
In October 2014, the office of the United Nations Secretary-General released the report "Supporting Efforts to End Obstetric Fistula." This highlights recent achievements in the fight against fistula since the previous report of 2012 and includes recommendations on actions needed to eliminate fistula, primarily at the national level. These recommendations include increasing and strengthening investments in health systems; ensuring availability of and accessibility to adequately trained health workers; developing costed, time-bound national strategies and action plans for ending fistula; increasing financial commitments; providing reintegration services to all women and girls with fistula, including those deemed incurable or inoperable; strengthening awareness-raising and advocacy; and creating and monitoring of obstetric fistula as a nationally notifiable condition in affected countries in order to report, track and follow up on fistula cases, so that no woman or girl suffers for years with no help, treatment, or support.

United Nations General Assembly Resolution on "Intensification of efforts to end obstetric fistula"

In response to the report of the Secretary-General, the United Nations General Assembly adopted UNFPA-backed resolution 69/148 on "Intensification of efforts to end obstetric fistula" in December 2014. This resolution was co-sponsored by more than 150 UN Member States and echoes the recommendations of the Secretary-General's report, including making fistula a nationally notifiable condition.

Second-Annual International Day to End Obstetric Fistula (IDEOF)

The second-annual International Day to End Obstetric Fistula (IDEOF) on 23 May 2014 was commemorated by numerous Campaign partners and UNFPA country, regional and global offices worldwide with the theme 'Tracking Fistula – Transforming Lives.' For the second year in a row, The Lancet Global Health published a UNFPA Comment [10] urging intensification of activities to end fistula.



A short documentary on the use of mobile technology to aid fistula survivors in Tanzania was released on the International Day to End Obstetric Fistula. Mama Hadija describes her experience.

UNFPA/The Campaign to End Fistula, in partnership with a filmmaker, Lisa Russell, released a short documentary film[11] on the advantages of mobile technology in providing services to women and girls with fistula. The film highlights the work of a Campaign partner, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), which uses a mobile banking system called M-PESA to transfer funds to cover a fistula patient's transport to the hospital to receive care. Innovative activities, such as CCBRT's M-PESA programme, enable Campaign partners to better provide their services and to help the hardest to reach and most excluded "invisible" women and girls suffering from fistula.

Additionally, UNFPA participated as a guest speaker in a global webinar on fistula, organized and hosted by the Clinton Global Initiative, and provided an overview of the Campaign to End Fistula, including its vision, strategy, achievements and the way forward.

International Obstetric Fistula Working Group (IOFWG) Meeting

The two-day meeting of the International Obstetric Fistula Working Group (IOFWG), hosted by UNFPA Uganda and the Ugandan Ministry of Health, was held in October in Kampala. More than 170 fistula surgeons and advocates worldwide attended the meeting, which preceded the biennial meeting of the International Society of Obstetric Fistula Surgeons (ISOFS). Multiple Campaign partner organizations, including Direct Relief International, Fistula Care Plus/EngenderHealth, Healing Hands of Joy (Ethiopia), Johns Hopkins University, One-by-One and Terrewode (Uganda) took part in the meetings' sharing of best practices and research on issues, such as the prevention and treatment of obstetric fistula; social reintegration of fistula survivors; the development and implementation of national strategies for ending fistula; and the use of technology, such as mobile phones, to enhance service delivery. Ugandan and Nigerian fistula survivors shared their stories. The meeting provided a chance for IOFWG partners to agree on priorities for the way forward.

Obstetric fistula is preventable and most cases of obstetric fistula can be treated.

FIGO Fistula Initiative Review Meeting

With the objectives of gathering experiences of fistula surgery trainers, training centers and trainees; considering opportunities and challenges for improving the FIGO Fistula Initiative; and strategizing on the future of the FIGO Fistula Initiative, FIGO hosted the 'Competency-Based Fistula Surgery Training Programme review meetings' in Dar es Salaam, Tanzania, in June 2014. UNFPA/The Campaign to End Fistula participated in this meeting of key stakeholders in the fistula community, which also featured a workshop on 'Moving Results of the EngenderHealth/WHO Randomized Trial into Standardized Training and Practice & Demonstration of an Interactive Simulation for Standardized Training.'

10 http://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2814%2970251-7/fulltext?rss=yes
11 http://www.endfistula.org/video/mobile-technology-and-obstetric-fistula

Bina Kathayat (46) developed fistula after delivering a stillborn child in a remote hill area. She is part of the 6% of patients with incurable fistula.

Nicolas Axelrod/Ruom for UNFPA 2014, Dharan, Nepal.

Fistula and Sexual and Reproductive Health Advisers Meeting

UNFPA held a meeting in December 2014 that served as an informal listening session on the sidelines of the annual MHTF global planning meeting. All interested UNFPA country and regional offices working on fistula were invited to share ideas, questions, experiences and lessons learned. Participants represented a dozen country offices as well as UNFPA headquarters. Discussion topics included data and research, treatment and quality of care, training and accreditation, prevention, social reintegration and resource mobilization. The meeting provided a forum for sharing good practices, collaborating on ideas across regions and identifying the next steps forward.

Regional Highlights

The First African Obstetric Fistula Conference for Fistula Survivors

The First African Obstetric Fistula Conference for Fistula Survivors took place in March 2014 in Nigeria. In the first-ever meeting of this caliber, 82 fistula survivors participated in the one-day conference organized by Campaign partner Fistula Foundation Nigeria and the Institute for African Women's Health. This was the first meeting of its kind to include input from fistula survivors on a large scale. Discussion groups were convened on such topics as hygiene and living with incontinence and issues related to social reintegration. Key findings and recommendations from this conference were shared by Fatima Aliyu Lawal, a Nigerian fistula survivor, and Dr. Gloria Esegbona, an obstetrician, gynaecologist and advocate, at the IOFWG and ISOFS meetings in Kampala in October. Their powerful voices, words and stories provided a vital woman-and-patient centered perspective to the meeting, which was considered highly valued and insightful by surgeons and other participants.

COUNTRY HIGHLIGHT

Ghana National Task Force

Many fistula-affected countries have created national task forces in recent years to oversee and guide national-level fistula activities. In May 2014, an 18-member national task force on obstetric fistula was inaugurated by the Ghana Health Service with support from UNFPA to coordinate and oversee fistula programmes in the country. Members of the task force include representatives of the Ministries of Health and Gender, the Ghana Health Service, WHO, UNFPA, local NGOs and teaching and research facilities. Formation of the task force is a big step toward steering planning, implementation and delivery of fistula programmes in Ghana as it employs a multi-sectoral approach, harnessing the comparative advantage of its members towards the common goal of ending obstetric fistula.

The task force is currently overseeing the progress of the first national study on obstetric fistula, aiming to establish the burden as well as quality, accessibility and acceptability of fistula care throughout Ghana. The assessment will also inform the development of a national strategy to eliminate fistula, and the task force will lead development of this strategy in 2015.

Country Highlights

National Strategies for Ending Fistula

UNFPA and the Campaign to End Fistula promote national leadership and ownership of ending obstetric fistula by advocating for and supporting the development and implementation of costed, time-bound national strategies and action plans for eliminating fistula in affected countries, among other approaches.

Formation of National Fistula Task Forces

UNFPA/The Campaign to End Fistula has long emphasized that each country affected by fistula should have in place a national task force, led by the Ministry of Health and in collaboration with UNFPA and all key fistula stakeholders, to support the development, implementation and monitoring of a national strategy and action plan to end fistula. UNFPA works to support numerous countries in establishing and successfully operating such task forces.

Certification of Fistula Training Centres

A serious need exists for more qualified, expert surgeons and healthcare workers who can conduct repair surgeries and support the health needs of women and girls with fistula. Accreditation by the International Federation of Gynecology and Obstetrics (FIGO) of fistula training centers is seen by UNFPA and the Campaign to be an important component for ensuring quality of care, including standardization of and adherence to training guidelines.

Ebola: Action Amid Crisis

Liberia, one of the three West African countries hit hard by the Ebola outbreak in 2014, channeled much of its resources and activities in directly responding to the outbreak. While some regular activities, such as a social reintegration programme for fistula survivors, were put on hold, other activities continued to provide services to fistula survivors. Even amid the crisis, UNFPA Liberia commemorated the International Day to End Obstetric Fistula by identifying 59 fistula survivors, who were recruited to receive treatment and raising awareness of fistula in several communities.

COUNTRY HIGHLIGHT

Ethiopian National Plan to Eliminate Fistula by 2020

In 2014, the government of Ethiopia announced it was creating a plan to eliminate fistula in the country by 2020, as part of its broader Health Sector Transformation Plan. Ethiopia's plan utilizes the Campaign's three-pronged approach of fighting fistula through prevention, treatment and social rehabilitation of fistula survivors. The Ethiopia plan can be a model for other countries on how to develop and implement national strategies for ending fistula within a generation.

Development of New Training Materials

UNFPA **Nepal**, partnering with the Nepal Ministry of Health and Population and Jhpiego, developed an on-the-job training manual on Management of Obstetric Fistula for Health Care Providers. This manual is meant to be used in tandem with the Global Competency-Based Fistula Surgery Training Manual developed by FIGO, the International Society of Obstetric Fistula Surgeons (ISOFS), UNFPA, EngenderHealth and the Royal College of Obstetricians and Gynaecologists (RCOG).

COUNTRY HIGHLIGHT

First Certified Training Centre in Kenya

In 2014, Gynocare, a fistula treatment centre in Eldoret and a Campaign to End Fistula partner, became the first FIGO-accredited fistula training centre in Kenya. Another Campaign partner, Fistula Foundation, began sponsoring fistula surgical training for Kenyan surgeons at Gynocare as part of its Action on Fistula programme in Kenya, launched in 2014.

During the UNFPA-supported stakeholders meeting, partners welcomed this facility, which will also build capacity of health workers in the East African region.

Highlights of Results Achieved by Partners of the Campaign in 2014:

As the lead agency of the global Campaign to End Fistula and the international Secretariat for the International Obstetric Fistula Working Group, UNFPA coordinates, guides and supports the work of countless partners at global, regional, national and subnational levels.

Selected achievements of the key global Campaign partners are highlighted below.

Fistula Foundation began its three-year Action on Fistula programme in Kenya, which aims to provide fistula repair surgery to 1,200 women and girls from 2014-2017.

Fistula Care Plus (FC+)/EngenderHealth and the Maternal Health Task Force convened the first meeting of the FC+ International Research Advisory Group in July 2014. This two-day meeting brought together prominent actors in the field of fistula, including UNFPA/The Campaign to End Fistula, to discuss research issues such as clinical/biomedical factors, epidemiology and community factors; to share the latest approaches for measuring the burden of fistula; and to shape the global fistula research agenda going forward.

In addition, Fistula Care Plus (FC+) hosted a two-day consultation on measurement and estimation, providing a valuable opportunity to synthesize available approaches and identify priorities quantifying the burden of fistula prevalence, incidence and treatment backlog.

National Management Centre for Obstetric Fistula.
Nicolas Axelrod/Ruom for UNFPA 2014, Dhaka, Bangladesh.

Father Aldo Marchesini, a national of Italy who is also a medical doctor and has performed fistula repairs in Mozambique for the last 40 years, was a recipient of the 2014 United Nations Population Award, in recognition of his longstanding service and dedication to woman and girls living with fistula.

The International Federation of Gynecology and Obstetrics (FIGO) began its Fistula Training Initiative to strengthen the capacities of fistula surgeons in accredited training centres, using the Global Competency-Based Fistula Surgery Training Manual developed by FIGO and with support from UNFPA, the International Society of Fistula Surgeons (ISOFS), EngenderHealth and the Royal College of Obstetricians and Gynaecologists (RCOG).

