



ANNUAL REPORT 2009

THE MATERNAL HEALTH THEMATIC FUND

Accelerating Progress towards Millennium Development Goal 5



THE MISSION OF UNFPA

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

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Cover photo by Lynsey Addario/VII

A pregnant Congolese woman seen at her home in the neighborhood of Birere, Goma, North Kivu province, Democratic Republic of the Congo. April 10, 2008.

Table of Contents photo by GMB Akash/Panos Picture

A husband visits his wife and child at the Fistula Repair Centre at Dhaka Medical College Hospital in Bangladesh. 2005.

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We thank you all and look forward to further collaboration and active participation in the future.

LIST OF ABBREVIATIONS AND ACRONYMS

AMDD	Averting Maternal Death and Disability Program – Columbia University
DHS	Demographic and Health Surveys
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
HMIS	Health management information system
ICM	International Confederation of Midwives
IHP+	International Health Partnership
IMMPACT	Initiative for Maternal Mortality Programme Assessment – University of Aberdeen
H4	WHO, UNICEF, UNFPA and The World Bank
GPRHCS	Global Programme on Reproductive Health Commodity Security
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MHTF	Maternal Health Thematic Fund
MMR	Maternal mortality ratio
MNH	Maternal and newborn health
MoH	Ministry of Health
MPoA	Maputo Plan of Action
NPC	Non-physician clinician
OF	Obstetric Fistula (Global Campaign to End Fistula)
SRH	Sexual and reproductive health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNDP	United Nations Development Programme
WHO	World Health Organization



A Masai woman in the Rift Valley province, Kenya. Photo by Seamus Murphy/VII.

FOREWORD

Werner Haug, Director Technical Division, UNFPA

We, as a global community have committed to improving maternal health. More concretely, as mapped out in Millennium Development Goal (MDG) 5, we have agreed to reduce, by 2015, the global maternal mortality ratio by three quarters, using 1990 as a baseline. To this overall goal another target was added in 2007 — that of ensuring universal access to reproductive health by 2015.

To back up our commitment to maternal health, two UNFPA initiatives — the Global Programme on Reproductive Health Commodity Security and the Maternal Health Thematic Fund — represent a focused effort to accelerate progress towards MDG 5 in the 60 countries that have the highest maternal mortality and are furthest from achieving universal access to reproductive health. Toward this end, UNFPA complements its core resources where the need is greatest to ensure that every pregnancy is wanted and every birth is safe.

The Maternal Health Thematic Fund (MHTF) became operational in 2008, and 2009 represents the first full year of operations. As this annual report illustrates, significant progress can be made by adopting proven strategies — including family planning, skilled care during childbirth (particularly midwifery services), expanded access and utilization of emergency obstetric and newborn care — combined with partnerships for better coordination under national leadership.

To increase the effectiveness and efficiency of country support, reduce administrative and transaction costs, and foster closer alignment with government procedures, the Midwifery Programme (launched in 2008 with generous support from the Swedish government and since supported by other donors as well) and the Campaign to End Fistula (launched in 2003 with multi-donor support) were programmatically integrated into the Maternal Health Thematic Fund in April 2009 and September 2009, respectively. Both initiatives will continue to operate as targeted efforts in programme countries under the umbrella of the Maternal Health Thematic Fund. As such, the 2009 MHTF Annual Report reflects outcomes and achievements of the Maternal Health Thematic Fund activities, including the Midwifery Programme and the Campaign to End Fistula.

I would like to take this opportunity to thank countries, donors, WHO, UNICEF, the World Bank, other partner organizations, and all concerned colleagues for this effective collaboration.



Young girls in Afghanistan. Photo by Lynsey Addario/VII.

EXECUTIVE SUMMARY

In early 2008 the United Nations Population Fund (UNFPA) launched the Maternal Health Thematic Fund (MHTF). This effort — UNFPA's contribution to boost maternal and newborn health — aims to provide support to countries with a high maternal mortality burden to scale up proven interventions needed to save mothers and infants. In synergy with the UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS), technical assistance is provided to develop capacity.

In 2009 UNFPA integrated its thematic funds to improve the effectiveness and efficiency of its programmes while reducing transaction costs to countries. As a result, the Maternal Health Thematic Fund now serves as the umbrella under which UNFPA's Midwifery Programme and Campaign to End Fistula operate. This document highlights MHTF actions taken and results achieved in 2009.

This summary identifies bottlenecks to maternal health services in priority countries, strategies available to address these bottlenecks, results achieved in the past year, and, looking ahead, key challenges for 2010. One critical bottleneck to improving maternal health, for example, is the shortage of supply in family planning — a high priority for UNFPA. To learn more about scaling up family planning services, readers are invited to consult the annual report of UNFPA's Global Programme on Reproductive Health Commodity Security.

Identifying Bottlenecks in Maternal Health Care

In order to identify bottlenecks in maternal health care, UNFPA relies upon information from a variety of sources. One such source is the mapping exercise conducted by UNFPA, UNICEF, WHO and the World Bank (known as the H4), which was designed to identify those countries with the greatest need to reduce maternal mortality and set priorities. Other sources of information include: inception missions, country health indicators, emergency obstetric and neonatal care needs assessments, midwifery desk reviews, obstetric fistula needs assessments, and factors underlining high maternal mortality ratios. Among the latter are very low access to and uptake of family planning, and weak health systems (particularly inadequate midwifery skills, poor service delivery and limited financial investment).

Strategies to Address Bottlenecks

The Maternal Health Thematic Fund employed several strategies to address the bottlenecks identified above, namely:

- ▶ Raising awareness and political will through public outreach, advocacy and working with the media;

- ▶ Contributing to the launch of country-led initiatives, such as Malawi's Campaign to Accelerate Reduction of Maternal Mortality in Africa (CARMMA), which aims to leverage resources and ensure that maternal health is a national priority;
- ▶ Strengthening the capacity of UNFPA country offices to better provide technical assistance and support national processes through the recruitment and posting of Technical Advisors for maternal health, midwifery and obstetric fistula. Technical Advisors are at work in Madagascar, Ethiopia, Haiti, Guyana and Benin, and more are under recruitment in Nigeria, Mali and DRC;
- ▶ Strengthening monitoring and evaluation through better planning, including: annual work plans; peer review exercises; discussing, amending and finalizing results frameworks; and institutionalizing maternal death reviews to identify cause of death. The peer review process was cited by the UNFPA Division of Oversight Services as a best practice that country offices could implement with core funding to improve efficiency;
- ▶ Improving documentation to promote advocacy and information sharing;
- ▶ Building partnerships with UN and non-UN organizations to coordinate efforts and maximize results.

Key Contributions and Results

In 2009, the Maternal Health Thematic Fund (MHTF) provided support to 15 countries (**Benin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi, Sudan, Cote d'Ivoire, Ghana, Uganda and Zambia**), among which four were supported only for midwifery (**Cote d'Ivoire, Ghana, Uganda and Zambia**). The Campaign to End Fistula supported 25 countries (**Benin, CAR, Chad, Cote d'Ivoire, Congo, DRC, Eritrea, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mauritania, Niger, Nigeria, Senegal, Zambia, Afghanistan, Bangladesh, Nepal, Pakistan, Somalia and Sudan**).

In order to deliver support to priority countries, MHTF has strengthened partnerships with scientific and academic communities, such as the International Confederation of Midwives, the International Society of Fistula Surgeons (ISOFS), Johns Hopkins University, Columbia University and the University of Aberdeen, among others, for evidence-based support to priority countries. Also, during 2009, joint WHO, UNFPA, UNICEF and World Bank (H4) missions were organized in Ethiopia, Nigeria, and DRC — three of the six countries that account for half of all maternal deaths. These missions embody the “deliver as one” principle by fostering collaboration among UN agencies and the efficient use of technical and financial support.



Two malnourished children lie in a feeding center in the Oure Cassone camp in Bahai, Chad, roughly seven kilometers from the Sudan border. Photo by Lynsey Addario/VII.

Below, listed under each of the Maternal Health Thematic Fund's seven outputs, are the results achieved in 2009:

OUTPUT 1:

Enhanced political and social environment for Maternal and Newborn Health (MNH) and Sexual and Reproductive Health (SRH)

The activities conducted under this output included:

- ▶ Funding of the Malawi Campaign to Accelerate Reduction of Maternal Mortality in Africa (CARMMA);
- ▶ Contributing to Ethiopia's MDG Performance Fund;
- ▶ Technical inputs to Nigeria's International Health Partnerships compact proposal, which prioritizes maternal and reproductive health;
- ▶ Funding celebrations commemorating the International Day of Midwives in 12 MHTF countries;

- ▶ Technical and financial support to establish national obstetric fistula coordinating teams;
- ▶ Speaking engagements on maternal health and fistula at the High-Level Segment of the ECOSOC meeting in July 2009;
- ▶ Producing documentaries, both globally and nationally, on maternal health issues and arranging special viewings for political audiences;
- ▶ Working with global and national media to raise awareness of maternal health, midwifery and obstetric fistula issues.

The main results in 2009 included:

- ▶ Maternal health and reproductive health are generally better positioned in health development and poverty reduction plans;
- ▶ The African Union (AU) Ministers of Health launched a Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This is a nationally-driven and owned process with strong partnerships that bring together the UN, bilaterals and NGOs. Its focus is to generate and provide data on maternal and newborn deaths, mobilize political commitment and support among key stakeholders (including national authorities and communities), and accelerate action to reduce maternal deaths. MHTF contributed to the Malawi CARMMA launch, which resulted in a two-year work plan that leverages resources for maternal health;
- ▶ 18 Campaign to End Fistula countries supported fistula survivors to sensitize communities, provide peer support and advocate for improved maternal health at both the community and national level;
- ▶ 400 ambassadors and ministers of health and foreign affairs attending the ECOSOC High-Level Segment were addressed on maternal health and obstetric fistula issues;
- ▶ Documentaries on maternal health emergencies reached more than 200 million viewers and political decision makers. Global media coverage of maternal health rose by 20 per cent between 2008 and 2009.

OUTPUT 2:

Up-to-date needs assessments for the Sexual and Reproductive Health (SRH) package, with a particular focus on family planning, human resources for MNH, and Emergency Obstetric and Neonatal Care (EmONC)

The activities conducted under this output included:

- ▶ Funding and technical expertise for EmONC needs assessments in eight countries;
- ▶ Midwifery needs assessments with regard to education, regulations, associations and planning;
- ▶ Participating in the joint WHO, UNFPA, UNICEF and World Bank Mapping Exercise of the 25 priority high maternal mortality countries, the purpose of which is to target where support is required.

The main results achieved in 2009 were:

- ▶ In-depth analyses of the availability of maternal health services within the priority countries, which identify bottlenecks to improvement. Ethiopia, Madagascar, Haiti and Cambodia have successfully conducted the EmONC needs assessment and the resulting data is being used to scale up and monitor the availability of EmONC services;
- ▶ 12 of the 15 MHTF countries have conducted midwifery needs assessments, the results of which were used to make adequate plans in the areas of education, regulations and associations.