The International Society of Fistula Surgeons (ISOFS) held its fifth international conference in October 2014 in Kampala, Uganda, titled "End Fistula: A Shared Responsibility." Hundreds of fistula surgeons and partners attended the two-and-a-half day meeting. Highlights included presentations of new research on prevention, treatment and social reintegration, a research methods workshop led by Fistula Care Plus, "hands-on" surgical workshops led by leading ISOFS surgeons and UNFPA's presentation summarizing key messages, highlights and recommendations from the preceding IOFWG meeting.

The manual provides guidelines for implementing on-the-job training for surgeons in Nepal, in order to ultimately increase the volume of quality fistula surgical repairs. Additionally, it can be adapted and replicated by other countries seeking to standardize and strengthen their on-the-job training of fistula surgeons. Nepal has also created guidelines on the treatment of pelvic organ prolapse, to address the broader spectrum of reproductive health morbidities suffered by women in the country.

South-South Training and Collaboration

UNFPA/The Campaign to End Fistula continued to facilitate South-South exchanges across many countries and regions, strengthening global capacity for fistula treatment and programming. For example, in **Yemen**, despite instability, UNFPA Yemen has continued to provide services and support to fistula survivors. In 2014 activities included training of two surgeons, three nurses and two social workers at the Addis Ababa Fistula Hospital in **Ethiopia**. The surgeons received 1.5 months of training. The health workers then brought back their newly acquired skills and knowledge to two regions in Yemen. Strengthening of South-South collaborations and knowledge sharing is essential in the fight against fistula.

In conclusion, while much has been done towards solving the health and human rights tragedy of obstetric fistula, much remains to be done. The UN Secretary-General has called upon world leaders to commit to ending the scourge of fistula in our lifetime. To do so, he stated, the international community must significantly intensify support to nations with the greatest need.

Having supported over 57,000 fistula repair surgeries since the launch of the global Campaign to End Fistula — enabling countless women and girls to "get their lives back" — UNFPA will not be satisfied until all women and girls suffering from fistula have been treated and supported and no new cases occur. UNFPA's leadership of the Campaign remains strong and well positioned to lead the fight to eliminate fistula (together with preventable maternal and newborn mortality and morbidity) in the post-2015/ Sustainable Development era.

By continuing to lead key strategic initiatives, including heightening awareness and support at global, regional and national levels through advocacy; providing technical leadership, guidance and standard setting; building capacity at national (and subnational) levels to scale up cost-effective prevention, treatment and reintegration approaches; convening and coordinating a growing coalition of key stakeholders; and facilitating evidence-based advocacy, policymaking and programming, UNFPA/The Campaign to End Fistula remains deeply committed to completing the unfinished agenda of eradicating fistula and ensuring the health, rights and dignity of women and girls everywhere.

Maternal Death Surveillance and Response

5

Uganda, 2015: Maternity Ward, Soroti Referral Hospital

Highlights

The MHTF supports countries in implementing MDSR systems and helping to improve notification rates, the quality of data and the appropriate response. The MHTF allowed UNFPA to contribute to the development, with the CDC and WHO, of a MDSR guidance document. An MDSR system serves to identify, register and report the cause for every maternal death, with necessary action to be implemented to prevent the fatalities and arrange for follow-up.

When a country sets up a national MDSR system, all maternal (and perinatal) deaths occurring at facility and community levels are communicated regularly by being entered into the central data system. It is recommended to liaise MDSR with the national disease notification system to maximize local capacities.

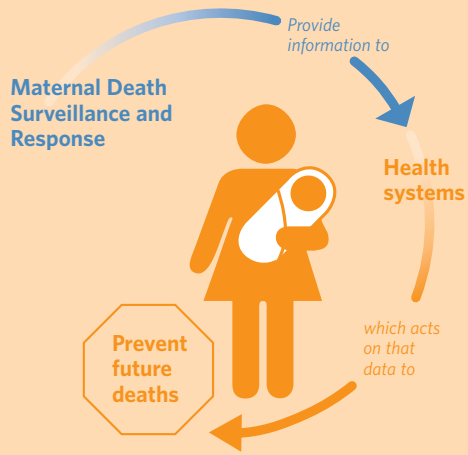
Such routine registration of maternal death information allows for the identification of not only the main causes of maternal deaths but also the geographical origin and variations in mortality burden and its causes. Action has to be taken based on the recommendations drawn from case reviews at local, district and national levels within the national MDSR committees. MDSR is aimed at supporting health professionals, including managers, communities and policymakers' mobilization to end preventable maternal and neonatal deaths and stillbirths.

Results:

Questionnaire to measure progress in MDSR implementation at policy and programmatic levels applied in all countries with high MMR. Results of this global survey will be known in 2015.

New indicators to establish scope and quality of MDSR data introduced in all MHTF countries

National capacity for MDSR strengthened in three countries through South-South collaboration.



Maternal Death Surveillance and Response

MHTF actively supports countries to switch from maternal death reviews to Maternal Death Surveillance and Response (MDSR). As a result of continuous sensitization and advocacy, more and more countries work to adapt an MDSR approach. The added value of MDSR is that not only every maternal death is reviewed and registered but also that action is taken on this information; a response is instituted using the qualitative data to improve the health systems, including at community level.

Global Highlights

At facility and district levels, MDSR is a powerful means to improve quality of care. Well analyzed, the tragedy of a maternal death becomes a lesson learned that contributes to prevent future deaths.

Thus there is great recognition of the benefits of the MDSR approach, and many countries have started to implement this strategy. UNFPA is working with WHO at global and regional levels to monitor the progress of implementation documenting how challenges are addressed, and the level of financial and technical support that is required to do so. In 2014, MHTF and WHO designed an MDSR survey based on the implementation guidance launched in 2013, to be carried out in every MHTF country annually.

Well analyzed, the tragedy of a maternal death becomes a lesson learned that contributes to avoiding similar cases having the same tragic outcome in the future.

In addition to the immediate advantages at the facilities level, MDSR systems can potentially inform policymakers, programme managers, professionals, community leaders and media about maternal mortality with real data, and can also make possible a national analysis of maternal death trends, their causes and how they can be avoided. For this purpose, the MHTF successfully advocated for the use of new performance indicators on the proportion of notified deaths as related to the expected number of maternal deaths and on the proportion of reviewed cases as related to the number of notified maternal deaths.

In general, MDSR programmes in developing/MHTF countries are facing three issues:

- low notification rate
- poor quality of data collected from maternal deaths review
- lack of development of the response phase of MDSR

The tools developed by the MHTF-support countries address all these issues.

Regional Highlights

In 2014, UNFPA regional offices continued to play a key role in MDSR development. After a sensitization phase, they now focus on the MDSR planning process in countries and the required technical support. With MHTF support, UNFPA regional offices also focus on the documentation of the process.

In November 2014, a regional meeting was organized by **UNFPA Asia and Pacific Regional Office (APRO)** with MHTF support for nine Asian and Pacific countries (Afghanistan, Bangladesh, Bhutan, Cambodia, Lao, Mongolia, Myanmar, Nepal, Timor-Leste, Vietnam). These countries indicated a need for technical assistance in MDSR planning.

Colleagues from UNFPA country offices and representatives from national Ministries of Health presented a situation analysis; three main challenges were identified:

- Many countries experience quality issues in maternal deaths reviews. There are often a lack of confidentiality and weaknesses in the methodology used to collect relevant information and the diagnosis process to establish the cause of death.
- The national coverage for maternal death notification and review varies a lot from one country to another. Full coverage exists in Mongolia where MDR (maternal death review) has been implemented since the 70s. Among countries that have implemented MDSR more recently, a group of countries shows notification coverage around 30 percent (Cambodia, Lao, Nepal, and Vietnam). A third group shows low coverage around 5-10 percent (Afghanistan, Bangladesh, Myanmar).

Timor-Leste has just started MDSR development. However, in most countries, maternal death reviews are particularly challenging at the community level.

- Consolidating and analyzing data is still very challenging in most countries. There is often no mechanism to provide recommendations using such findings and no publication of a MDSR national report. The excellent presentation of the Malaysian MDSR system revealed to the participants the value of having a well-functioning MDSR system to inform and improve maternal health policy. It also highlighted the importance of monitoring the MDSR system to ensure that quality issues are documented by the system.

The UNFPA **East and Southern African Regional Office (ESARO)** in collaboration with the African Union Commission, the National Department of Health in South Africa, WHO and UNICEF as well as support from the UK (DFID) organized a four-day meeting to strengthen the institutionalization of MDSR by improving the capacity of in-country experts on maternal death data collection, analysis and report writing. The use of data to support governments in designing and implementing policies and programs that improve maternal health care was also covered at the meeting. The experiences and results realized through the MHTF were well positioned to inform the process.

The meeting brought together national teams (comprising programme managers from UNFPA, WHO, UNICEF and MoH) from Angola, DRC, Eritrea, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, South Africa, South Sudan, Swaziland, Tanzania, Zambia and Zimbabwe, totaling 78 participants from 18 countries attending.

The meeting provided a platform to share and learn from different country experiences, including activities financed through the MHTF, and to discuss challenges that countries are facing in institutionalizing, collating and analyzing MDSR data in the East and Southern Africa (ESA) region. It allowed countries to reach consensus on key issues, to formulate actionable recommendations and to review and revise their work plans to strengthen MDSR institutionalization in their countries and the region.

On an ongoing basis, the ESARO carefully follows progress in the development of MDSR in East and Southern Africa and launched a survey to more systematically assess implementation. Preliminary analysis shows that 16 countries in ESA are now carrying out MDSR at different stages of implementation. Figures 5 and 6 highlight the status of MDSR implementation in the region.

Figure 5. Number of countries with notification of Maternal Deaths in East and Southern Africa

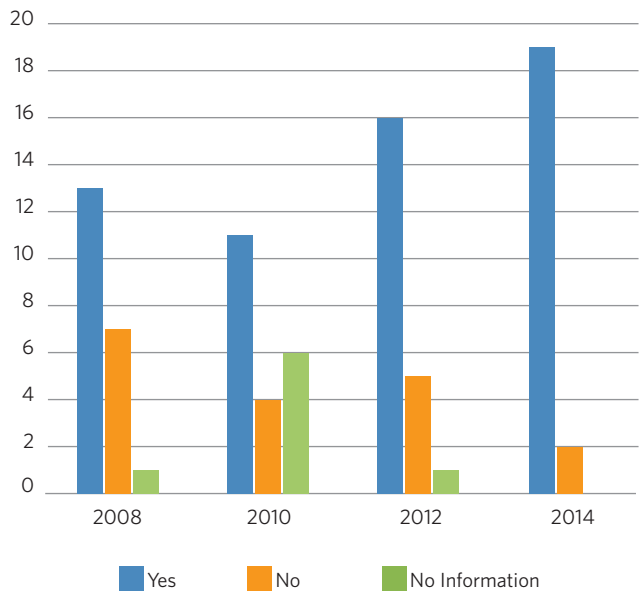
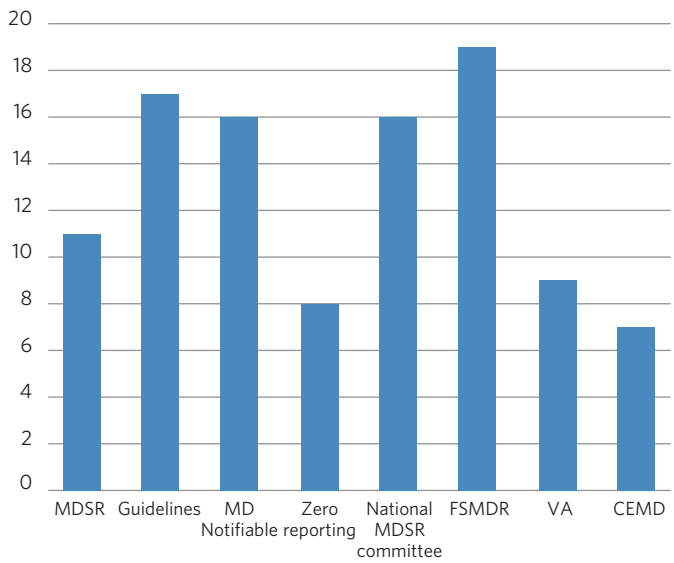


Figure 6. Number of countries with institutionalized MDSR components in East and Southern Africa



FBMDR: Facility based maternal death review
VA: Verbal autopsy
CEMD: Confidential enquiries into maternal deaths.