OUTPUT 3:

National health plans focus on sexual and reproductive health, especially family planning and EmONC, with strong linkages between reproductive health and HIV to achieve the health MDGs

The activities conducted under this output included:

- ▶ Posting four international maternal and neonatal health experts in Ethiopia, Madagascar, Haiti and Guyana;
- ▶ Posting a total of 14 midwife advisors in UNFPA country offices to review, advise, advocate and develop, with stakeholders, national policies and programmes on midwifery education, regulation and association building;
- ▶ Hiring two Regional Midwife Advisors (one each for English and French-speaking countries) to provide guidance on behalf of the International Confederation of Midwives;
- ▶ Supporting two international fistula advisors for priority countries in Africa;
- ▶ Conducting technical peer reviews of national MHTF proposals to ensure that they may have a significant impact on maternal mortality reduction;
- ▶ Developing technical guidance to direct national processes;
- ▶ Enabling national partners to attend scientific and technical conferences to share experiences and build capacity. Examples include the International Society of Fistula Surgeons conference in Kenya attended by fistula surgeons from Benin, DRC, Senegal and Somalia, and the Inception Forum for Country Midwife Advisors and Capacity Building Workshops in Ghana and Zambia.

The main results achieved in 2009 were:

- ▶ Improved advocacy and media outreach, thanks to the work of fistula advocates in focus countries and celebrations to mark the International Day of the Midwife;
- ▶ Improved country proposals for MHTF as a result of the peer review process;
- ▶ Development of technical guidance tools and mapping exercises, including: the roll-out of a handbook for emergency obstetric and neonatal care; the launch of the Averting Maternal Death and Disability Program by Columbia University's Mailman School of Public

Health, UNFPA, UNICEF and WHO; the development of a standard module on obstetric fistula, now part of the EmONC assessment tool; and completion and pilot testing of the internationally standardized competency-based training manual for fistula treatment and care;

- ▶ Broadened knowledge among healthcare professionals of fistula prevention and treatment and midwifery education, regulation and association.

OUTPUT 4:

National responses to the human resource crisis in MNH, with a focus on planning and increasing the number of midwives and other mid-level providers

The activities conducted under this output included:

- ▶ Providing technical and financial support, together with the International Confederation of Midwives and government partners, for activities related to the education, regulation and association of midwives and other mid-level providers;
- ▶ Funding and technical support for the Addis Ababa Conference on Human Resources for Maternal and Newborn Survival and Task-Shifting;
- ▶ Developing an advocacy and communication strategy focusing on the need to scale up midwifery services.

The main results achieved in 2009 were:

- ▶ Technical and financial support for the high-level Conference on Human Resources for Maternal and Newborn Survival, including Task Shifting/Sharing for Emergency Obstetric and Newborn Care, convened in Ethiopia. This conference brought together ministerial-level delegations from 29 African countries. During the meeting the delegates shared experiences on tackling human resource crises and adopted the Addis Ababa Call to Action for innovative and complementary approaches, such as task-shifting/sharing of EmONC among midwives and other health professionals;
- ▶ A rise in the number of schools training midwives and in the number of midwifery students in focus countries. For examples, in **Cambodia**, with support from UNFPA, a new three-year direct entry midwifery training programme was created, recruiting 830 students in 2009, as compared to 335 the previous year. In **Cote d'Ivoire**, 40 maternity services were strengthened to provide lifesaving services, and 290 midwifery graduates received two additional months of clinical training before deployment. In **Sudan**, the one-year midwifery curriculum was expanded to a new two-year competency-based curriculum, and a national midwifery committee was established. Through a new district programme in **Uganda**, 40 midwives from nine districts commenced their training, after which they will be deployed for three-year assignments in remote areas.

OUTPUT 5:

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

The activities conducted under this output included:

- ▶ Employing the technical expertise of MNH advisors at country, regional and headquarters levels to prioritize maternal health services in national plans;
- ▶ Advocating for greater resource allocation for maternal health and increased coverage of MNH services;
- ▶ Collaborating with other stakeholders for more effective and efficient scale-up of maternal health services.

The main results achieved in 2009 were:

- ▶ Increased number of UNFPA supported initiatives to develop midwifery. In **Chad**, for example, a midwifery programme was developed in partnership with the International Confederation of Midwives to support midwifery education, regulation and association;
- ▶ With UNFPA support, more than 4,400 women were treated for fistula, more than 100 health facilities in 23 countries introduced fistula prevention and treatment, and more than 1,000 healthcare personnel were trained for fistula care — including over 160 doctors, 245 nurses and midwives, and more than 600 community health workers;
- ▶ Partnerships formed with WHO, UNICEF and the World Bank in Ethiopia, Nigeria and DRC, three of the six countries that account for half of all maternal deaths each year. These represent the “deliver as one” principle by fostering collaboration among the UN agencies and an efficient, effective means of scaling up maternal health services.

OUTPUT 6:

Monitoring and results-based management of national MNH efforts

The activities conducted under this output included:

- ▶ Together with the University of Aberdeen (Scotland), the Institute of Tropical Medicine (Antwerp) and the University of Bobo-Dioulasso (Burkina Faso), in February 2009 UNFPA supported a Monitoring and Evaluation training for UNFPA country office staff and national maternal health experts from five French-speaking countries (Burkina Faso, Mali, Congo, Chad and Gabon) to track progress towards MDG 5;
- ▶ In August 2009 in Arusha (Tanzania), a similar course was organized for eight English-speaking countries (Tanzania, Namibia, Kenya, South Africa, Uganda, Zimbabwe, Botswana and Zambia);
- ▶ UNFPA strengthened the capacity of country office staff to better monitor results frameworks for both the Maternal Health Thematic Fund and the Global Programme on Reproductive Health Commodity Security in the Africa region.

The main results achieved in 2009 were:

- ▶ An improved focus on results-based management, as illustrated through the annual work plans with indicators, baselines and targets;
- ▶ Four more countries (Benin, Burkina Faso, Cambodia and Madagascar) have started the process of institutionalizing maternal death reviews, a tool that will be useful to improve the quality of care.

OUTPUT 7:

Leveraging of additional resources for MDG 5 from governments and donors

The activities conducted under this output included:

- ▶ Supporting national processes aimed to strategically position maternal health issues, such as the MDG performance fund in Ethiopia, and CARMMA in Malawi;
- ▶ Leveraging resources for maternal health — particularly for midwifery, obstetric fistula, and emergency obstetric care;
- ▶ Engaging strategic partnerships and conducting media outreach in selected countries;

The main results achieved in 2009 were:

- ▶ Enhanced media coverage of maternal health and obstetric fistula issues;
- ▶ Maternal Health Thematic Fund support for EmONC needs assessments matched by significant contributions from UNICEF and partner governments to conduct the surveys in 8 of the 15 MHTF countries;
- ▶ Inclusion of obstetric fistula in the Ghana health insurance scheme.

Key challenges for 2010: the way forward

In 2010 UNFPA will focus on the following priorities:

- ▶ Strengthening national capacity and that of country office staff;
- ▶ Strengthening family planning efforts by supporting policy development, service delivery, and stimulating greater public demand for family planning;
- ▶ Working more closely with midwifery schools, midwifery trainers and governments to put in place a recommended curricula for midwifery. UNFPA will also focus on expanding enrollment in midwifery schools, recruiting graduates to serve where they are most needed, and motivating midwives;
- ▶ Building on the success of the Campaign to End Fistula, UNFPA will seek to mainstream fistula programming into national plans and develop a three-year strategy to eradicate fistula based on the findings of the campaign's evaluation;

- ▶ Having made a strong start in 15 priority countries, UNFPA seeks to consolidate the resources needed to continue this work and mobilize additional resources to expand the programme to other countries;

In response to the agency's focus on policy, advocacy, technical support and catalytic funding, UNFPA seeks to ensure sufficient, predictable resources for MDG 5 globally, as well as to effect a change in national environments that reflect:

- ▶ National commitment to MDG 5, and financing commensurate with that commitment, reaching 15 per cent of national expenditures for health;
- ▶ District-based maternity care service delivery plans based on EmONC needs assessments, community health care services and referrals to EmONC;
- ▶ National recognition of the importance of scaling up midwifery services, with an emphasis on quality clinical training, better management, deployment and retention to ensure that district services are adequately staffed;
- ▶ An increase in fistula identification, treatment centers and social rehabilitation;
- ▶ National scale-up of quality family planning;
- ▶ An effective national health management information system.

In 2010, MHTF programming will be carried out in 30 countries, including midwifery and obstetric fistula. In addition, another 12 countries will receive support for obstetric fistula programmes only.



Atchelewa Boukar lives in a residential ward of a fistula treatment programme while she waits for surgery in Niamey, Niger. The fistula programme in Niger is supported by UNFPA. Photo by Thomas van Houtryve/Panos Pictures, December 2009.

INTRODUCTION

THE STORY OF HALIMA FROM NIGER

Maternal death rates remain the greatest health divide between developed and least developed countries. Most maternal deaths and disabilities are preventable. While we know what to do to prevent death and disability, one woman continues to die every minute from complications related to pregnancy and childbirth, and 20 more suffer a birth injury. Halima from Niger is one of the latter. Married off at 13, she got pregnant at 18 with her first child. Unable to leave her village and far from any health centers or medical professionals, Halima endured three painful days of labour before she lost her child and developed obstetric fistula. Leaking urine uncontrollably, she was abandoned by her husband and ostracized by her community, bravely facing the daily consequences of fistula on her own. Yet Halima was one of the lucky obstetric fistula victims. She recovered after receiving surgery and returned to her husband and family. After getting pregnant again last year, she attended pre-natal consultations and underwent a series of tests. At the time of delivery, Halima was admitted to a maternity ward in Niamey, where she had a Caesarean section; she named her healthy baby boy Mahamadou. Easing the suffering of fistula sufferers like Halima is one of the main goals of the Maternal Health Thematic Fund.

As part of its efforts to improve maternal and newborn health, UNFPA has launched thematic funds and programmes to provide enhanced support to countries as they implement and scale up effective maternal and newborn health interventions. These initiatives, designed to be integrated into national health plans and systems, include: UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the Midwifery Programme and the Maternal Health Thematic Fund.

These represent UNFPA's focused efforts in countries with high maternal mortality ratios, high fertility and low contraceptive prevalence rates to improve access to and use of family planning, skilled care at delivery, and quality maternal health services — including emergency obstetric and newborn care, fistula treatment and social reintegration. In order to increase the effectiveness and efficiency of country support — as well as to reduce administrative and transaction costs at the country, regional and global level — the Midwifery Programme and the Campaign to End Fistula were integrated into the Maternal Health Thematic Fund in September 2009. The

Midwifery Programme and the Campaign to End Fistula will continue to operate within the context of the overall Maternal Health Thematic Fund as targeted efforts to improve maternal health. By incorporating them under one umbrella, UNFPA not only facilitates greater efficiency, but greater alignment at the country level. This 2009 MHTF Annual Report reflects outcomes and achievements of Maternal Health Thematic Fund (MHTF) activities, including the Midwifery Programme and the Campaign to End Fistula.