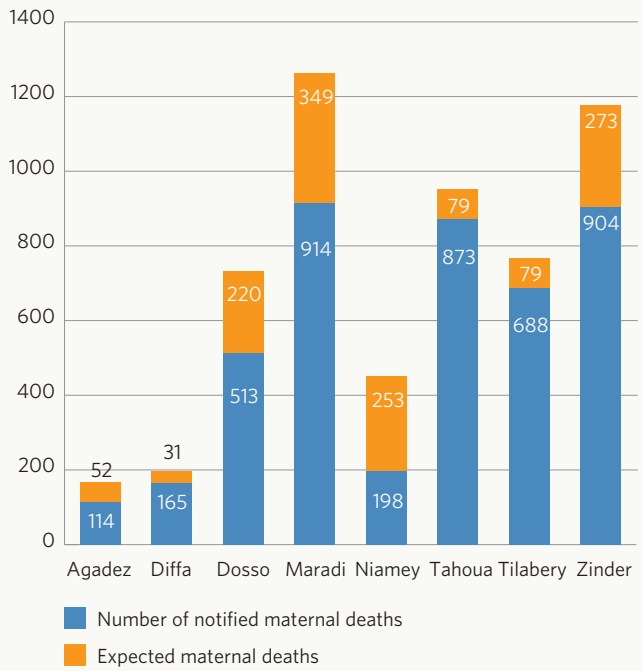
Niger: A Rapid MDSR Scaling-Up

Niger experiences 4,300 maternal deaths every year. Following a sensitization workshop organized by UNFPA and WHO regional office in 2012, the Niger MoH committed to implementing MDSR at the national level to address this unacceptable situation. At the MoH's request, the UNFPA country office in Niger made a situation analysis of the MDSR implementation, which found that **Niger had developed some key elements for scaling up MDSR:**

- A national MDSR committee was officially created by ministerial decree in August 2013;
- Notification is mandatory for maternal deaths in facilities;
- Review of notified maternal deaths is mandatory;
- 392 health providers are trained in MDSR;
- Performance indicators developed:
  - a) proportion of expected maternal deaths that are notified and
  - b) proportion of notified maternal deaths that are reviewed;
- Qualitative indicators are also implemented for the notification phase: promptness and completeness;
- The three elements of MDSR (notification, review/analysis and the response) are implemented.

In 2014, 1,336 maternal deaths (31 percent) were notified versus only 307 in 2013. These are facility maternal mortality notifications. The data are disaggregated by region (Figure 7) and district.

Figure 7. Number of notified maternal deaths in facilities according to the expected maternal deaths



The disaggregated data will enable regional and district analysis to help boost notification performance.

A 31 percent national notification rate (facility based data) is still insufficient for an in-depth national analysis of maternal deaths causes in Niger. However, 31 percent coverage is an excellent start, putting Niger

The graphs show a progressive increase in notification of maternal deaths, review of maternal deaths and government funding for the programme, which is important for its sustainability. Partners continue to be the main funders of the programme in a number of countries.

Country Highlights

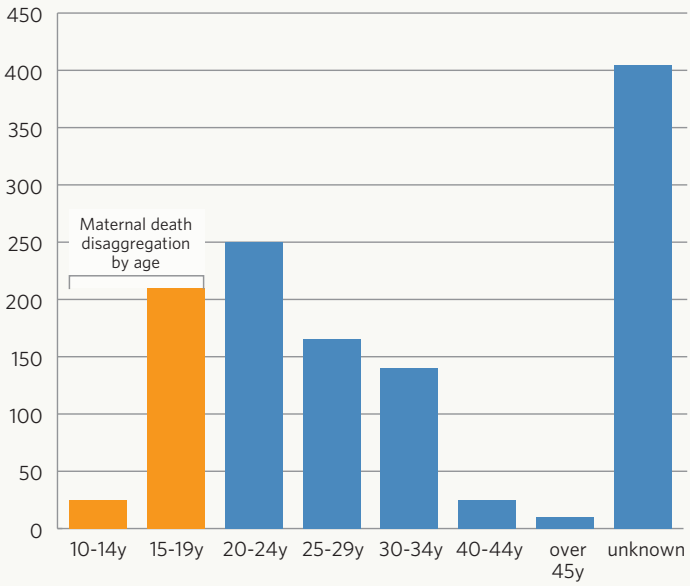
Supporting the Implementation of MDSR

In **Burkina Faso**, the MHTF supports MDSR development nationally. The notification procedure is implemented weekly. In the first half of 2014, 310 notifications were made.

The MoH in **Kenya** has an ambition to implement a MDSR system nationally. UNFPA with other H4+ partners have strongly supported the MoH's effort to develop this system. A MDSR review supported by UNFPA was conducted so that the MoH could get an overview of the main challenges that need addressing.

In **Malawi**, MDSR is implemented in all 29 districts of the country. The national MDSR guidelines have been developed by the MoH with MHTF support. The proportion of expected maternal deaths notified in facilities is 19 percent; among the 668 maternal deaths notified, 80 percent were reviewed.

Figure 8. Notified maternal deaths in facilities by age



among the best MDSR performers in developing countries in Africa and Southeast Asia.

The proportion of notified maternal deaths that are reviewed is 23 percent; it varies from 1 to 94 percent, depending on the regions. This huge variation suggests that quick improvements can be expected if a focus is made on the underreporting regions, in particular those that notify a significant amount of maternal deaths.

Another interesting finding is the maternal death disaggregation by age (Figure 8), notably the number of deaths among very young girls and the proportion (29 percent) of the 10-19 year-olds in these deaths. This provides evidence to advocate against early marriage and early pregnancy.

The MDSR system in Niger set up the response phase in which the findings of the maternal deaths reviews are used at all levels of the system to improve functioning and prevent similar cases in future. Obstacles to referrals, lack of guidance and protocols, lack of skilled staff, poor quality of care and lifesaving commodities stock-out are the main factors in maternal deaths identified in the reviews.

Based on this analysis, the MoH and partners took action. Nationally, more equipment and targeted training will be provided to the EmONC facilities. New protocols of care have been developed. Regionally, the focus is on supervision and SBAs (skilled birth attendants) deployment.

The next target of UNFPA's country office is to develop subnational MDSR committees and support community involvement in MDSR to develop maternal deaths notification at this level. MDSR is a political matter, requiring commitment from ministries, decision-makers and religious and community leaders.

The MoH began using the findings to improve implementation of the national maternal and newborn health programme. Among the main steps are improving availability of magnesium sulphate and Misoprostol; training of midwives in lifesaving skills and emergency obstetric care; and deployment of equipment and staff to B-EmONC.

The ongoing MDSR global survey will contribute immensely to providing information on country progress and needs.

In conclusion, the Maternal Death Surveillance and Response is a new approach being proposed to countries. It reflects the need for society to concretely recognize that every single maternal death is unacceptable, and that the health system needs to learn from each maternal death to address dysfunctions and improve quality of care. The commitment of the governments and partners is critical to develop MDSR at national scale.

The role of the MHTF in MDSR development is to facilitate technical expertise in countries to implement such a system on a national scale and foster ownership of consistent situation analyses and drafting of national reports.

Resources and Management

6

The Maternal Health Trust Fund comprises two multi-donor funding streams: the **Thematic Trust Fund for Maternal Health** and the **Thematic Fund for Obstetric Fistula**. Funding for fistula is increasing also channelled through the Thematic Trust Fund for Maternal Health.

In 2014, the **Thematic Trust Fund for Maternal Health:**

- reached an **operating budget of USD 24.6 million.**
- achieved an **implementation rate of 95 percent.**
- allocated **83.1 percent (USD 14.62 million) for regional and country programmes** in 40 countries, and 16.9 percent (USD 2.96 million) for global programmes.

In 2014, the **Thematic Fund for Obstetric Fistula:**

- reached an **operating budget of USD 0.69 million.**
- achieved an **implementation rate of 73 percent.**
- allocated **100 percent (USD 0.68 million) for regional and country programmes, primarily in sub-Saharan Africa.**

In terms of MHTF expenditure, **the midwifery programme** and the **Campaign to End Fistula** accounted for the majority, with 49 percent and 29 percent, respectively.

Sia Sandi, student midwife from The School of Midwifery in Masuba, Makeni, on placement at Makeni Regional Hospital, Bombali District, Sierra Leone.

Abbie Trayler-Smith

In 2014, the MHTF continued to contribute to significant results spanning 42 high maternal mortality countries. These results were achieved through resources generously provided by the MHTF donors.

As a funding mechanism, the MHTF consists of two multi-donor funds: the Thematic Trust Fund for Maternal Health (ZZT06) and the Thematic Fund for Obstetric Fistula (ZZT03). The two have been programmatically integrated under the MHTF since 2009, and most of the funding for the Campaign to End Fistula is now provided from the Thematic Trust Fund for Maternal Health (ZZT06).

Thematic Trust Fund for Maternal Health (ZZT06)

Contributions

Table 3 shows that USD 18.3 million was received in 2014. This compares to USD 13.5 million in 2013, representing a 36 percent increase in 2014.

Table 3. Total contributions, revenues and contributions payments received for maternal health (ZZT06) in 2014

Donors	Contributions revenues* (USD)	Contributions payments received (USD)
Friends of UNFPA	136,873	136,873
Germany	1,251,564	1,317,523
Luxembourg	1,576,763	1,551,020
Spain	683,995	683,995
Sweden*		7,704,160
Sweden*		6,905,124
TOTAL 2014	**3,649,195**	**18,298,695**

* The contributions received from Sweden in 2014 are not included in the 2014 contributions revenue list because they were recognized in 2013, the year the agreement was signed. With the adoption of the international Public Sector Accounting Standards (IPSAS), UNFPA recognizes revenue when a binding agreement is signed by a donor, not when payments are received. By recognizing revenue this way, UNFPA is better equipped to understand its revenue inflows and expenses, therefore providing cash-flow management, programme planning and prediction of cash-flow needs. This represents a major step in improving the quality and transparency of financial information provided to donors and partners.

Table 4. Operating budget for maternal health activities in 2014

Donors	Contributions (USD)
Carry-over from 2013	13,304,717
Germany	1,317,523
Luxembourg	1,551,020
Spain	683,995
Sweden	7,704,160
TOTAL	**24,561,415**

Operating Budget

To establish the available operating budget for 2014, the carry-over from 2013 needs to be factored in. As Table 4 shows, the carry-over of USD 13.3 million constituted a significant proportion of the contributions in 2014. A main explanation was that a USD 10.5 million contribution from Sweden was received in the fourth quarter of 2013, and therefore used for implementation in 2014. Likewise, the second Swedish contribution in 2014 of USD 6.9 million, and the contribution from Friends of UNFPA of USD 0.14 million were received in the fourth quarter of

Figure 9. Operating budget for maternal health in 2013 and 2014 (in USD millions)

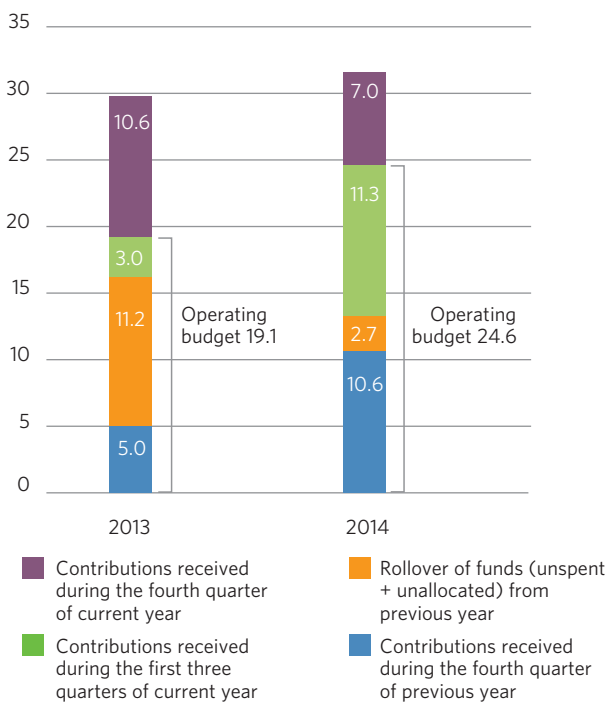
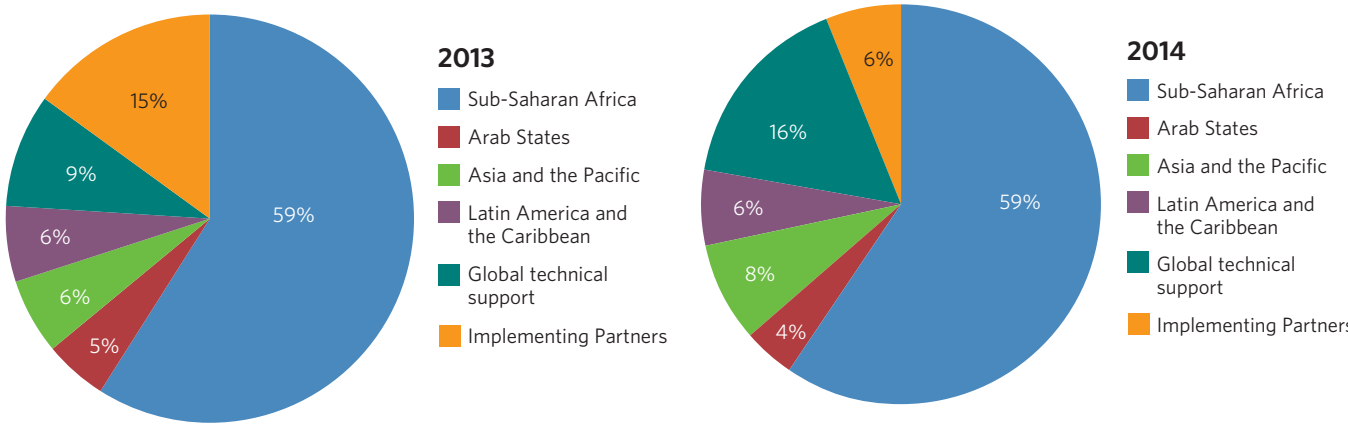


Figure 10. Share of expenditures for maternal health by region and globally in 2013 and 2014



2014 and applied to operations in 2015. With these adjustments, the operating budget for the Thematic Trust Fund for Maternal Health totalled USD 24.6 million in 2014, representing an increase of USD 5.5 million, or 29 percent, as compared to 2013.

Figure 9 provides an overview of how the payments received in the fourth quarter of one year (purple) become (the blue) part of the operating budget for the following year. In practical terms these "early" contributions greatly facilitate more timely planning processes and ensure continuity in activities.

Expenditures

In 2014, expenditures for maternal health totaled USD 16.79 million, compared to USD 17.27 million in 2013. During 2014, the level of spending for country and regional programmes, including spending by international NGOs (INGOs) and institutions in support of activities at the country level, accounted for 84.0 percent (USD 14.10 million) of the total MHTF expenses for maternal health. The remaining 16.0 percent (USD 2.69 million) covered spending on global programmes. This compares to 90.8 percent (USD 15.68 million) for country and regional programmes in 2013, and 9.2 percent (USD 1.59 million) for global programmes. Figure 10 shows the distribution of expenditures among regions and the global level in 2013 and 2014.

The expenditure level of USD 16.8 million in 2014 on maternal health represented a financial implementation rate of 95 percent against the total allocation of USD 17.6 million (Table 5 / Figure 11). For comparison, the financial implementation rate was 94 percent in 2013, 91 percent in 2012 and 88 percent in 2011. This shows a rising trend of implementation despite challenges faced in countries such as humanitarian situations, like the Ebola crisis in 2014.

Support to Country, Regional and Global Programmes

As mentioned above, the total allocation to country, regional and global programmes in 2014 totalled USD 17.61 million, compared to USD 18.39 million in 2013. Of the 2014 allocation, 83.1 percent (USD 14.62 million) was allocated for regional and country programmes,

Figure 11. Operating budget, allocations and expenditures for maternal health in 2013 and 2014 (in USD million)

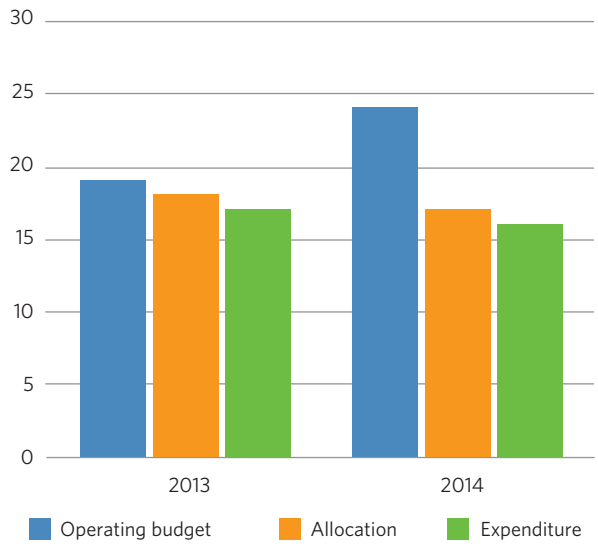


Table 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2013 and 2014

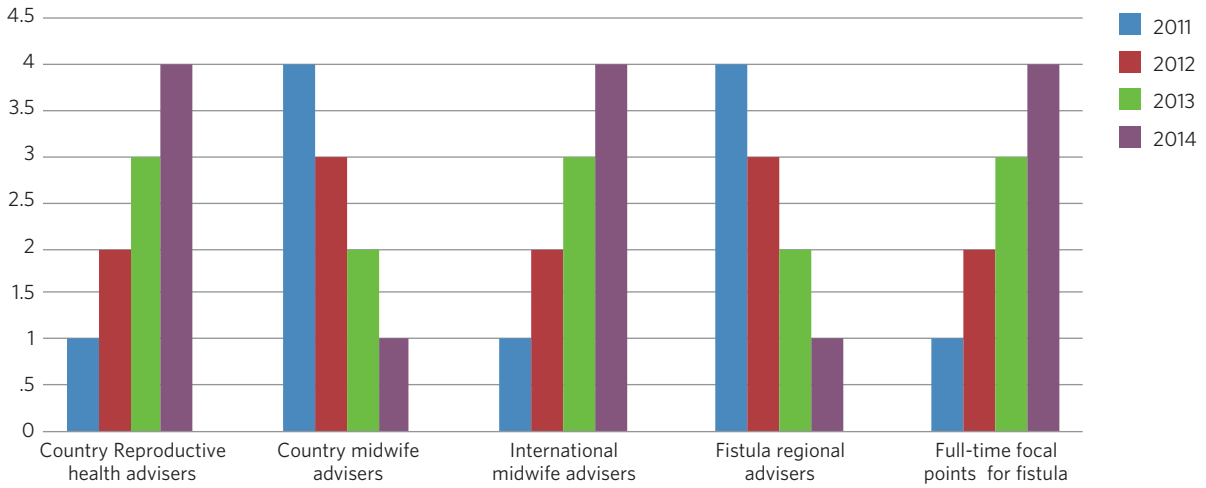
	2013			2014		
Regional office/country office/global technical support/partners	Approved allocation (USD)	Expenditure (USD)	Implementation rate (%)	Approved allocation (USD)	Expenditure (USD)	Implementation rate (%)
Sub-Saharan Africa						
East and Central Africa Regional Office/ Johannesburg	350,000	324,957	93	262,500	155,094	59
Western and Central Africa Regional Office/Dakar	210,000	178,241	85	210,000	28,903	14
Benin	420,000	380,034	90	420,000	395,190	94
Burkina Faso	500,000	489,403	98	500,000	399,268	80
Burundi	385,000	479,500	125	385,000	397,055	103
Cameroon	25,000	25,320	101	35,000	30,554	87
Central African Republic	350,000	295,314	84	128,079	63,121	49
Chad	960,000	990,432	103	960,000	820,773	85
Congo	25,000	33,112	132	120,000	115,064	96
Côte d'Ivoire	420,495	442,017	105	443,539	380,951	86
Democratic Republic of the Congo	1,020,000	938,653	92	1,001,630	962,921	96
Eritrea	12,500	11,537	92			
Ethiopia	750,000	812,933	108	750,000	1,485,731	198
Ghana	270,000	409,398	152	270,000	272,987	101
Guinea	37,500	47,429	126	180,000	94,017	52
Guinea-Bissau	25,000	3,316	13	140,000	100,187	72
Kenya	25,000	9,000	36	215,000	191,250	89
Liberia	210,000	204,320	97	210,000	185,725	88
Madagascar	595,000	710,569	119	595,000	554,535	93
Malawi	420,000	418,181	100	315,000	279,041	89
Mali	120,000	103,252	86	120,000	56,164	47
Mauritania	25,000	24,807	99	60,000	55,862	93
Mozambique	140,000	132,390,	95	140,000	134,497	96
Namibia	50,000	40,474	81			
Niger	280,000	293,001	105	280,000	272,196	97
Nigeria	400,000	361,695	90	300,000	281,886	94
Rwanda	150,000	132,897	89	150,000	149,964	100
Senegal*	200,000	170,469	85		-12,764	
Sierra Leone	500,000	557,676	112	515,000	525,018	102
South Sudan	700,000	680,360	97	612,500	610,441	100
Togo	-	-	-	100,000	99,729	100
Uganda	350,000	322,956	92	350,000	428,843	123
Zambia	245,000	195,770	80	300,000	292,708	98
Zimbabwe	25000	19106	76	112,500	150,301	134
Sub-Saharan Africa total	**10,195,495**	**10,238,520**	**100**	**10,180,748**	**9,957,213**	**98**

Table 5. Approved allocations, expenditures and financial implementation rate for maternal health in 2013 and 2014 (continued)

	2013			2014		
Regional office/country office/global technical support/partners	Approved allocation (USD)	Expenditure (USD)	Implementation rate (%)	Approved allocation (USD)	Expenditure (USD)	Implementation rate (%)
Arab States						
Djibouti	90,000	87,531	97			
Republic of Yemen	25,000	24,612	98	100,000	75,026	75
Somalia	300,000	280,203	93	300,000	306,372	102
Sudan	425,000	421,614	99	425,000	369,950	87
Arab States total	**840,000**	**813,960**	**97**	**825,000**	**751,348.71**	**91**
Asia and the Pacific						
Afghanistan	500,000	444,048	89	438,800	398,911	91
Bangladesh	120,000	53,060	44	120,000	119,985	100
Cambodia	100,000	87,494	87	80,000	79,935	100
Timor-Leste	100,000	55,449	55	156,000	136,472	87
Lao People's Democratic Republic	200,000	218,426	109	282,587	267,492	95
Nepal	100,000	82,990	83	100,000	95,480	95
Pakistan	62,500	34,256	55	250,000	229,981	92
Asia and the Pacific total	**1,182,500**	**975,723**	**83**	**1,427,387**	**1,328,256**	**93**
Latin America and the Caribbean						
Latin America and the Caribbean Regional Office	87,500	87,376	100	87,500	74,691	85
Subregional Office Kingston*	0	7006		0	3,534	
Guyana	0	446				
Haiti	940,751	918,807	98	950,599	935,246	98
Latin America and the Caribbean total	**1,028,251**	**1,013,634**	**99**	**1,038,099**	**1,013,470**	**98**
Global technical support						
Global technical support, including implementing partners	4,900,467	3,977,798	81.2	3,606,627	3,210,603	89
Information and External Relations Division	150,000	186,240	124	282,800	278,290	98
Media and Communications Branch	100,000	66,788	67	250,000	249,431	100
Global technical support total	**5,150,467**	**4,230,826**	**82**	**4,139,427**	**3,738,323**	**90**
GRAND TOTAL	**18,396,713**	**17,272,664**	**94**	**17,610,660**	**16,788,611**	**95**

* countries showing in 2014 carry-over expenditures from 2013

Figure 12. Staff positions in UNFPA country office supported by the MHTF



including INGOs and institutions supporting programme activities at the country level. This compared to 88.7 percent (USD 16.32 million) in 2013. 16.9 percent (USD 2.96 million) of the total 2014 allocation was for global programmes, compared to 11.3 percent (USD 2.07 million) in 2013.