This report first presents overall MHTF results, followed by detailed overviews of the UNFPA-ICM Midwifery Programme and the Campaign to End Fistula. The report ends with priorities for 2010 and the way forward.

MATERNAL HEALTH THEMATIC FUND OVERALL RESULTS

Background

In 2000, the global community committed to achieving the Millennium Development Goals (MDGs), one of which focuses on improving maternal health. Millennium Development Goal 5 calls for a three-quarter reduction of the maternal mortality ratio by 2015, as compared to 1990 levels. This goal was further strengthened in 2007 by the addition of a new target: universal access to reproductive health by 2015, enshrining in the Millennium Development Goal framework what had been agreed to by member states at the International Conference on Population and Development (Box 1).

Box 1. Millennium Development Goal 5¹

Targets and Indicators

- ▶ Reduce maternal mortality ratio by three quarters, between 1990 and 2015
 - Maternal mortality ratio
 - Proportion of births attended by skilled health personnel
- ▶ Achieve, by 2015, universal access to reproductive health
 - Adolescent birth rate
 - Antenatal care coverage (at least one visit and at least four visits)
 - Unmet need for family planning
 - Contraceptive prevalence rate

There are around 350,000 to 500,000 maternal deaths each year.² And, every year over one million newborns die within their first 24 hours of life from lack of quality care. Maternal death is the largest health inequity in the world; 99 per cent of deaths occur in developing countries — mainly in sub-Saharan Africa and South Asia. Six countries — Afghanistan, Bangladesh, DRC, Ethiopia, India and Nigeria — account for over half of maternal deaths worldwide.

¹ United Nations. Report of the Secretary-General on the work of the Organization. General Assembly. Official Records. Sixty-second Session. Suppl No. 1 (A/62/1). October 2007.

² Note: Previous 2005 UN estimates were around 500,000 maternal deaths per year. A recent Lancet article would indicate around 350,000 maternal deaths annually in 2008 (Hogan MC, Foreman KJ, Naghani M, et al. Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5. Lancet. Published online April 12, 2010). The UN will release updated figures following consultations with member states later this year.

While progress has been slow and unequal over the past two decades, recent evidence suggests that significant progress is being made in all regions, including in sub-Saharan Africa and South Asia, the regions that account for the most maternal deaths.

Fortunately, we have a solid understanding of why women die during pregnancy and childbirth and how to prevent it. Most maternal and newborn deaths and disabilities can be avoided by establishing universal access to family planning, emergency obstetric care, and skilled birth at delivery. It is critical to strengthen national health systems and closely partner with communities to deliver these cost-effective interventions as well as to address the social and cultural factors that increase the risk of maternal mortality.

The Value-Added Proposition of the Maternal Health Thematic Fund

Designed as a pro-poor, performance-based and MDG-driven mechanism, the MHTF provides support in the form of national capacity development, technical expertise and financial resources to priority countries showing the least progress on Millennium Development Goal 5. Funding from the MHTF is intended to be strategic by quickly identifying and addressing bottlenecks that are preventing progress in maternal health, and to be catalytic in stimulating joint support to the nationally-led efforts to improve reproductive, maternal and newborn health. The Maternal Health Thematic Fund is also an important vehicle to focus global and national awareness on the topic and foster further commitment.

The MHTF is guided by a business plan that is based on scientific and programmatic evidence and a clear focus on results, with seven essential country-level outputs. The business plan also includes a detailed results framework that is anchored to MDG 5 targets and indicators as well as to UNFPA's Strategic Plan 2008-2011.³

The Maternal Health Thematic Fund: Operations and Countries Supported in 2009

Countries are supported based on recommendations from UNFPA regional offices and on:

- ▶ High maternal mortality (>300 per 100,000 live births);
- ▶ Committed country teams (government and partners);
- ▶ Potential for scale-up, including participation in recent global and regional initiatives and the availability of additional resources;
- ▶ Support by the Global Programme on Reproductive Health Commodity Security (GPRHCS);
- ▶ Recommendations of the H4 — WHO, UNFPA, UNICEF and the World Bank — which initially identified 25 priority countries.

Based on firm available revenue from donors for that year, and in close consultation with UNFPA regional and sub-regional offices, countries are then invited to submit a proposal to the MHTF. The proposal is then subject to a peer review, and, if necessary, amended before it is approved. Once support to a country has begun, it should be continuous, based on a satisfactory performance that follows the annual work plan.

³ UNFPA Maternal Health Thematic Fund. Business Plan 2008-2011.
<http://www.unfpa.org/public/site/global/lang/en/pid/3085>

The MHTF became operational in 2008 and received much of its initial funding in the second half of that year. By the end of 2008 it was able to launch work in **11 countries**, among them: **Benin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi** and **Sudan** (see MHTF 2008 Annual Report).⁴

In 2009, MHTF support to these 11 countries continued and, with the integration of the Midwifery Programme, four additional countries were supported — **Cote d'Ivoire, Ghana, Uganda** and **Zambia** — raising the total to 15 countries.

The Campaign to End Fistula, launched in 2003, was integrated programmatically and financially into the MHTF in 2009. Country support from both funding streams included all the countries named above, plus the following 16 countries for the fistula component: **Afghanistan, Bangladesh, Central African Republic, Chad, DRC, Eritrea, Ghana, Guinea, Kenya, Liberia, Mauritania, Nepal, Niger, Pakistan, Senegal** and **Zambia**.

The MHTF thus supported 31 countries in 2009 with one or more components of the programme. As programmatic integration progresses over time, more countries are receiving the full range of MNH support. In order to facilitate this country support, the MHTF gave technical and/or financial support to the four regional offices covering these countries: Africa, Asia, the Arab States, and Latin America and the Caribbean.

Key results for each of the essential country-level outputs of the Maternal Health Thematic Fund

The Business Plan describes seven essential country-level outputs. In collaboration with government and key partners, the MHTF will support:

- ▶ An enhanced political and social environment for maternal and newborn health (MNH) and sexual and reproductive health (SRH);
- ▶ Up-to-date needs assessments for the SRH package, with a particular focus on family planning, human resources for MNH, and EmONC;
- ▶ National health plans focusing on SRH, especially family planning and EmONC, with strong RH/HIV linkages to achieve the health MDGs;
- ▶ National responses to the human resource crisis in MNH, with a focus on planning and scaling up of midwifery and other mid-level providers;
- ▶ National, equity-driven scale-up of family planning and EmONC services and maternal and newborn health commodity security;
- ▶ Monitoring and results-based management of national MNH efforts;
- ▶ Leveraging of additional resources for MDG 5 from governments and donors.

⁴ MHTF 2008 Annual Report. <http://www.unfpa.org/public/cache/offonce/publications/pid/3083>

OUTPUT 1:

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

Political will coupled with a supportive legal, social and economic environment are critical to achieving the Millennium Development Goals, and particularly MDG 5. The thematic funds aim to be “catalytic”, stimulating awareness, donor contributions and collaboration at the global and national levels. To achieve this objective, the Fund’s processes and mechanisms must be aligned with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. As per the Declaration, the approaches to aid effectiveness include ownership, alignment, harmonization, managing for results and mutual accountability.

Ownership

To ensure national ownership, the fund supports initiatives enabling countries to set their own policies, goals, strategies and actions for improving maternal health. One such example is the Campaign to End Fistula in Niger, which has been integrated into the UNFPA Country Programme Action Plan (CPAP 2009/2013), the National Health Development Plan (Plan de développement sanitaire 2005-2010) and the National Reproductive Health Programme. Also, in 2009, the MHTF supported activities to commemorate the International Day of the Midwife (IDM) in 12 priority countries, launching the global slogan, “The world needs midwives now more than ever” (see midwifery excerpt). These actions contributed to an increased awareness of and commitment to midwifery services.

As a funding mechanism, it is important for the Maternal Health Thematic Fund to be aligned with national processes and to use local systems. An example is the USD 1,000,000 contribution from the MHTF in 2009 to the MDG Performance Fund in Ethiopia, which was aligned with the country decision to have an MDG pooled fund to secure a place at the table to strategically position maternal health, and more broadly, to leverage more resources for the implementation of the ICPD Agenda in Ethiopia.

Highlight: Ethiopia MDG Performance Fund

In order to make external aid more effective through better harmonization and alignment, the Government of Ethiopia and development partners first signed a national compact, under the International Health Partnership (IHP+), in August 2008. A Joint Financing Arrangement (a multi-donor pooling arrangement) was signed that resulted in the establishment of the **MDG Performance Fund**, which includes the health sector from global initiatives (Global Fund, GAVI, PEPFAR), multilateral agencies and bilateral donors. The Maternal Health Thematic Fund made a direct contribution of USD 1,000,000 to the MDG Performance Fund in 2009 and will continue in 2010 to address critical areas identified by this country-led process to improve maternal health. In the framework of the Ethiopia IHP+ compact, it provides flexible resources, consistent with the ‘one plan, one budget and one M&E mechanism’. UNFPA’s participation in all key processes of IHP+ Compact development is critical to ensure the necessary programme and financial procedures are followed according to new aid funding modalities. It also ensures that UNFPA’s core mandate is strategically positioned in government strategic plans and processes.

Harmonization

In order to improve aid effectiveness, there is a need for better coordination not only within UNFPA, but also among governments, UN agencies, and development and technical partners to simplify procedures, reduce the administrative burden, and to avoid duplication of efforts. To achieve better harmonization, in 2009 UNFPA initiated an internal process of integrating funds (the Campaign to End Fistula, the Midwifery Programme, the Maternal Health Thematic Fund and the Global Programme on Reproductive Health Commodity Security). An illustration of harmonization is the H4 joint UN support to countries described later.

Managing for Results

The Maternal Health Thematic Fund is focusing on the most cost-effective interventions to reduce maternal mortality, including family planning, emergency obstetric and neonatal care, and skilled care at delivery. Toward this end, the MHTF jointly developed strategies with priority countries and the Global Programme on Reproductive Health Commodity Security. This clearly depicts its role as a performance-based and results-driven mechanism to accelerate progress towards MDG 5. There is increased attention to better planning, to indicators for tracking progress and to monitoring and evaluation processes and systems. One example is the effort of focus countries to institutionalize routine maternal death reviews/audits, while another is the evidence-informed communication project launched by UNFPA in four countries (Ethiopia, Malawi, Nigeria and Sierra Leone), which aimed to increase community awareness and mobilization. In addition, international maternal and neonatal health experts have been posted in Ethiopia, Madagascar, Haiti, and Latin America and the Caribbean, where they have a strong emphasis on monitoring and evaluation.

Mutual Accountability

Although the UNFPA thematic funds can only be accountable for outputs, the funds — along with other UN and development partners, governments, and civil society — are all accountable for the development outcomes. To increase the likelihood of positive impact from the thematic funds, an inter-divisional working group has established review committees to provide guidance during the country proposal process.