When divided among regions, sub-Saharan Africa accounted for most of the allocated funds to maternal health, or 57.8 percent (USD 10.18 million). Asia and the Pacific accounted for 8.1 percent (USD 1.43 million); Latin America and the Caribbean for 5.9 percent (USD 1.04 million); and the Arab States accounted for 4.7 percent (USD 0.83 million) of allocations.

The MHTF also contributed to increasing the human resource capacity of UNFPA at all levels, especially at country level (Figure 12).

Thematic Trust Fund for Obstetric Fistula (ZZT03)

Regarding the Thematic Trust Fund for Obstetric Fistula (ZZT03), trends of less direct funding by donors continued in 2014. Yet funding for obstetric fistula activities continued to be increasingly channelled through the Thematic Trust Fund for Maternal Health (ZZT06).

Contributions

Table 6 shows that contributions, revenues and contribution payments received in 2014 corresponded and reached a level of USD 0.4 million as compared to USD 0.9 million in 2013.

Operating Budget

Table 7 shows that the operating budget for the Thematic Fund for Obstetric Fistula for 2014 is significantly larger than contributions received in 2014 because it includes carry-over funds from 2013. The 2014 contribution from Friends of UNFPA, however, was not included, since it was received in the fourth quarter of 2014; it will therefore be spent for interventions in 2015.

Figure 13 shows how the 2014 operating budget for the Thematic Fund for Obstetric Fistula (ZZT03) compares to 2013. As indicated above, the downward trend is not an indication of failing support to fistula but rather an indication that more funds are channelled through the Thematic Trust Fund for Maternal Health.

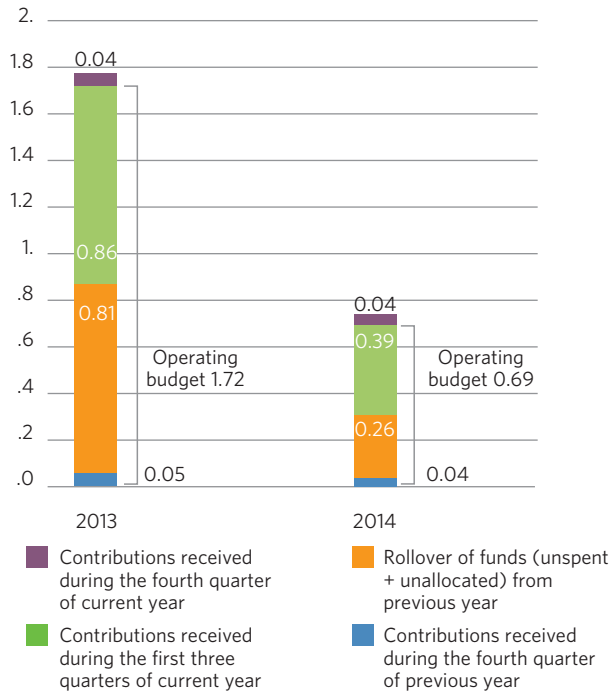
Table 6. Total contributions, revenues and contributions payments received for the Thematic Fund for Obstetric Fistula (ZZT03) in 2014

Donors	Contributions revenue (USD)	Contributions payments received (USD)
Friends of UNFPA	40,837	40,837
Iceland	105,226	105,226
Luxembourg	285,714	285,714
TOTAL 2014	**431,777**	**431,777**

Table 7. Operating budget for the Thematic Fund for Obstetric Fistula (ZZT03) for 2014

Donors	Contributions (USD)
Carry-over from 2013	298,146
Iceland	105,226
Luxembourg	285,714
TOTAL 2014	**689,086**

Figure 13. Operating budgets for obstetric fistula in 2013 and 2014 (USD millions)



Expenditures

Expenditures in 2014 from the Thematic Fund for Obstetric Fistula reached a total of USD 0.49 million, compared to USD 1.48 million in 2013. In light of the limited resources available for ZZT03 it was decided to make only allocated ZZT03 funds available for country programmes, including spending by INGOs and institutions supporting programme activities in countries – mainly sub-Saharan Africa. The share of expenditures among regions is evident in Figure 14.

The total expenditures of USD 0.49 million represent a financial implementation rate of 73 percent when compared to the total allocations of USD 0.68 million. In 2013, the financial implementation rate was 86 percent. (see Figure 15).

Figure 15: Operating budget, allocations and expenditures for obstetric fistula in 2013 and 2014 (USD million)

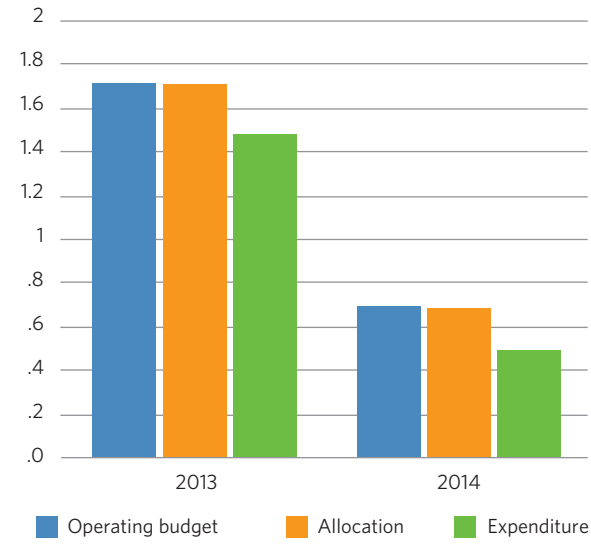
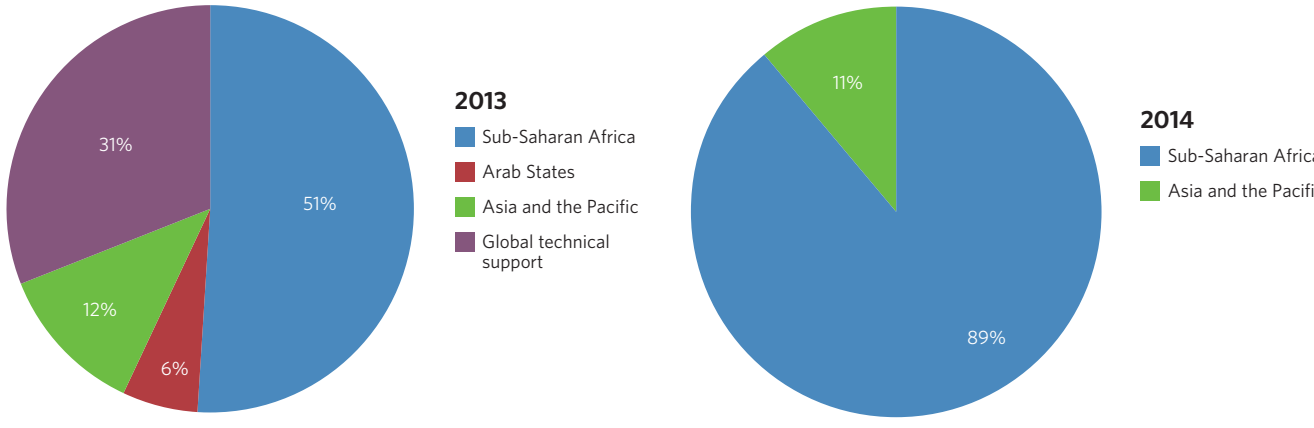


Figure 14. Share of expenditures for obstetric fistula by region and globally in 2013 and 2014



Support to Country Programmes

Allocations to country, regional and global level programmes for obstetric fistula totaled USD 0.68 million in 2014, compared to USD 1.72 million in 2013. As mentioned, 100 percent of allocations went to country level activities in 2014, compared to 66.6 percent (USD 1.15 million) in 2013.

As a region, sub-Saharan Africa represented the largest share of allocations at 91.0 percent (USD 0.62 million). Asia and the Pacific region accounted for 9.0 percent (USD 0.06 million). Table 8 shows allocation, expenditures and the financial implementation rate by region, by country and globally in 2013 and 2014.

Table 8. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2013 and 2014

	2013			2014		
Regional office/country office/ global technical support/ partners	Approved Allocation (USD)	Expenditure (USD)	Implementation Rate %	Approved Allocation (USD)	Expenditure (USD)	Implementation Rate %
Sub-Saharan Africa						
Benin*		1716			191	
Cameroon	75,000	73,787	98	65,000	43,808	67
Congo	75,000	54,236	72		0	
Côte d'Ivoire	79,505	76,709	96	56,461	20,736	37
Democratic Republic of the Congo	280,000	234,617	84	48,370	26,687	55
Eritrea	37,500	10,160	27	50,000	48,000	96
Guinea*	112,500	103,144	92		(42)	
Guinea-Bissau*	75,000	65,749	88		27	
Kenya*	75,000	60,057	80		18	
Liberia		213*			0	
Mauritania	75,000	74,121	99	40,000	38,439	96
Nigeria				100,000	92,979	93
Senegal		130*		200,000	135,096	68
South Sudan				57,500	32,790	57
Sub-Saharan Africa total	**884,505**	**754,638**	**85**	**617,331**	**438,731**	**71**
Arab States						
Republic of Yemen	75,000	66,236	88		0	
Somalia		27,619			0	
Arab States total	**75,000**	**93,855**	**125**		**0**	
Asia and the Pacific						
Afghanistan				61,200	53,237	87
Pakistan	187,500	180,573	96		0	
Asia and the Pacific total	**187,500**	**180,573**	**96**	**61,200**	**53,237**	**87**
Global technical support						
Global technical support, including implementing partners	576,776	455,490	79		0	
Global technical support total	**576,776**	**455,490**	**79**		**0**	
GRAND TOTAL	**1,723,781**	**1,484,556**	**86**	**678,531**	**491,968**	**73**

*Countries showing in 2014 carry-over expenditures from 2013

Linking Results to Financing

In order to link results to resources spent, Figure 16 provides an estimate of how MHTF resources were spent by key intervention area in 2014. The midwifery programme took up the largest part of resources with USD 5.3 million spent, equaling 49 percent of expenditures. Emphasizing that most funding for the fistula campaign is now channeled through the Thematic Trust Fund for Maternal Health, the Campaign to End Fistula accounted for 29 percent of MHTF expenditures, totaling expenses of USD 3.1 million. Costs for EmONC activities amounted to USD 1.9 million, or 18 percent of MHTF expenditures. MDSR (USD 0.3 million, or 3 percent) and activities for first-time young mothers (USD 0.07 million, or 1 percent) remain relatively small in terms of cost.

In addition to this overall breakdown, the introduction of the new Results Indicators Framework has both allowed and called for further breakdown of resources vis-à-vis activities (Figure 17).

This further breakdown will enable the MHTF Phase II throughout its lifetime to link RIF results closely to costs, making more analysis possible of the most cost-effective interventions. Nevertheless, several components of the MHTF — within key focus areas and between them — are intrinsically linked and could not be implemented independently of one another.