Communication

Over the last three years, advocacy and media communication outreach on issues related to maternal health and fistula has been a priority for UNFPA and the maternal health and fistula thematic funds.

Partnering with other organizations on myriad communication initiatives related to maternal health is one effective strategy UNFPA uses to foster political awareness and commitment, while promoting and pitching the issue to the media is another. An important part of both these strategies has been building the capacity of UNFPA country office staff to effectively communicate about maternal health issues to a variety of audiences, including donors, journalists and policy makers.

Global media coverage of maternal health issues increased between 2008 and 2009 by more than 20 per cent. At the same time, UNFPA has been instrumental in securing a place for maternal health, fistula, midwifery strengthening, family planning and Millennium Development Goal 5 on the political agenda — both at the global and national level.

OUTPUT 2:

Analyzing the Needs

In 2008, the first year of the Maternal Health Thematic Fund, a macro situation analysis was conducted to address the relevance of selected countries based on their most recent maternal mortality ratio (MMR), contraceptive prevalence rate (CPR), unmet need for contraception, adolescent fertility rate, lifetime risk of maternal death, and coverage of basic and comprehensive emergency obstetric and neonatal care. In 2009 the focus of the analysis shifted to an in-depth country context to better understand and identify bottlenecks for improving maternal health, and adequately plan with indicators, baseline data and targets. The mechanisms used in this needs analysis include inception missions (Benin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi and Sudan), desk reviews and situation analysis for midwifery (education, regulations and associations — Cote d'Ivoire, Ghana, Uganda and Zambia), emergency obstetrics and neonatal care needs assessments, and the mapping exercise carried out by the H4 in the 25 priority countries. For obstetric fistula, the needs assessments started in late 2002. To date, more than 40 OF assessments have been conducted.

MHTF Support for Situation Analysis

Needs assessments are critical in each area of maternal health and family planning.

A handbook for emergency obstetric and neonatal care was jointly developed and launched in 2009 by the Averting Maternal Death and Disability Program (AMDD) at the Columbia University Mailman School of Public Health, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). In addition, a standard module on obstetric fistula was completed and is now part of the EmONC assessment tool.

UNFPA, together with AMDD (Columbia University) and UNICEF, is supporting high maternal mortality countries to conduct needs assessments in emergency obstetric and neonatal care. These needs assessments are conducted wherever there is no previous EmONC needs assessment, or when the most recent one to have been conducted is more than five years old. These EmONC needs assessments are national facility-based surveys which include all facilities currently carrying out a minimum number of deliveries.

These EmONC needs assessments have three functions:

- ▶ They serve as a baseline for the current level of service delivery in all districts of a country; it is against this baseline that future progress will be measured;
- ▶ They serve as a strong basis for evidence-based advocacy and resource mobilization;
- ▶ They provide data for district micro-planning of priority facilities (health centers and district hospitals) in terms of need for rehabilitation, improvement and consolidation of service delivery, quality of care and priority needs in strengthening the supply chain management for lifesaving equipment, supplies and drugs.

These needs assessments have been completed in **Ethiopia, Haiti, Madagascar** and **Cambodia**. Plans are under way for **Benin, Burkina Faso, Burundi, Cote d'Ivoire** and **Niger**.

Highlight: The Madagascar EmONC needs assessment and use

Out of 294 health facilities (which included all hospitals as well as basic health centers with more than 20 deliveries per month), only three met the requirements of basic EmONC facilities and 19 met the requirements of comprehensive EmONC facilities. As the minimum recommended number is five EmONC health facilities per 500,000 population, Madagascar needs the equivalent of 194 EmONC health facilities, of which nearly 160 should be basic EmONC facilities.

The institutional delivery rate is 18.4 per cent and the proportion of deliveries in EmONC health facilities is 4.1 per cent.

The Caesarean section rate is only 1.5 per cent, compared to the recommended range of 5 to 15 per cent. Direct obstetric case fatality is 2.2 per cent, and only 47 per cent of health facilities use partographs for monitoring labour and delivery, while 42 per cent of health facilities use protocols for managing obstetric complications.

Maternal death audits are not conducted at any health facility.

71 per cent of hospitals have a means of transport for obstetric emergencies, which include ambulances (27.2 per cent), vehicles (26.5 per cent), stretchers (26.5 per cent) and ox carts (0.7 per cent).

The Government of Madagascar is using these baselines to plan for improved access and uptake of emergency obstetric and neonatal care and to monitor progress.

Highlight: The Ethiopia EmONC needs assessment and use

As of 2008, only 51 per cent of hospitals qualified as comprehensive and only 1 per cent of health centers (25 facilities) could be considered basic EmONC. Nationally, only 7 per cent of births occurred in hospitals and health centers, and 90 per cent in government facilities.

- ▶ The proportion of Caesarean deliveries is less than 1 per cent, with huge disparities in access (45 per cent of Caesarean deliveries occurred in private, for-profit facilities).
- ▶ More than half of the hospitals (56 per cent) had a case fatality rate of less than 1 per cent, and 28 per cent had a case fatality rate of 3 per cent or higher. Main causes of death were ruptured uterus (6.4 per cent), sepsis (4.7 per cent) and severe pre-eclampsia/eclampsia (3.6 per cent). 85 per cent of maternal deaths documented took place in hospitals, and 15 per cent in health centers.
- ▶ Less than half (45 per cent) of the facilities provided safe abortion, of which 86 per cent are hospitals and 38 per cent are health centers/clinics; only 5 per cent provided cervical cancer screening, which occurred only in a few hospitals.
- ▶ Four out of five hospitals had access to an electrical grid and a back-up generator, while only 20 per cent of health centers could claim similar access to electricity. Meanwhile, 16 per cent of health centers had no source of electricity.

The Federal Ministry of Health swiftly developed district 'fact sheets' and shared them with District Health Teams to assist with the planning of scaling up EmONC signal functions.

This programme is coordinated through an inter-agency teleconference every two weeks with AMDD, UNFPA and UNICEF to exchange information and update the list of countries as well as the progress of needs assessments and follow up.

As EmONC needs assessments are a key component for planning and scale-up of MNH services, they are being planned and conducted in more countries than those supported by the MHTF in 2009. This is essential to ensure that future MHTF support in other countries is evidence-based and data-driven.

MHTF countries with EmONC needs assessment completed

Ethiopia, Haiti, Madagascar, Cambodia

Countries with ongoing EmONC needs assessment

(Establishment of national committee, development of tools, budget available)

Benin, Burkina Faso, Cote d'Ivoire, Niger

Countries with ongoing discussions and planning for an EmONC needs assessment

Tanzania, Laos, Nepal, Bangladesh, DRC (partial), India (partial),
Afghanistan (partial)

In 2009, findings from midwifery needs assessments in the MHTF countries revealed that among the 15 MHTF priority countries, 11 reported the existence of midwifery training institutions whose trained midwives are authorized to administer the core set of lifesaving interventions. Only a third (5 out of 15) reported the existence of a national midwifery council/board — either a stand-alone entity or one that is integrated within the nursing council/board. In nearly all of the supported countries (14 out of 15), midwives do not benefit from compulsory supportive supervision systems, nor is continued education available to ensure quality of care and updating of skills and competencies. It is therefore critically important that these areas be targeted in 2010 to strengthen midwifery. Three countries — Burundi, Djibouti and Guyana — require special attention and technical support in order to strengthen midwifery and ensure that every pregnancy is wanted and every birth is safe.

The Campaign to End Fistula supported 25 countries in 2009 to conduct various assessments aimed at improving national obstetric fistula strategy development. Some countries have concentrated on analyzing the overall situation in a selected number of districts or states, while others concentrated on issues related to fistula treatment and rehabilitation services.

An assessment of the MHTF country proposals regarding maternal health advocacy and communication was carried out in 2009, which revealed a need to strengthen this area.

OUTPUT 3:

National health plans focus on SRH, especially family planning and EmONC, with strong linkages between reproductive health and HIV to achieve the health MDGs

Addressing country policies and strategies is at the core of the MHTF. Three strategies have been used:

- ▶ Strengthening of country office capacity. For example, Chief Technical Advisors have been recruited in **Benin, Chad, Madagascar, Ethiopia** and **Haiti**; other countries are planning to strengthen country office capacity;
- ▶ Conducting H4 (joint UNICEF, WHO, UNFPA and The World Bank) missions in priority countries. For example, in **Ethiopia** the situation analysis and MNH planning are used to develop the Health Sector Development Plan IV, which includes MNH as a top national priority. In **DRC**, outlining the minimum package of interventions together with the health ministry will guide the implementation of MNH interventions. In **Haiti**, new policies regarding midwifery training and deployment have been developed with the Ministry of Health;
- ▶ Implementing progress follow-up (regular conference calls and reporting).

At the country level, UNFPA is working to ensure full support to national MNH and HSS priorities and plans. The requests for funding are in line with national plans and developed in collaboration with governments and partners, including the H4. At UNFPA Headquarters an inter-divisional working group and interdisciplinary teams have been formed to peer review all country proposals prior to recommendation for allocation. This helps to ensure that vitally important issues — such as family planning, emergency obstetric and neonatal care, obstetric fistula, and sexual and reproductive health and HIV linkages — are well reflected.

OUTPUT 4:

National responses to the human resource crisis in MNH, with a focus on planning and increasing the number of midwives and other mid-level providers

One of the weakest links of the developing world's health systems is the insufficiency of human resources for health. To successfully improve maternal health, countries need to scale up the number of highly trained and competent midwives and other professionals with midwifery skills, such as non-physician clinicians who can perform at least all the basic lifesaving functions.

To alleviate the scarcity of midwives and other professionals with midwifery skills, UNFPA and the International Confederation of Midwives launched the Midwives Programme in 2008. The Programme seeks to: provide technical support to priority countries to improve the quality of midwifery education (based on revised and culturally appropriate curricula as defined by essential WHO/ICM competencies); strengthen regulations surrounding midwifery practice (to ensure that midwives are authorized to administer the core set of lifesaving interventions); ensure that midwives benefit from compulsory supportive supervision and continued education; and build or strengthen professional associations so that midwives can have a platform from which to state their concerns and promote their profession.

Indeed, when empowered and authorized with all essential basic lifesaving competencies, midwives can help avert the majority of all maternal deaths. The existence of a national association and council of midwives will help ensure quality of care by establishing practices of certification and accreditation.

In addition, an intense degree of advocacy is needed to urge policy makers to create a conducive legislative environment so that midwives can practice their skills, as well as to ensure that national maternal health frameworks include and promote this essential profession.

Highlights: The Addis Ababa Conference on Human Resources for Maternal and Newborn Survival

In order to better address the issue of human resources for MNH, Columbia University's AMDD Program, UNFPA and Ethiopia's Ministry of Health used important technical and financial support from the MHTF to organize a major African conference in Addis Ababa in July 2009. Over 300 participants from 29 African countries were represented at the ministerial level.