Figure 16. Approximate distribution of resources by MHTF focus areas

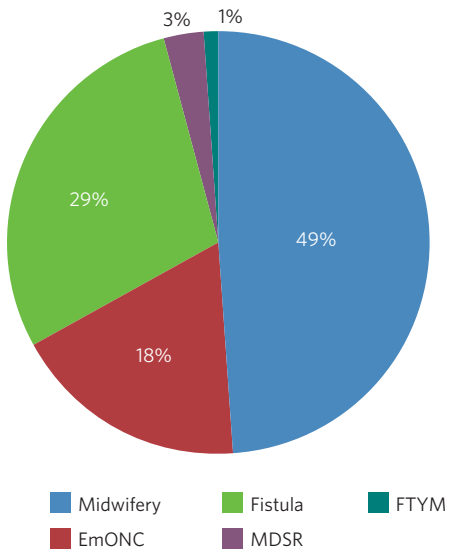
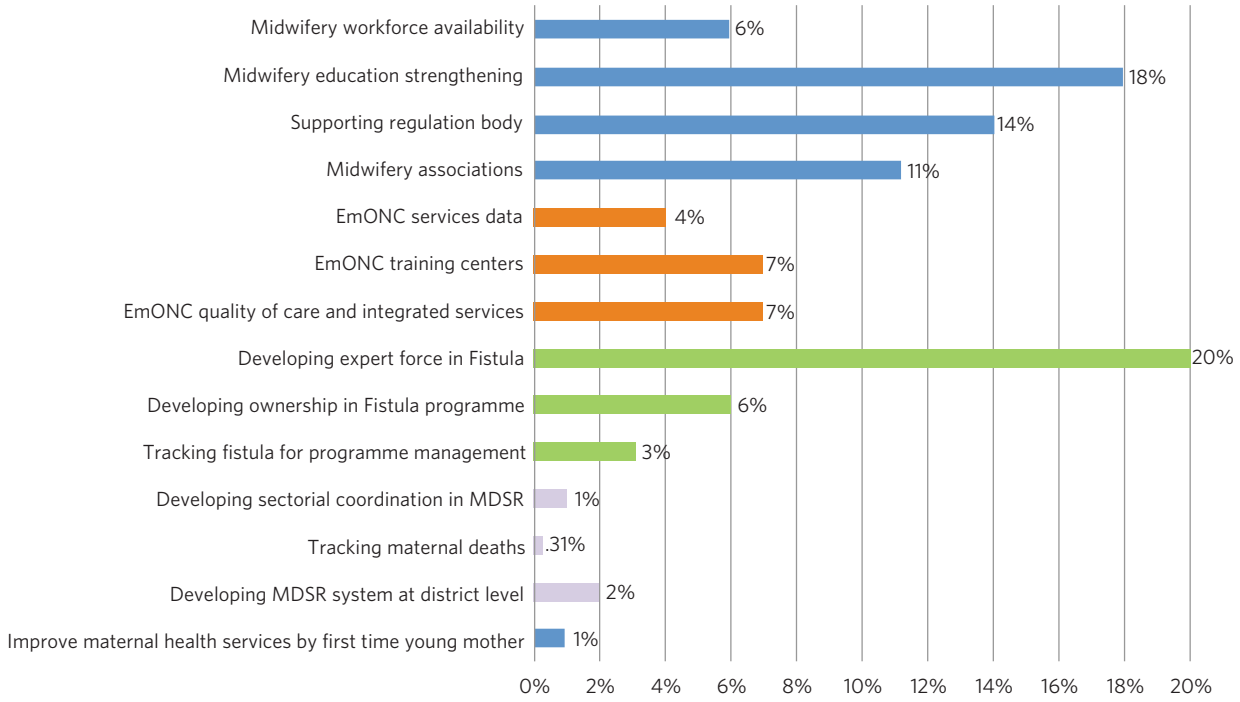
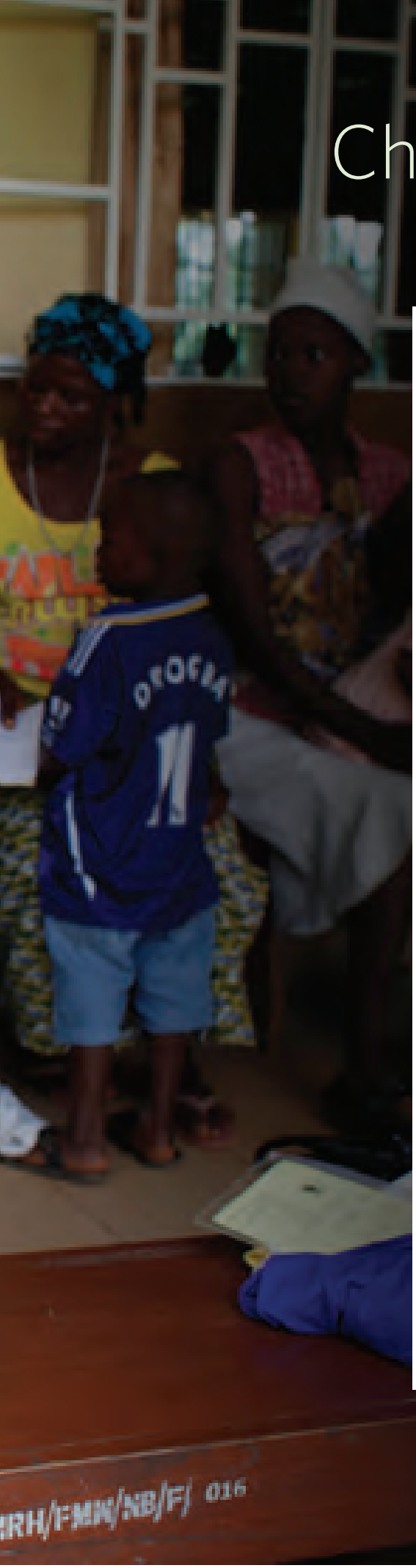


Figure 17. Breakdown of expenditures by intervention area



This further breakdown will make it possible throughout the MHTF Phase II lifetime to link RIF results very closely to costs, making further analysis possible of the most cost-effective interventions. That being said, several components of the MHTF — with key focus areas and between them— are intrinsically linked and could not be implemented idependent from one another.

A teenage patient at Makeni Regional Hospital. First-time young mothers is part of the way forward for the MHTF.



Challenges and the Way Forward

7

Looking forward and drawing on lessons learned, the MHTF will continue to:

- **support** national, regional and global efforts to advance the achievement of the maternal health output targets of UNFPA's Strategic Plan 2014-17;
- **intensify** efforts to realize the unfinished agenda of MDG5 and to be a critical contributor to Transforming Our World: The 2030 Agenda for Sustainable Development;
- **foster and escalate** global actions on ending preventable maternal and newborn mortality, morbidity and stillbirths; and ensuring universal access to sexual and reproductive health services and universal health coverage as targets agreed on by the 193 Member States of the United Nations in "The 2030 Agenda for Sustainable Development" outcome document; and
- **support** the second phase of the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) by backing country-led efforts to strengthen health systems...

by contributing to:

- **ensuring** adequate numbers of well-trained healthcare providers, particularly midwives;
- **supporting** the elimination of morbidities like obstetric fistula;
- **helping countries** to plan, manage, distribute and make accessible quality health facilities; and
- **developing** innovative programmes to improve quality and access to services, particularly SRH, while strengthening the monitoring, evaluation and accountability mechanisms through interventions such as MDSR.

Better **quality of care**, **equity in access** and **ensuring the availability of services to the most marginalized** people will remain the hallmarks of MHTF interventions. The MHTF will continue to be rapidly responsive and adaptable to changing country contexts, including MHTF-supported countries impacted by conflict, natural disasters and other crises, so as to protect **the right and access to quality maternal health services as part of ensuring universal access to sexual and reproductive health services.**

The Midwifery Programme

Challenges and Lessons Learned

Strengthening midwifery skills and capacities will continue to play a major role in global efforts to complete the unfinished MDG agenda, and to achieve the new SDG targets of ending preventable maternal and newborn mortality and achieving universal access to SRH services. The MHTF was instrumental in elevating the role of midwives globally, and many countries that did not receive MHTF support are now investing in midwives. Though global recognition of midwifery as a key intervention to address maternal and newborn mortality and morbidity and to promote health in communities grows, midwifery still faces many challenges in countries where government commitment is inadequate, particularly in low-resource settings with competing priorities and challenges.

Most important, midwifery regulation is weak, and legal and policy barriers prevent midwifery from being recognized as an autonomous profession. Low-income countries continue to have an overall shortage of health workers with midwifery skills, particularly in remote, rural areas, where these skills are most needed. Clinical training sites are still limited and poorly resourced; and midwifery tutors need to have their teaching, clinical and mentorship skills upgraded. Overall, standards of training in midwifery education need improvement as do deployment, distribution and retention.

The lack of a supportive environment presents an important challenge, as it prevents midwifery from being a much-in-demand profession. Low salaries, poor incentives, lack of career opportunities and poor supportive supervision lead to low motivation among midwives.

Though the number of national and subnational midwifery associations is increasing, weak capacity, lack of leadership and low membership still prevent these groups from being effective.

An important lesson is to mainstream midwifery in the national human resources for health policy and to ensure that there are adequate numbers and well-distributed posts for newly trained midwives.

Another lesson learned from humanitarian crisis settings such as Syria and West Africa during the Ebola outbreak is that midwives can play a very important role by providing essential health care to communities.

Way Forward

Strengthened national capacity to develop, implement and monitor costed midwifery workforce plans and strategies aligned with ICM global standards will remain a key focus. Strong evidence-based advocacy will be done using the latest data from the SoWMy 2014 report, the national midwifery workforce assessments and the midwifery Lancet series to ensure stakeholder commitments.

In 2015, a global initiative to engage health workers and midwives in the elimination and prevention of FGM will be launched and e-training materials will be globally disseminated. The Mano River Midwifery Response project will continue to be operationalized to help restore the health systems in Ebola-affected countries. E-learning will be widely deployed to scale up the lifesaving skills and capacities of the health workers with midwifery skills. The leadership, training and monitoring capacities of midwifery associations and regulatory mechanisms and councils will also be strengthened.

While better understanding of the major role that midwives play in ending preventable maternal and newborn deaths and disabilities, advocacy will continue to be critical to ensure a sustained focus as well as resources. The MHTF will continue to play a pivotal role in making midwifery a key intervention for maternal health within the context of sexual and reproductive health and for strengthening health systems.

Emergency Obstetric and Newborn Care

Challenges and Lessons Learned

EmONC NA surveys and other available data that track the EmONC availability indicator also show that few MHTF countries (15 percent) have reached half the international standard (one C-EmONC and four B-EmONC per 500,000 inhabitants), reflecting low prioritization, limited resources and/or ineffective targeting of available resources.

The EmONC surveys and the MHTF follow-up in countries clearly show the need for more B-EmONC facilities that are well distributed geographically and well connected to a C-EmONC for easy referrals.

These references also underline the critical link between functioning EmONC systems and the deployment of SBAs to reduce maternal and newborn mortality and morbidity. Insufficient development of B-EmONC is also a result of lack of deployment of SBAs in well-functioning teams in EmONC facilities.

Many Ministries of Health at national and subnational levels lack operational information and data to efficiently plan and manage maternal health programmes. This slows implementation, so that what works and what does not work are poorly identified; successes are not scaled-up nationally; and weaknesses are inadequately addressed.

Integration of SRH services in facilities remains very challenging in most countries. Only 8 of 39 MHTF countries can document immediate post-partum family planning service delivery and the proportion of women receiving contraceptive methods in post-abortion care.

Way Forward

It is critical to strengthen the data-to-action process. In 2015, new EmONC needs assessments will be implemented or finalized in Malawi, Rwanda and Zambia. This will provide an opportunity for those countries to sharpen their MNH action plans and improve EmONC met-need.

MHTF will strongly encourage countries to undertake the development of EmONC monitoring systems. Ideally, EmONC monitoring should be implemented immediately after an EmONC NA. Such monitoring will facilitate progamme management, provide information on the number of SBAs working in EmONC facilities and increase the availability of well-functioning EmONC facilities that efficiently manage or refer emergency cases.

In 2015, UNFPA will develop a guidance note on EmONC monitoring to provide harmonized technical support to Ministries of Health and UNFPA country offices to support maternal health programmes. EmONC availability and geographical distribution should become two process indicators for countries developing a functioning EmONC network.

MHTF will contribute to duplicate best practices from successful countries. It will also foster development of high-impact interventions that can move EmONC services forward. Among these is the development of high-standard B-EmONC training centers for midwives, which will support health system managers to address quality of care and training standards. It will also allow graduated midwives to contribute to making every delivery safe and provide good quality care to women and their newborns.

The new RIF of the MHTF is a tool that enables countries to strengthen the integration of services. This tool could be used in EmONC facilities where staff members have relatively more skills and means to integrate maternal health, family planning and HIV/STI services as a first step.

The MHTF will continue to support functioning EmONC facilities to ensure strengthen and sustainable health systems.

The Campaign to End Fistula

Challenges and Lessons Learned

In the Campaign to End Fistula, a major challenge is insufficient human, institutional and financial resources to tackle the magnitude of this medical problem. It is still estimated that only a small fraction of women suffering from fistula receive treatment. Thus, far more needs to be done to eliminate the tragic and staggering backlog of cases (estimated at over two million), in addition to preventing new cases. Stronger political commitment and investment is needed at all levels, and UNFPA continues to advocate for fistula's inclusion and prioritization in key strategic global initiatives.

It is a positive lesson learned that efforts that are matched with strong, diverse partnerships and concerted, coordinated action globally, regionally and nationally have brought additional focus to fistula. In addition, such efforts have led to increasingly shared experiences on how best to move ahead and to continuously expanded partnerships and networks to end fistula.

Way Forward

UNFPA has strongly and systematically lobbied to ensure the aim of "leaving no one behind" in the post-2015 development agenda and reaching the furthest behind first, including the most marginalized and vulnerable people, such as women and girls suffering from fistula, pregnant women and their babies affected by conflict and humanitarian crises and the poor.

UNFPA and partners in the Campaign to End Fistula remain committed to mobilizing political will and resources to achieve the goal, as called for by the UN Secretary-General, to end fistula "in our lifetime." To do so, UNFPA and the Campaign support governments to establish and implement costed, time-bound national strategies and action plans. Generating updated evidence on the prevalence and incidence of fistula to enable countries to conduct evidence-based planning and policymaking is a high priority in the coming year.

The goal of establishing fistula as a nationally notifiable condition is a key step forward in ending this preventable suffering and ensuring that no woman or girl slips through the cracks and languishes for years without support. Establishing it as a condition will also enhance the ability of governments and healthcare providers to identify women and girls with fistula, perform surgery to repair the fistula and provide ongoing support, including if and when a woman becomes pregnant again. This will also lead to more precise data on the incidence and prevalence of obstetric fistula, which will help inform policy. Therefore, UNFPA and the Campaign to End Fistula are working with key partner organizations, governments and experts to develop guidelines and recommendations for establishing obstetric fistula as a notifiable condition.

UNFPA and Campaign partners will also continue to reap the benefits of concerted, collaborative and complementary actions at global, regional and national levels to achieve a vision of: no new cases; all cases successfully treated; all fistula survivors followed up and reintegrated into society; and women and girls deemed inoperable or incurable be given the support they need for as long as they need it.

Maternal Death Surveillance and Response

Challenges and Lessons Learned

The MDSR system has started developing in almost all MHTF countries. It plays a strategic role in advocacy, leveraging opportunities/entry points and ongoing development at global level. UNFPA regional offices have sensitized countries to MDSR development and prioritization. Notwithstanding progress, MDSR development at the country level requires increased technical support, backstopping and funding targeted to those areas that can advance MDSR.

Low MDSR coverage and facility-based maternal deaths notification introduce bias in the maternal death analysis. In its early stage, MDSR systems should focus on responding to recommendations from maternal death reviews.

Way Forward

In looking ahead, the MHTF will continue to advocate for and engage with the policy level in support of MDSR and its development; and will help build new strategic alliances with partners who have the capacity to add value to technical support and capacity strengthening to MDSR development in countries. Through a country questionnaire, the MHTF will monitor in collaboration with others the development and implementation of the MDSR. The MHTF will continue to support countries that expressed a need for a MDSR situation analysis and for technical support while also actively promoting MDSR relevance in other countries to build evidence-based action plans that enable countries to track every maternal death; identify and address countries' bottlenecks/problems that contribute to those deaths; and tailor effective interventions/programs/policies to avoid such deaths in the future.

Conclusions and Opportunities for the Future of MHTF

8

MHTF Added Value

The MHTF has the **technical expertise** to advance the field of maternal and newborn health globally; to support countries to implement high-impact interventions at national scale; to ensure the sharing of best practices; and to measure progress to identify cost-effective approaches.

The MHTF fosters a **programme approach** at national level to facilitate the scaling up, alignment and coordination of individual projects within the framework of national plans for maternal and newborn health.

The MHTF has built an **extensive network of partnerships** with key professional organizations, academic institutions and private sector entities in addition to working with numerous leading inter- and non-governmental organizations in the field of maternal and newborn health.

MHTF financial and technical support and facilitation of South-South collaboration allow **UNFPA country offices to play a leading role** in advancing the implementation of key high-impact interventions targeted at those **most in need**.

MHTF support for **generating, disseminating and acting on data** allows countries to improve the implementation of national maternal and newborn health programmes, thus contributing to the **strengthening of health systems.**

MHTF **evidence-based advocacy** increases global and national focus on the unacceptability of the current levels of maternal and newborn mortality and morbidity, which constitute **human rights violations.**

The MHTF **comprehensive and integrated approach** ensures that interventions in the MHTF key focus areas are **interlinked, complementary and mutually reinforcing** in their contributions to the goal of ending preventable maternal and newborn mortality and morbidity.

Thus, with its experience, technical expertise, professional partnerships and presence on the ground, the MHTF is strategically well positioned—at global, regional and country level—to help advance the Sustainable Development Goals in the years to come.

Nov. 20, 2014 - Khiljee, Nepal. Tara Khatri Chhetri (50), a skilled birth attendant, with Yamkala Basnet (26). Yamkala delivered her second child at the Khiljee sub-health post, with the assistance of a skilled birth attendant. In Khiljee 100 percent of babies from roughly 800 households are being born by the hands of such attendants. This is a landmark goal in maternal health care in Nepal, where traditionally Nepalese mothers in remote villages such as Khiljee have given birth at home.

The MHTF in Phase II is a **more focused** MHTF: on impact; on **evolving** and keeping up to date with state of the art evidence and best practices; on **innovating** to promote equality, quality and accountability; and on **targeting** specific vulnerable groups, such as first-time young mothers. It is a more **integrated** MHTF, with improved and responsive management tools that will ensure it continues to be forward looking and prepared for the future.

As evident from this annual report, the MHTF Phase II focuses on well-defined results and high-impact interventions that will contribute to improved maternal and newborn health.

The MHTF promotes a programmatic rather than a project approach, contributing under country leadership to promote capacity building and sustainability of gains achieved in MNH and health systems strengthening. The intervention areas are comprehensive, complementary, well integrated and reinforce one another. This is reflected when EmONC needs assessments pinpoint the necessity for increasing availability and upgrading skills of midwifery workforces; when well-functioning EmONC facilities serve to prevent new cases of fistula and to better serve those most at risk, such as first-time young mothers; when MDSR serves to continuously target improvements in the quality of EmONC; or when improved referral systems help deal better with obstetric emergencies (like postpartum haemorrhage and other leading causes of maternal death), to prevent maternal and newborn mortality and severe morbidities such as obstetric fistula.

The MHTF Phase II Business Plan and results indicators enable better management of the MHTF. As already discussed in this report, a new level of detail can be provided; for instance, the reporting results and resources distribution as related to the five intervention areas of the MHTF. This enables countries to generate improved evidence that they can use to plan and implement key strategic policies and programs, and also provides a greater level of transparency and assurance to stakeholders, partner countries, MHTF donors and ultimately the beneficiaries.

The MHTF has made significant contributions to accelerate efforts to close the MDG5 gap. However, as the MDGs reach their deadline and the world moves toward the post-2015 sustainable development agenda, global development efforts and the work of the MHTF will continue to focus on ending preventable maternal and newborn mortality and morbidities and ensuring universal access to sexual and reproductive health services and universal health coverage. The MHTF will also support the second phase of the Secretary-General's New Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, by supporting country-led health strategies; ensuring adequate numbers of trained healthcare providers, such as midwives; investing in innovative programmes to improve quality and access to services; and improving monitoring, evaluation and accountability mechanisms.

The MHTF will therefore continue to support countries to realize the unfinished agenda of MDG5 while contributing to the sustainable development goals, particularly:

The MHTF will therefore continue to play a key role in supporting countries to realize the unfinished agenda of MDG5 while contributing to the new Sustainable Development Goals, particularly Goal 3, to ensure healthy lives and promote well-being for all at all ages (targets 3.1, 3.2, 3.7 and 3.8) and Goal 5, to achieve gender equality and empower all women and girls (target 5.6). A health system that cares for pregnant women and their newborn is a strengthened health system with a foundation to provide care for other health issues.

Building on key achievements from its first phase, the MHTF is already well positioned to leverage key areas such as midwifery and fistula components to support and expand the availability of well-trained and competent human resources for health; and the EmONC and MDSR initiatives in contributing to universal access to sexual and reproductive health services, in particular the availability of well-functioning EmONC facilities linked to good referral systems as key elements of a national health system.

As evident from this report, MHTF Phase II has moved forward, embracing the lessons learned and results achieved from Phase II. It is an MHTF "fit-for-purpose," strongly positioned and responsive in facilitating change in high maternal mortality countries to help ensure that no woman or girl should die giving life...

The Midwifery Programme
Emergency Obstetric and Newborn Care
The Campaign to End Fistula
Maternal Death Surveillance and Response
First-Time Young Mothers

...In 2016,

the world will move to implement the recently agreed Sustainable Development Goals. Within the health and gender agreed goals in particular, the MHTF has a critical role to play as an experienced financing technical facility. It has built its capacity from supporting more than 42 high-burden countries to achieve the MDG5 of improving maternal health and achieving universal access to sexual and reproductive health. This work is still unfinished and the countries of the world have recognized as much by including these issues as targets in the new world agenda. To this end, the MHTF expertise is an asset for all new initiatives that will be developed to achieve the Sustainable Development Goals.