The Addis Ababa Call to Action⁵ and participating country teams have since begun strengthening their national programmes based on the resulting knowledge exchange. Recognizing the need to scale up the services of midwives and non-physician clinicians to provide comprehensive emergency obstetric and newborn care is one important outcome. Indeed, midwives and others with midwifery skills at primary care level are crucial to addressing sexual and reproductive health, namely, maternal health, family planning, skilled attendance at all births and basic emergency obstetric care — including timely referrals for EmOC and HIV prevention. In addition, midwives have a critical role to play in newborn care and are the first to detect HIV infection in pregnant and non-pregnant women.

Highlights: Strengthening Midwifery in Haiti

In 2009 nurse-midwifery schools in Haiti were assessed; recommended lists of equipment and books needed for midwifery schools and training centers were prepared. Skills upgrading has been identified as an urgent issue. With the assistance of an International Midwife Advisor, the support of the Ministry of Health and the School of Nursing and in partnership with the Society of Obstetricians and Gynecologists of Canada (the ALARM programme), the midwifery training curriculum has been revised to ensure that nurse-midwives can perform the seven basic functions of EmONC.

The impact of the deployment of nurse midwife interns throughout the country is already perceptible. At two field sites, Petite Rivière de l'Artibonite and Lascahobas, a larger number of pregnant women are being assisted by the midwifery interns, resulting in a monthly average of 200 childbirths without a single maternal death. Aside from their training in the maternity ward, nurse midwives also acquire practice in community outreach through community health meetings. Through their dual medical and social role, nurse midwives have contributed to the reduction of maternal deaths in Haiti, and their skills continue to be put to vital use in the aftermath of the devastating earthquake that affected Haiti.

A documentary film of this work was done and aired on one of the main TV stations in the U.S.

⁵ Addis Ababa Call to Action on Human Resources for Maternal and Newborn Survival, including Task Shifting/Sharing for Emergency Obstetric and Newborn Care, 2 July 2009. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/call_to_action.pdf

The UNFPA's Midwifery Programme excerpt in this Report provides an in-depth review of UNFPA's support to midwifery education, regulations and professional associations.

Highlights on Obstetric Fistula

The scarcity of human resources for health in the developing world is well documented. Treatment and care for obstetric fistula is constrained by minimal national expertise and skills for the management of fistula cases. With support from UNFPA and partners, many countries have utilized external experts — to provide training and treatment — as well as the limited number of national skilled fistula experts to conduct internal treatment missions.

Ghana Highlights

Countries supported by the Campaign to End Fistula are increasingly focused on the development of a national plan and investment in effective national capacity strengthening.

To call attention to the social determinants of maternal health, beauty pageant winner Miss Ghana served as an Ambassador for Obstetric Fistula in Ghana in 2009. With the support of her government, Miss Ghana led a maternal health advocacy campaign. Sixty fistula advocates from Ghana's three northern regions (Northern, Upper East and Upper West) where obstetric fistula is most prevalent were trained to help raise awareness about preventing maternal death and disability — particularly obstetric fistula. The advocacy campaign targeted religious and community leaders as well as men's and women's support groups with information on issues related to girls' education, laws prohibiting female genital mutilation, early marriage, family planning, skilled attendance at birth, emergency obstetric care, and treatment and rehabilitation/reintegration of fistula patients.

In addition, with the support of UNFPA, an abandoned facility donated by the Northern Regional Directorate of Health was upgraded to a fistula center of excellence, addressing treatment, rehabilitation, advocacy and prevention. The center was officially commissioned by the Ministry of Health and the Ministry of Women and Children's Affairs.

A key component of this effort is the development and use of quality assurance mechanisms, including supportive supervision and follow-up. All capacity strengthening is conducted within the context of national and global partnership, with professional societies playing a primary role. The International Society of Fistula Surgeons (ISOFS) is one such society leading the efforts to ensure that there are sufficient human resources for fistula treatment and care. Additionally, the standardized, competency-based training manual (developed within the international Obstetric Fistula Working Group by an expert team coordinated by FIGO) will contribute to training quality and the development of standards and protocols. The challenge in the coming years is to scale up the workforce of doctors, nurses and social workers for fistula management.

Learning from the Madagascar Success Story in Family Planning

Family planning is the first pillar of maternal health. The success of Madagascar's family planning programme is not presented here as a result of MHTF investment, but as a best practice to demonstrate that investment in family planning is not only feasible, but that it pays. The Maternal Health Thematic Fund takes no credit in the achievement of this programme, but is

contributing to its sustainability together with the Global Programme on Reproductive Health Commodity Security. It will support priority countries to achieve similar success.

Madagascar Family Planning Success Story

To address the recurrent shortage of reproductive health commodities, particularly contraceptives, the Ministry of Health together with UNFPA, USAID, WHO, UNICEF and the World Bank, decided to revamp its strategic plan to include comprehensive condom programming (CCP). The different steps of the process were to: 1) convene a workshop with all players and stakeholders in reproductive health commodity security to reach a consensus on conceptual framework, data collection tools and the CCP; 2) conduct a situation analysis; 3) update the national commodity security strategic plan; and 4) develop a costing tool model, the validation of a 2010–2015 plan towards universal access to reproductive health commodities in Madagascar.

The goal was to increase each year the contraceptive prevalence rate by 2 per cent, by:

- ▶ Increasing the demand for voluntary family planning. The strategy included effective inter-sectoral collaboration at all levels (national, regional, district), as well as the involvement of all community, religious, political or administrative leaders;
- ▶ Improve supply at all facility levels (commodities, training of staff). All the health facilities provide family planning services, with very low stock-out rates. Family planning services have been integrated into HIV Voluntary and Counseling Treatment Centers. Outreach activities have been implemented for hard-to-reach populations by community workers in all regions;
- ▶ Establishing free contraception in 2007 and implementing an effective logistics system. As an example, 300 district medical officers and regional medical officers were trained in 2009 on the use of CHANNEL logistics and procurement of commodities;
- ▶ Improving the policy environment through adopting a national strategy for reproductive health commodity security, partnerships, and regulations for access to family planning.

This holistic approach of supply, demand and policy has resulted in a steady increase of the contraceptive prevalence rate over the years, with a remarkable annual progression of 2.2 per cent from 2004 to 2009. This success of the family planning programme, combined with the recent national policy exempting fees for emergency obstetric care and the institutionalization of maternal death audits, is likely to result in a significant drop in the maternal mortality ratio by 2015. This is an excellent example that other countries can learn from, and the MHTF is keen to provide support.

OUTPUT 5:

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

There is a need to scale up services to improve coverage and generate demand for uptake of quality maternal health care.

Highlights: Scaling up Access to Emergency Obstetric and Neonatal Care

Haiti has the highest maternal mortality rate in the Western Hemisphere, and **Madagascar** has one of the world's highest maternal mortality ratios. These high-priority countries completed EmONC assessments in 2009, each of which covers hundreds of facilities. The data are now being used to strengthen maternity services in health centers and district hospitals, as well as to monitor the scale-up of EmONC services.

Highlights: Scaling up Obstetric Fistula Services

In 2009, following the support of advocacy and awareness activities, greater focus was placed on fistula programme implementation. This involved the establishment of centers of excellence for obstetric fistula management, including complex cases at country level, such as in **Benin** (St. Jean de Dieu Hospital in Tanguieta), **Ghana** (Northern Regional Health Directorate), **Bangladesh** (10 referral centers) and **Pakistan** (regional centers renovated and made fully functional in Karachi, Multan, Lahore, Quetta, Larkana, Peshawar and Islamabad). The development of South-South and North-South collaboration has improved the availability of skilled human resources for fistula treatment and care, as well as the development of social rehabilitation activities. Examples include missions conducted by Professor Gueye from Senegal in **Benin** and **Guinea**, by Dr. Kees Waaldijk of Baban Ruga Hospital in Katsna (Nigeria) in **Niger, Chad, Ethiopia** and **Bangladesh**, and by Professor Charles-Henry Rochat from Geneva in **Madagascar** and **Benin**.

However, in 6 of the 15 MHTF countries (**Burundi, Cambodia, Djibouti, Madagascar, Haiti** and **Guyana**), the Campaign to End Fistula has yet to be mainstreamed in national programmes, and the challenge remains to move from fistula repair camps to a health system that is responsive to the needs of fistula patients.

Investing in social rehabilitation to enable women to recover their dignity and productivity should be the ultimate goal of care for fistula patients. Few countries have developed this component, and it is a priority area for the campaign in 2010. From a public health perspective, however, prevention should remain key and a lot remains to be done — particularly in the areas of preventing underlying social and cultural factors of fistula. Indeed, scaling up services (emergency obstetric care and midwifery) should dovetail with efforts to create a conducive environment, such as changing laws and policies to ban early marriage, promoting girls' education and empowering women to be decision makers. Until these social factors are addressed there will be little change in fistula prevention; our goal for 2010 is to focus on these priority areas while ensuring that services are available and accessible to all women. We need to engage civil society, parliamentarians, policy makers and NGOs to ensure that the rights of women are protected.

The Campaign to End Fistula excerpt in this report provides an in-depth review of UNFPA's support to fistula prevention, treatment and social reintegration.

Highlights: Scaling up Midwifery

In **Cote d'Ivoire** intensive clinical training for almost 300 midwives is under way, with midwives undergoing an additional two months of clinical training in 40 identified maternity services. This,

together with an increase in the availability of equipment, supplies and drugs, will enable these highly-trained midwives to perform the seven essential lifesaving functions of basic emergency obstetric and newborn care.

In **Haiti** the National School of Nursing is strengthening its curricula to ensure graduates can perform the seven key functions of basic emergency obstetric and newborn care. Student nurse-midwives are now being placed in resource-poor field locations and are already contributing to the reduction of maternal deaths.

Highlights: Scaling up Lifesaving MNH Equipment, Supplies and Drugs

MNH equipment, supplies and drugs are essential to save the lives of women with complications during labour or delivery and of newborn infants. In 2009, at the instigation of the MHTF team, the H4 updated the essential lists of medical devices and essential drugs required to deliver the nine lifesaving functions of basic and comprehensive EmONC for the labour and delivery period in resource-poor settings, identifying the needed commodities at health center (B EmONC) and at district hospital (B+C EmONC) levels. The MHTF team also sought to identify the areas of strength in procurement among respective agencies and areas in need of strengthening, such as national supply chain management or upstream issues such as pre-qualification or sufficient global supply. This work is now fully integrated within the Global Programme in Reproductive Health Commodity Security and is being taken forward with partners through the Partnership for Maternal, Newborn and Child Health (PMNCH).

In **Benin**, a national family planning advocacy campaign was launched, with a national performance contest for 24 main health facilities. The campaign, under the leadership of the Ministry of Health, identified performance criteria (new clients with modern methods, age distribution of clients, stock out at service delivery point, etc.). It is important to note that there is no incentive to clients or providers; the best facilities receive a symbolic plaque in recognition of effort to improve family planning.

OUTPUT 6:

Strengthening HMIS, Monitoring and Results-Based Management

MGD 5, achieving a 75 per cent reduction in maternal deaths by 2015, has witnessed the least progress of any of the Millennium Development Goals. A goal that is not monitored cannot be achieved, nor can it be missed. While it is important to carefully plan and ensure that the most cost-effective interventions are promoted, it is equally important to ensure that national health information systems are strengthened to generate quality data to track progress.

The Maternal Health Thematic Fund has strengthened its result framework with baselines and targets for indicators, and has organized a working session on the results framework with UNFPA African country offices in 2009 to ensure relevance and feasibility.

Highlights

In 2009 and 2010 MHTF identified several areas for improving monitoring and evaluation, in particular the monitoring of quality of care through the institutionalization of routine maternal death reviews. For example, with the support of UNFPA and WHO, several priority countries (**Benin, Burkina Faso, Niger, Mali, Ethiopia, Cambodia, Ghana and Madagascar**) have now planned and are implementing the institutionalization of maternal death reviews/audits. This is a critical step to improve care using a quality assurance mechanism in all comprehensive emergency obstetric and neonatal care facilities.

Cambodia Highlights

The maternal mortality ratio remains high in Cambodia, largely due to: very low access to and uptake of emergency obstetric and neonatal care (Caesarean sections occur in only 2 per cent of all births); and low coverage of family planning, as illustrated by the unmet need for family planning (25 per cent); and low contraceptive prevalence rate using modern methods (26 per cent). In recognition of the low proportion of births attended by skilled health personnel (55 per cent) and antenatal care visits (33 per cent), the Government of Cambodia is expanding midwifery services and surveillance of maternal deaths.

The Cambodian Ministry of Health, with technical support from UN development partners, including WHO and UNFPA, has taken a major step toward strengthening maternal death surveillance. A maternal death surveillance room has been set up within the Department of Planning and Health Information, with a weekly maternal death report. The Surveillance Room, with its Maternal Mortality Weekly Report (MMWR), aims to ensure better monitoring, and to improve the investigation of cause of deaths and access response measures. This is a major step in the control of maternal mortality in Cambodia.

After a national midwifery assessment, a High-Level Midwifery Task Force chaired by the health ministry was established. The responsibilities of the Task Force include: revising midwifery school curricula, adding teaching staff, preparing teaching materials (books, anatomic models), training midwifery teachers on lifesaving skills, establishing an incentives policy for midwives, and distributing the IMPAC manual on Complications during Pregnancy and Childbirth to 830 midwifery students and 150 midwives attending the Midwives' Day in June 2009. In addition, a new three-year, direct-entry midwifery training programme was introduced, recruiting a large number of midwifery students. In 2009, 830 received training, compared to 335 in 2008.

The UNFPA country office has continuously highlighted this undertaking in its advocacy and communication outreach to ensure that the results were publicized to the key stakeholders and decision makers.

OUTPUT 7:

Health Financing, Leveraging of Resources from Governments and Donors

The Maternal Health Thematic Fund is a catalytic fund that complements UNFPA core resources and other support from technical and financial partners and programme country donors to improve maternal health. As such, the success of MHTF is also measured by how successful the Fund is in leveraging resources from governments and donors, as well as reducing financial barriers to access and uptake quality maternal services. The following highlights are selected examples of the catalytic nature of the Fund in leveraging resources and in health financing.



Scene from inauguration of the the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in Malawi. Photo by UNFPA Malawi.

Highlights: Leveraging Resources Towards MDG 5

The Malawi MDG 5 CARMMA

With support from MHTF, Malawi has launched its Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). This joint initiative between the African Union Commission and UNFPA promotes the Maputo Plan of Action for Reduction of Maternal Mortality in the Africa Region. It is nationally driven and owned, with strong partnerships across UN agencies, bilaterals and NGOs. It focuses on four key areas:

1. Building ongoing efforts, particularly in best practices;
2. Generating and providing data on maternal and newborn deaths;
3. Mobilizing political commitment and support of key stakeholders, including national authorities and communities;
4. Accelerating actions aimed at the reduction of maternal and associated infant mortality in Africa.

(continued on the next page)

The Malawi MDG 5 CARMMA (continued)

The outputs of the Malawi CARMMA launch were: a) a country work plan for Malawi CARMMA, a two-year initiative aligned with the UN Business Plan (UNDAF), UNFPA Country Programme and Malawi health strategy plans; b) an advocacy and resources mobilization plan for maternal and neonatal care; and c) an opportunity for Malawi to leverage resources within the UN, with development partners, and with other stakeholders, including the target community and private sector.

Highlights: Financing for Maternal Health

In the developing world, women often don't get the care they need simply because they cannot afford it. Reducing financial barriers to quality delivery care for the poorest is therefore critical to the success of any maternal health programme.

In **Madagascar**, a nation-wide fee exemption policy was introduced in 2008 by the Government for emergency obstetric care, particularly Caesarean sections.

With its own resources and those from the MHTF and GPRHCS, the UNFPA country office supported the initiative by ensuring the availability of Caesarean section kits at all hospitals. By monitoring the distribution of the Caesarean section kits, the country office has improved logistic management and reduced supply shortages that have hindered the provision of care in the past.

In **Ghana**, through advocacy efforts by the Ministry of Health/Ghana Health Service and health technical and development partners, including UNFPA, in 2009 obstetric fistula treatment was included under the national health insurance scheme (NHIS). This is a significant step toward reducing financial barriers preventing fistula patients from accessing treatment services at designated obstetric fistula centers. Advocacy was also conducted to recruit voluntary clients to register under the scheme: in March 2009, out of the 30 obstetric fistula clients treated at the Upper East Regional Hospital, 25 of them had registered under the scheme and were therefore treated free of charge. This mechanism is effective in increasing national ownership and sustainability of the obstetric fistula programme.

Partnerships and Communication

The WHO, UNICEF, UNFPA and the World Bank (H4) Collaboration

The H4 is a collaborative mechanism established by WHO, UNICEF, UNFPA and the World Bank to improve coordinated support to national maternal and newborn health programmes. Since the Joint Statement on Maternal and Newborn Health was signed by the H4 principals on 25 September 2008⁶, the four agencies have been working together to improve coordinated support to national maternal and newborn health programmes in the 25 priority countries with a very high maternal mortality burden. This includes a special focus on the six countries where half of all global maternal deaths occur each year.

Joint inception missions have been conducted or are planned in the priority countries. The MHTF funding to priority countries has already made an important financial contribution to the H4 work. A series of national EmONC needs assessments are being supported jointly by UNFPA and UNICEF with technical support from Columbia University's Averting Maternal Death and Disability (AMDD) Program and WHO. Since the July 2008 signing of the UNFPA-UNICEF-AMDD Memorandum of Understanding to strengthen EmONC, three capacity building workshops (two in Africa and one in Asia) were held to launch the programme, through which national EmONC needs assessments will be carried out in the 25 priority countries.

Communication and Media Outreach on Maternal Health

A series of global, regional and national level activities took place in 2009 to better position maternal health in the media and to influence decision makers in the political and development arenas. Throughout 2009, UNFPA's communication specialists around the globe worked strategically to gain a more prominent position for maternal health and UNFPA's related work in the media, and to educate and inform agents of change, such as journalists, members of the U.S. Congress, parliamentarians in Asia and others. This intensified work was partially in response to the widespread realization that Millennium Development Goal 5 has made the least progress and is the most underfunded of the health-related MDGs.

Support for the Documentary "Grace Under Fire"

UNFPA and the Maternal Health Thematic Fund provided funding for the documentary, "Grace Under Fire", which aired worldwide in September on BBC World, reaching 200 million households. The film follows Dr. Grace Kodindo, a leading advocate for women's health, as she travels to North Kivu in the Democratic Republic of the Congo to investigate how the conflict there impacts women. Dr. Kondindo meets women who have suffered from the brutal sexual violence that has plagued the area and speaks to them about how they have managed pregnancy and childbirth under such trying conditions. She also visits health facilities and finds that the availability of maternal and reproductive health care and supplies is virtually non-existent.

The film highlights one of UNFPA's key priorities — providing maternal and reproductive health care to women in crises. The film has been used in a variety of ways and settings, as are the majority of UNFPA's communication tools. In addition to the BBC broadcast, the film was:

- ▶ Screened on Capitol Hill and at the State Department;
- ▶ Distributed to NGOs and media groups throughout Africa to use for advocacy;

⁶ WHO, UNFPA, UNICEF, the World Bank: Joint statement on maternal and newborn health. Accelerating Efforts to Save the Lives of Women and Newborns; 25 September 2008.
http://www.who.int/pmnch/media/news/2008/20080925_unjointstatement.pdf

- ▶ Given to donor partners to give a better understanding of reproductive and maternal health requirements in emergency settings.

Communicating Data and “Adding it Up”

UNFPA’s strategic communications work in 2009 also focused on pushing out new maternal health-related data. With MDG 5 so severely underfunded, it was clear that the maternal health investment argument had to be strengthened. Together with The Guttmacher Institute, UNFPA produced the report: “Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health”. The report included new figures on what it would cost to reduce maternal deaths by 75 per cent and provided a wealth of new information to enhance our communications work on maternal health. UNFPA and The Guttmacher Institute conducted global media outreach focusing on UK, Latin America and U.S. outlets, and the report received strong coverage around the world. “Adding it Up” has also been distributed to thousands of international actors working on the issue of maternal health and family planning to maximize its impact. Today, it is a key resource for advocates in the field of maternal health and family planning.

Success Stories

A conscious effort was also made in 2009 to focus on highlighting maternal health success stories. A grant was given to White Ribbon Alliance for Safe Motherhood for the joint project, Stories of Mothers Saved, which builds on the successful Stories of Mothers Lost (2007). The project is collecting individual stories of women who survived pregnancy and childbirth, which will be used for media outreach and advocacy throughout 2010 and beyond. The materials were prominently featured at the global Women Deliver Conference in June 2010, in Washington D.C.

Revitalizing Ties to U.S.-based Media

With a new administration in Washington D.C., and the United States’ resumption of funding to UNFPA, the agency also intensified its work with U.S.-based media outlets and decision makers. Leading journalists and major media outlets in the U.S. covered maternal health in 2009. The *New York Times* columnist Nicholas Kristof did several columns focusing on the issue, with the support of UNFPA HQ and country offices in Haiti and Sierra Leone. The American TV station PBS’ prestigious long-format news programme, NOW, did a half-hour documentary on maternal health in Haiti, which has the highest maternal mortality rate in the Western Hemisphere.

Countries in Media

Another strategy put forward in 2009 for communications around maternal health was securing global media coverage for the programme’s priority countries. Overall global media coverage of maternal health issues increased by more than 20 per cent between 2008 and 2009, and the coverage within many of the hardest hit countries increased as well, thanks to the orchestrated effort.

Ethiopia, for example, where 1 in every 27 women has a lifetime risk of dying in pregnancy or childbirth, was one focus country. In August, CNN featured two stories about the need for family planning and maternal health care in Ethiopia’s rural districts. In September, The Huffington Post, one of the most widely read and influential blogs in the world, featured a five-part series on maternal health in Ethiopia. And in October, during the High-Level Meeting on MDG 5 in Addis Ababa, BBC dedicated a full day to maternal health and fistula with stories from Ethiopia, Afghanistan, Malawi and the U.S.