ANNEX 1: Campaign to End Fistula Partners

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

ANNEX 1: Campaign to End Fistula Partners (continued)

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: Results Indicators Framework

Outcome A: Strengthened national capacity to implement comprehensive midwifery programs

Indicators	Proportion of births attended by skilled health personnel for the poorest quintile of the population	A national costed midwifery workforce plan is incorporated in the national HRH plan	Curriculum for midwifery pre-service training is based on ICM/ WHO standards	Number of midwifery schools supported by the MHTF	A governing body regulates midwifery practice	The national midwifery association has a "budgeted Strategic Action Plan"
Afghanistan	-	N	Y	0	N	Y
Bangladesh	31.7%	N	Y	16	N	N
Benin	84%	Y	Y	1	Y	N
Burkina Faso	50.5%	Y	Y	8	Y	Y
Burundi	73%	N	Y	1	N	N
Cameroon	19.1%	-	Y	0	N	Y
Central African Republic	33.1%	Y	Y	0	Y	N
Chad	-	Y	Y	1	N	N
Congo	-	N	Y	2	Y	N
Côte d'Ivoire	35%	Y	Y	5	Y	Y
DRC	-	N	Y	6	N	Y
Ethiopia	16%	N	Y	31	N	Y
Ghana	38.6%	N	Y	20	Y	Y
Guinea-Bissau	-	Y	Y	-	-	-
Guinea Conakry	45%	Y	Y	-	Y	Y
Haiti	9.6%	N	Y	1	N	N
Kenya	44%	-	Y	0	Y	N
Lao	-	Y	N	9	Y	N
Liberia	61%	N	Y	4	Y	Y
Madagascar	27%	N	N	6	Y	N
Malawi	71%	Y	Y	1	Y	Y
Mali	-	Y	Y	5	Y	Y
Mauritania	-	-	N	2	N	N
Mozambique	-	Y	Y	0	N	N
Nepal	-	N	N	0	N	Y
Niger	-	Y	N	2	N	N
Nigeria	6%	N	N	0	Y	N
Pakistan	-	Y	N	16	Y	-
Rwanda	-	N	N	0	Y	N
Senegal	-	N	Y	0	N	N
Sierra Leone	-	N	N	0	Y	N
Somalia	-	Y	Y	6	Y	N
South Sudan	-	N	Y	1	N	N
Sudan	-	N	N	-	N	-
Timor-Leste	-	N	Y	1	N	N
Togo	-	N	Y	2	N	N
Uganda	-	Y	N	18	Y	N
Yemen	17%	N	Y	0	N	N
Zambia	-	Y	N	3	Y	N

ANNEX 2: Results Indicators Framework (continued)

Outcome B: Strengthened national capacity for quality integrated maternal health services, including emergency obstetric and newborn care (EmONC)

Indicators	Proportion of women with major direct obstetric complications treated in EmONC facilities	The health national costed plan includes EmONC facilities development with annual targets	EmONC services are monitored in prioritized EmONC facilities	Each midwifery national school has at least one B-EmONC and one C-EmONC facilities accredited as midwifery training centers	Direct obstetric complications are documented in each EmONC facility	Case Fatality Rate (CFR) per direct obstetric complication are systematically documented at C-EmONC level	A costed plan exists for RH integrated services in EmONC facilities	Proportion of women leaving EmONC facilities with a contraceptive modern method
Afghanistan	–	Y	Y	Y	Y	N	Y	–
Bangladesh	–	N	Y	N	Y	–	N	–
Benin	23%	Y	Y	Y	Y	N	Y	–
Burkina Faso	18%	Y	Y	Y	Y	Y	Y	–
Burundi	51%	Y	Y	Y	Y	Y	N	–
Cameroon	–	Y	N	N	N	N	–	–
Central African Republic	29%	N	N	Y	N	N	N	–
Chad	–	Y	N	N	N	N	Y	–
Congo	–	Y	N	N	N	N	N	–
Côte d'Ivoire	39%	N	Y	N	N	N	N	–
DRC	–	Y	Y	N	Y	Y	N	–
Ethiopia	–	–	–	Y	–	–	Y	–
Ghana	–	Y	Y	Y	Y	Y	N	N
Guinea-Bissau	–	Y	Y	Y	–	–	–	–
Guinea Conakry	–	Y	Y	Y	Y	Y	Y	68%
Haiti	20%	N	Y	Y	N	N	N	N
Kenya	3.70%	Y	Y	Y	Y	Y	N	–
Lao	–	N	Y	N	N	N	N	–
Liberia	–	Y	Y	Y	Y	Y	Y	N
Madagascar	N/A	Y	N	Y	N	N	Y	N/A
Malawi	–	Y	Y	–	Y	Y	Y	–
Mali	–	Y	Y	Y	Y	Y	Y	–
Mauritania	–	N	N	N	N	N	Y	N
Mozambique	–	Y	Y	N	Y	2.4	Y	N/A
Nepal	–	N	Y	N/A	Y	Y	N	–
Niger	–	Y	Y	N	Y	Y	Y	–
Nigeria	–	Y	N	Y	Y	Y	Y	–
Pakistan	–	–	–	–	–	–	–	–
Rwanda	–	N	N	–	–	–	–	–
Senegal	–	N	Y	N	Y	Y	Y	–
Sierra Leone	–	Y	Y	Y	Y	–	Y	–
Somalia	–	N	Y	Y	Y	Y	Y	39%
South Sudan	–	N	N	N	N	N	N	N/A
Sudan	–	–	–	–	–	–	–	–
Timor-Leste	–	N	N	N	N	–	Y	N
Togo	–	Y	Y	N	Y	Y	N	–
Uganda	–	N	N	Y	Y	N	–	–
Yemen	40%	Y	N	Y	Y	N	Y	–
Zambia	–	N	Y	Y	N	N	Y	N

ANNEX 2: Results Indicators Framework (continued)

Outcome C : Enhancing national capacity for prevention, treatment and social reintegration for obstetric fistula

Indicators	A costed human resources for health strategy is in place which includes fistula surgeons	Number of skilled, expert fistula surgeons meets projected needs for number of fistula repairs in the country	A costed national plan/ strategy for ending fistula is developed and being implemented as part of an overall health strategy	A functioning National Task Force for Fistula is in place	A national register is in place to record notifications and track fistula cases at community and facility level
Afghanistan	N	N	N	N	N
Bangladesh	N	–	N	N	N
Benin	Y	N	Y	N	N
Burkina Faso	Y	Y	Y	Y	Y
Burundi	N	N	N	Y	N
Cameroon	N	N	N	Y	N
Central African Republic	Y	Y	N	Y	N
Chad	N	–	Y	Y	N
Congo	N	N	N	Y	Y
Côte d'Ivoire	Y	Y	Y	N	N
DRC	N	–	N	Y	N
Ethiopia	Y	–	Y	Y	N
Ghana	N	N	N	N	Y
Guinea-Bissau	–	–	Y	Y	Y
Guinea Conakry	Y	–	Y	Y	N
Haiti	–	–	–	–	–
Kenya	N	–	N	Y	N
Lao	–	–	–	–	–
Liberia	Y	–	Y	Y	Y
Madagascar	Y	N	N	N	N
Malawi	–	–	N	Y	N
Mali	Y	–	Y	Y	–
Mauritania	N	–	N	N	N
Mozambique	N	N	Y	Y	N
Nepal	N	N	N	Y	N
Niger	Y	–	Y	Y	N
Nigeria	N	–	Y	Y	N
Pakistan	–	–	–	–	–
Rwanda	N	N	N	N	N
Senegal	Y	–	Y	Y	Y
Sierra Leone	N	N	Y	N	Y
Somalia	N	N	N	N	N
South Sudan	N	N	N	N	N
Sudan	–	–	–	–	–
Timor-Leste	–	–	–	–	–
Togo	N	N	Y	Y	N
Uganda	Y	N	Y	Y	N
Yemen	N	–	N	N	N
Zambia	N	N	N	N	N

ANNEX 2: Results Indicators Framework (continued)

Outcome D: Enhanced national capacity for maternal death surveillance and response.

Indicators	Proportion of countries where maternal deaths that are notified at a) facility level; b) at community level reach 80 percent of expected deaths notified as defined every year for a) and b)	An inter-ministerial MDSR committee is functioning	The MDSR development system is monitored	All subnational subdivisions are producing an annual MDSR report
Afghanistan	–	N	N	N
Bangladesh	–	N	N	N
Benin	1,200	N	N	N
Burkina Faso	20%	Y	Y	Y
Burundi	Y	N	Y	N
Cameroon	–	–	–	–
Central African Republic	–	Y	Y	N
Chad	–	N	Y	N
Congo	–	N	Y	–
Côte d'Ivoire	N	N	Y	N
DRC	–	N	Y	N
Ethiopia	–	–	–	N
Ghana	–	N	N	N
Guinea-Bissau	–	Y	–	–
Guinea Conakry	–	Y	Y	Y
Haiti	18%	N	N	N
Kenya	–	N	Y	N
Lao	–	Y	Y	9/18
Liberia	Y	N	Y	N
Madagascar	–	N	Y	N
Malawi	–	Y	Y	N
Mali	–	N	N	Y
Mauritania	–	N	N	N
Mozambique	–	Y	N	N
Nepal	–	N	–	–
Niger	–	Y	Y	N
Nigeria	–	N	N	N
Pakistan	–	–	–	–
Rwanda	–	N	Y	N
Senegal	–	Y	Y	N
Sierra Leone	–	–	–	–
Somalia	–	N	N	N
South Sudan	–	N	N	N
Sudan	–	–	–	–
Timor-Leste	–	N	N	N
Togo	–	Y	Y	N
Uganda	–	N	Y	N
Yemen	N	Y	N	N
Zambia	–	N	N	N

ANNEX 2: Results Indicators Framework (continued)

Outcome E: Strengthened national capacity to reach and serve first-time young mothers

Indicators	Age-disaggregated ANC utilization: Percentage of girls and women aged 15-19 and 20-24 who had a live birth that received antenatal care provided by a doctor, nurse, or midwife at least once during pregnancy, and at least four times during pregnancy	Age-disaggregated Skilled Birth Attendance: Percentage of births to girls and women 15-19 and 20-24 attended by skilled health personnel (doctors, nurses or midwives)	14.1. First-time young mothers are a priority population in the national RMNCAH plan	15.1. At least one innovative, scalable approach to improving maternal health service utilization by first-time young mothers is implemented
Afghanistan	–	–	N	N
Bangladesh	–	–	N	N
Benin	86%	84%	Y	Y
Burkina Faso	inf 20 years 96,3%	inf 20 years 68,5%	Y	–
Burundi	100%	73%	N	N
Cameroon	N	N	N	N
Central African Republic	inf 20 years: 69%	–	N	Y
Chad	–	–	N	N
Congo	–	–	Y	N
Côte d'Ivoire	–	58%	N	N
DRC	–	–	N	N
Ethiopia	20%	19%	–	–
Ghana	–	–	Y	Y
Guinea-Bissau	–	–	–	–
Guinea Conakry	–	–	–	N
Haiti	N	N	N	N
Kenya	88.5% 93%	46.6% 42.7%	N	N
Lao	–	–	N	N
Liberia	97%	–	N	N
Madagascar	–	–	N	N
Malawi	–	–	–	–
Mali	–	–	N	–
Mauritania	–	–	N	N
Mozambique	–	–	N	N
Nepal	–	–	–	–
Niger	–	–	Y	N
Nigeria	–	–	N	N
Pakistan	–	–	–	–
Rwanda	–	–	–	–
Senegal	–	–	Y	N
Sierra Leone	–	–	–	–
Somalia	–	–	N	N
South Sudan	–	–	N	N
Sudan	–	–	–	–
Timor-Leste	–	–	–	–
Togo	–	–	Y	N
Uganda	–	–	N	N
Yemen	–	–	Y	Y
Zambia	–	–	Y	Y

The Maternal Health Thematic Fund:

Improving maternal health: Surging towards the 2015 deadline

2014 constituted the first year of the second phase of the Maternal Health Thematic Fund, which includes UNFPA's Midwifery Programme and the Campaign to End Fistula. In its second phase, the Maternal Health Thematic Fund has increased emphasis on high-impact interventions, based on lessons learned from the first phase.

For the five focus areas of the MHTF, such high-impact interventions include:

The Midwifery Programme:

- Training of midwives
- Jobs for midwives
- Deployment of midwives

Emergency Obstetric and Newborn Care (EmONC):

- Sufficient Basic EmONC and Comprehensive EmONC facilities that offer all essential services
- Establishment of efficient referral between facilities to create a health systems network
- Continued monitoring to continuously ensure and improve quality of care

The Campaign to End Fistula:

- Training of expert obstetric fistula surgeons
- Integration of obstetric fistula surgery into health systems for continuous care
- Identification of fistula cases for treatment, rehabilitation and social reintegration

Maternal Death Surveillance and Response:

- Establishment of national scale MDSR system
- Ensure quality of data
- Efficient response to identified causes of maternal mortality

First-Time Young Mothers:

- Outreach to young pregnant girls to ensure skilled assistance during pregnancy and childbirth
- Follow-up and longer-term support groups
- Further identification of innovative and scalable approaches to reach first-time young mothers

No woman should die giving life

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