For much more on communication and media activities in 2009, refer to the Midwifery and Fistula chapters.



Students at the UNFPA-supported Midwifery School of El Fasher examining a pregnant woman. El Fasher, Darfur, Sudan. June 2007. Photo by Sven Torfinn/Panos Pictures/UNFPA.

2009

STRENGTHENING MIDWIFERY UNFPA-ICM MIDWIFERY PROGRAMME

Background

The Midwives Programme was jointly launched by UNFPA and the International Confederation of Midwives (ICM) in April 2008 with generous funding from the Government of Sweden and since then supported by other donors as well. In 2009, UNFPA received another generous multi-year pledge from the Government of the Netherlands, with particular emphasis on global midwifery strengthening. In addition to these governments, UNFPA is also deeply grateful to all other donors — among them Austria, Finland, Ireland, Luxembourg and Spain — whose extraordinary support to the Maternal Health Thematic Fund has accorded the midwifery programme stability and scope to grow and expand.

The Midwives Programme was originally conceived in 2006-2007 as UNFPA's response to global concern regarding inadequate investments in human resources for health — the most critical component of health systems. UNFPA decided to focus on human resources for maternal health, i.e. midwives and others with midwifery skills.

The goal of the Midwives Programme is to improve skilled attendance at birth in low-resource settings by developing the foundations for a sustainable midwifery workforce. It aims to achieve this in three ways: 1) by establishing a critical mass of advisors on midwifery to work both nationally and regionally, providing strategic direction and national capacity building in efforts to strengthen national midwifery curricula; 2) by building and strengthening professional associations; and 3) by addressing policy-level issues surrounding retention and deployment of midwives, their distribution and supportive supervision skills. The programme's capacity building focuses on four areas: 1) developing/strengthening education and accreditation mechanisms; 2) promoting the development of midwifery associations; 3) strengthening regulatory mechanisms; and 4) advocacy and promotion of midwives as a key health workforce essential for the achievement of MDGs 4 and 5.

The first year (2008) of the Midwives Programme focused primarily on building the foundations of the multi-year programme by: identifying the key priority countries for Phase 1 of the Programme; establishing the Terms of Reference and hiring the key technical personnel and managers of the programme (UNFPA Programme Coordinator, ICM International Midwife Advisor, National and International Country Midwife Advisors); and finalizing country strategies and work plans. Major progress and consolidation of results was noted in 2009.

By the end of 2009, the Midwives Programme was active in 15 MHTF countries, mostly in Africa, the Arab States and in a few countries in Latin America. The programme is focused on reviewing and revising midwifery curricula to include all essential WHO/ICM competencies; equipping midwifery schools; strengthening midwifery faculty; strengthening midwifery associations and advocating, if necessary, for the establishment of a midwifery council/board to ensure that the practice of midwifery is properly regulated and that midwives have the requisite skills that are kept up to date.

The Key Highlights of 2009

Programmatic Integration with the Maternal Health Thematic Fund

The Midwives Programme, launched in 2008 in collaboration with the International Confederation of Midwives (ICM), was programmatically integrated within UNFPA's Maternal Health Thematic Fund (MHTF) effective 1 April 2009. The purpose of the integration was to ensure better alignment with national policies and greater aid effectiveness, thus following an integrated approach to addressing maternal health. In addition, this resulted in better integration of the Midwives Programme within the national maternal and reproductive health components of ongoing UNFPA country programmes. The MHTF was also strongly linked with the Global Programme on Reproductive Health Commodity Security. Newly recruited Country Midwife Advisors are now seen as full members of the UNFPA country team. Also, as a result of the integration, midwifery development activities were linked with the other components of the Fund, namely strengthening family planning, planning for human resources for maternal health, and strengthening emergency obstetric and newborn care (EmONC). For example, in **Madagascar**, despite severe political disturbances in 2009, the Midwives Programme was fully integrated in the revival of the family planning programme, contributing to an increase of 2 per cent in the contraceptive prevalence rate (MoPH). In **Guyana**, a training coordination mechanism has been created to review all training activities to strengthen human and technical resources for improving maternal health, primary healthcare and family planning services. These include representatives from the Ministry of Health, midwifery schools, the Nursing and Midwifery Association, PAHO and UNFPA.

Since the Fistula Campaign has also been fully programmatically integrated into the MHTF, midwifery is linked directly to the prevention component of the Fistula Campaign and seen as key to reducing new incidence of fistula.

Resources

- ▶ In 2009, approximately USD 4 million was spent on midwifery related activities supported by generous contributions from Austria, Finland, Ireland, Luxembourg, the Netherlands, Spain and Sweden.

Programme Countries Phase 1

- ▶ The Programme is now well under way in 15 MHTF countries: 10 in Africa (Benin, Burkina Faso, Burundi, Cote d'Ivoire, Ethiopia, Ghana, Madagascar, Malawi, Uganda and Zambia), two in Latin America (Guyana and Haiti), two in the Arab States (Djibouti, Sudan, both Northern and Southern) and one in Asia (Cambodia). Twelve countries (Benin, Burundi, Burkina Faso, Cote d'Ivoire, Ethiopia, Ghana, Djibouti, Guyana, Madagascar, Sudan, Uganda and Zambia) currently fall under the direct umbrella of technical support provided by the UNFPA/ICM Midwives Programme, with the ICM Regional Midwife Advisors providing direct technical support to the countries. With the remaining three countries — Cambodia, Haiti and Malawi — close synergies have been established and the ongoing midwives programmes in these countries have been linked to the joint UNFPA/ICM Programme.

Programme Staff and Establishment of Project Office

- ▶ Eleven national Country Midwife Advisors (CMAs) and three International Country Midwife Advisors (ICMAs, in Cambodia, Ethiopia and Haiti), have been placed in UNFPA country offices for reviewing, advising, advocating and developing national policies and programmes with stakeholders for midwifery education, regulation and association building. The recruitment process of three ICMAs for Djibouti, North and South Sudan is currently under way.

- ▶ ICM has hired two Regional Midwife Advisors — one for anglophone Africa and the other for francophone Africa.
- ▶ The ICM project office was established in Accra, Ghana in March 2009. The ICM International and Regional Midwife Advisors use this office as their regional headquarters for programme activities.
- ▶ The Regional Midwife Advisor for Asia will be hired in the first quarter of 2010 and posted in the region.

Key Results Achieved

Capacity Building of Country Midwife Advisors (CMAs)

Since the CMAs are the key advisors responsible for moving the midwifery agenda at the country level, it is essential that they have the necessary project management skills, strategic vision and advocacy competencies to work with their respective governments and stakeholders. It is also important that they share experiences and are able to effectively network within the region. To achieve this, the following two workshops were organized in 2009:

- a. ICM and UNFPA jointly hosted the first **Inception Forum for Country Midwife Advisors and Capacity Building Workshop in Accra, Ghana, 3-13 March 2009**. The workshop helped the newly recruited CMAs to build a strategic perspective in promoting and strengthening midwifery services at country level, with a specific focus on midwifery education, regulation and strengthening midwifery associations. In addition, the workshop provided an excellent opportunity for professionals from many countries to share experiences and learn from each other. Participants also took part in a three-day project management training programme as part of the workshop.
- b. ICM, in collaboration with the UNFPA Zambia country office, hosted the **second Capacity Building Workshop** for all national and international Country Midwife Advisors in Lusaka, Zambia for mid-year progress reviews, knowledge sharing, developing standardized strategies for reviewing national midwifery curricula, and strengthening the advocacy skills of the CMAs.

The impact of these trainings has been that the CMAs have a unified and harmonized perspective on the key goals and intended strategies of the programme. They have been able to deploy proper techniques by doing thorough needs assessments/desk reviews of the national midwifery situation, and have been able to analytically review the curricula prevailing in their countries, identify the weaknesses, compare these with global standards and suggest country specific solutions. They are also better equipped in doing advocacy and understanding the various global initiatives that exist (e.g. International Health Partnership, H-4 initiative) to mainstream midwifery. The evaluations of both the above trainings were overwhelmingly positive, with a 95 per cent approval rating; CMAs have requested that these be held on an annual basis.

Global Advocacy — Celebration of the International Day of the Midwife on 5 May 2009

The International Day of the Midwife (IDM) was celebrated globally with the slogan **“The world needs midwives now more than ever”**, an overarching theme which ICM will use between now and 2015.

Some countries, like Ethiopia and Sudan, combined the celebration with the formal launch of their national Midwives Programme. Events marking the occasion featured public debates, a television documentary in Benin, colorful marches and advocacy with political leaders in Sudan to highlight and promote the significance of midwifery in addressing maternal and neo-natal mortality. In addition to the national celebrations that took place under the “Investing in Midwives Programme”, the event was celebrated in countries far and wide, including Iran, Liberia, Solomon Islands, Mexico, and Sierra Leone. Each served to focus attention on the importance of strengthening midwifery services and bringing all the stakeholders together.

As a result, an increasing number of policy makers have become aware of the issues surrounding midwifery and the midwives themselves are coming forward to express their concerns and provide solutions.

Establishing baseline data on midwifery services, curricula, associations and regulations at country level

In 2009, all the programme countries conducted **detailed desk reviews and/or needs assessments** with regard to establishing baseline information on: prevailing standards of midwifery training (pre-service and in-service); prevailing legislative and regulatory environments to allow midwives to deliver lifesaving interventions; and assessing the status of professional midwifery associations. Ghana, Uganda, Ethiopia, Burkina Faso, Cote d’Ivoire, Burundi, Madagascar and North Sudan have completed their needs assessments/desk reviews.

Based on the findings of the needs assessments, many positive outcomes have been noted. In **Uganda**, a national workshop was held in August 2009 attended by 40 midwifery stakeholders, who developed a Midwifery Improvement Plan (MIP) based on the findings of the needs assessment. The stakeholders included Ministries of Education and Health, development partners and NGOs. The MIP aims to promote quality midwifery training and service provision as well as to strengthen the regulatory mechanisms for midwifery practice. The MIP will compliment the MoH in-service training strategy developed in 2007 and will be used to inform the Nursing and Midwifery Strategy being developed by the Ministry of Health. In **Northern Sudan**, the first ever **national midwifery strategy** has been developed to combat the extremely high levels of maternal mortality.

Some key findings point to a low profile and status of midwifery; acute shortages of midwives; negative attitudes amongst midwives; low motivation and a lack of incentives; the absence of midwives in policy making; and inadequate regulatory standards and supervisory mechanisms for midwives. The midwifery associations were found to be weak, lacking in advocacy skills and often facing leadership conflicts. Rates of emigration among midwives was high; retention and deployment policies were weak and incentives non-existent. Overall, there is a great need to strengthen government commitment and awareness among policy makers on the critical role that midwives play.

Midwifery Education

In 2009, **Madagascar** did a comprehensive study entitled “**Occupation of Midwifery in Madagascar**” based on a review of existing literature. The objective was to conduct a situation analysis of the current midwifery practice, covering training, association, regulation, supervision, work environment, deployment, and involvement of midwives and their impact on maternal and neonatal mortality reduction.

In Madagascar, the initial training of midwives is provided by six public institutions located in the capitals of six of Madagascar’s provinces and five private institutions. They produce an average of 330 midwives a year. The midwives receive specialized training in nursing, anesthesia, intensive care and nutrition. A midwife in office typically receives one to two supervisions per year. In 2006-2009, 110 midwives were given training in obstetric and neonatal emergency care. A typical midwife in Madagascar covers an average of 10,874 inhabitants, while the standard recommended by WHO is 5,000. In 2009, there was an estimated shortage of 2,011 midwives. This year, the Ministry of Health and Family Planning is planning to recruit 1,360 midwives. The legislation governing the midwifery profession of midwives is currently rather obsolete. The council of the College of Midwives is found only in the capital and the data on practicing midwives is not being regularly updated. To accelerate the reduction of maternal and newborn mortality, the implementation and monitoring of policy documents and strategic training and management of midwives, aligned with the needs of the health system, is essential. Also required is the establishment of a system that provides updated information on the distribution, skills and training of midwives to track the gaps and address these. Motivation and retention of midwives in the workplace are essential.

Maternal mortality is the second largest cause of female deaths in **Ghana**, accounting for 14 per cent of deaths of women aged 12-49. Approximately 927 women in Ghana died in health facilities in 2008 due to complications of pregnancy and childbirth. An acute shortage of midwives in Ghana (90 per cent of whom are above 50 years of age) exacerbates the situation. Currently the health sector has about 3,000 midwives and needs more than 5,000 to meet human resource requirements. To assist the government in its efforts to strengthen pre-service midwifery training, a nationwide **needs assessment of all 12 midwifery training schools** was conducted in the country as part of the joint UNFPA/ICM Midwives Programme.

An in-depth assessment of the Bolgatanga Midwifery Training School, one of the most deprived midwifery institutions in the country and the only government midwifery training school serving the three northern regions (or two-thirds of Ghana’s territory), has also been conducted and a comprehensive report presented to the Ministry of Health and UN partners. Following the report, the Minister of Health and Minister of Women’s and Children’s Affairs paid a visit to the school to assess the issues for themselves. UNICEF and UNDP also paid similar visits. Subsequently, computers/accessories, a school bus and TV/VCD sets have been provided and the facility was renovated. UNICEF is in the process of providing mechanized water to the facility while UNDP is planning on providing an energy-saving cooking facility for the school. UNFPA has provided some anatomic models for the midwifery skills training laboratory to aid teaching and learning.

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The general situation in the majority of the midwifery schools is similar to that of the Bolga Midwifery Training School. This is also compounded by inadequate and ill-equipped practical sites. However, the success of the Bolga Midwifery School project will be showcased to gain support for other schools; the upcoming EmONC assessment slated for 2010 will clearly identify the needs of the service areas.

Much before the devastating earthquake struck **Haiti**, UNFPA was working hard to improve the quality of the country's Nurse-Midwives Programme by improving their midwifery training curricula, supporting the certification and accreditation process, and addressing regulatory policy gaps governing the functions permitted by midwives. The initiative created a sustainable capacity development approach to enable nurse-midwives to perform the seven basic lifesaving functions of emergency obstetric and neonatal care.

The midwifery students in Haiti are making increasing contributions towards maternal mortality reduction. The contributions made by nurse-midwife interns to the selected facilities where they are deployed for training is highly valued. According to the medical officer in charge of the Maternity of Petite Rivière de l'Artibonite, the nurse-midwife interns have managed a monthly average of 200 deliveries, with no maternal deaths. The challenge remains to assist the Ministry of Health in deploying midwives to EmONC facilities where they are currently not practicing. A second challenge is increasing their community outreach.

Achievements: Midwifery schools have been assessed, their capacity gaps identified, and lists of standardized equipment and books needed for midwifery schools and training centers have been recommended. ICM is currently working on a standardized list of midwifery equipment and supplies guidelines. Anatomical models for skills labs have been distributed to over 20 midwifery schools in programme countries.

Ethiopia has conducted a Capacity Gap Assessment of seven midwifery training institutions and disseminated the results. The institutions have also been fully equipped with midwifery training materials and supplies, including models/mannequins.

The findings of the needs assessment in **Ghana** have helped to develop a database of all practicing and non-practicing midwives and their age distribution. In **Guyana**, a midwifery census has been conducted to determine the baseline number of midwife graduates. A training coordinating mechanism has been created to review all training activities to strengthen human and technical resources to improve maternal health, primary healthcare and family planning services. This includes representatives from the MoH, midwifery schools, nursing and midwifery associations, PAHO and UNFPA. The committee seeks to strengthen coordination and respond to local needs. Guyana is also supporting a roster of tutors to conduct supervisory visits to midwifery students. **Haiti** has also conducted a midwives census, which reveals a distortion in the distribution of professional nurse-midwives. Support has been provided to the National School of Nurses and Midwives to update curricula, and seven teachers were trained in basic midwifery education. Haiti has also developed three sites for practical training of student nurse-midwives, a crucial component of their education. A policy of "no maternal deaths" has been put in place and is being followed at these sites.

In **South Sudan**, talks have been initiated with the Ministry of Education for improving on cur-

rent training of community midwives to a diploma level. In **Burkina Faso**, a complete review of midwifery practices has been conducted and curricula revised using ICM essential competencies. New features of the revised curricula include training in management of post abortion complications, screening of cervical cancers at their onset and the use of the partogramme. A skills lab has also been installed and a website set up to answer midwives' queries. In **Benin**, midwives have been trained and authorized to use the manual vacuum aspiration devices as a means of improving post abortion care. In **Malawi**, a total of 84 midwifery educators have been oriented to various midwifery training tools.

In **Cote d'Ivoire**, the School of Nursing and Midwifery has integrated the training of Reproductive Health Commodity Security (RHCS) issues into the school's curriculum, effective November 2009. This was identified in 2009 as a best practice by the joint ACP UNFPA/EC RHCS Programme Evaluation Team for its long-term sustainability. Midwives are an important link in the service delivery of family planning; when they are trained on the issues of commodity security, they better understand the linkages with warehousing, supply chain, commodity shelf life, etc. The UNFPA-ICM programme is supporting a project in Cote d'Ivoire to strengthen the obstetric capacities of 290 young midwife graduates before deployment to prevent maternal deaths. The graduates undergo two months of additional clinical training in 40 identified maternity wards in Abidjan and its surrounding vicinity. Upon completion of training, these midwives are deployed to comprehensive and basic EmOC facilities. In **Burundi**, a refresher course has been proposed for in-service training of midwives, enabling 133 midwives to upgrade their skills. A similar approach has been adopted for community midwives. In **North Sudan**, there is now a revised curriculum that has been endorsed by the Government allowing qualified midwives to practice as skilled birth attendants.

In **Madagascar**, after a thorough review of midwifery practices, which took place in the private sector as well, the midwifery curriculum has been modified and upgraded; the result is a curriculum with a stronger focus on lifesaving functions and links to emergency obstetric and neonatal care. To aid in this training, mannequins have been donated to midwifery schools. In **Zambia**, technical support was provided to the General Nursing Council for a nursing and midwifery curricula review for registered and enrolled nursing and midwifery students. Midwifery tutors were also given an orientation in palliative care.

Challenges: The biggest challenges in midwifery education include: the lack of a standardized midwifery curriculum; a lack of qualified tutors, or insufficiently trained ones; a lack of standards for assessment systems; an absence of well-equipped teaching labs; and insufficient training in clinical skills. Other frequently reported challenges include the need to rapidly increase the number of trained and highly skilled tutors and to repair the crumbling infrastructure of overcrowded schools. The insufficiency of financial resources is often cited as a key factor impeding progress, as are the competing priorities of governments.

Midwifery Association Strengthening

Achievements: UNFPA and ICM have been working together to assess and address the capacities of existing midwives associations and to help create them in countries that do not have any. Efforts are under way to create a midwifery association in **Zambia**, for example, where all nurses and midwives currently fall under the Zambia Union of Nurses Organization (ZUNO). Similarly, midwives associations were non-existent in **North and South Sudan**, but a midwifery association has been formed in North Sudan, and efforts are under way to establish a council as well. **Ghana** and **Uganda**, on the other hand, have formidable midwifery associations, although they experience fragmentation. In **Guyana**, the launch of the first ever National Midwifery Association on the International Day of the Midwife (2009) has provided new impetus for

the advancement of the midwifery profession across the country. On 26 November 2009, the Association held its first national conference.

In **Djibouti**, efforts are under way to form a midwives association. In **Ethiopia**, the Programme has supported the establishment of Tigray and Amhara Regional midwifery associations. With these, Ethiopia now has one national and three regional associations, and a five-year strategic plan for the Ethiopia Midwifery Association has been developed. In **Benin** and **Burkina Faso**, among other countries, office equipment and supplies have been provided to some midwifery associations. In **Cote d'Ivoire**, an action plan has been made for the creation of a midwifery order, strengthening the advocacy skills of 25 midwives in the process. In **Madagascar**, 12 midwives have been trained to promote the association.

Challenges: Some findings indicate that certain midwifery associations suffer from the following: a lack of transparency and accountability; poor communication among association leaders and members; limited skills in advocacy, negotiations, fundraising, lobbying and public speaking; lack of good leadership, including resolving leadership conflicts; and political interference from other professions in the MoH and Government. The biggest challenge faced by midwifery associations is that they are by and large very weak: their membership is low, they lack programme management skills and some suffer from fragmentation. To strengthen them would involve building leaders, equipping offices, building websites and boosting their advocacy skills.



A midwife examining a patient in Cote d'Ivoire. Photo by Jane Hahn/UNFPA.

Midwifery Regulation

Achievements: The needs assessments revealed that regulatory bodies for nursing and midwifery exist in some countries — Ghana, Zambia and Uganda among them. However, these are not clearly defined in countries such as Sudan and Ethiopia.

Cambodia now has a new Midwifery Council and will be drafting a midwifery education, services and regulations framework. Support is being provided for capacity building, institutional development and strategic planning. **Guyana** is providing support to the General Nursing Council for improved regulations. In **Ghana**, support was provided to the MoH and the Ghana Health Service in organizing a four-day workshop looking at the falling standards of service provision by midwives and nurses. A strategic plan is being developed to address standards, and discussions with the Nursing and Midwifery Council are under way to develop and disseminate a code of ethics for midwives. In **Benin**, national supervisory guidelines on maternity services at peripheral levels have been established. The Ministry of Health in **Djibouti** has adopted a law that equates a midwifery certificate as the equivalent of a first level university degree. In **Northern Sudan**, the comprehensive needs assessment that was conducted led to the development of a national strategic plan and the establishment of a Midwifery Council. In **Zambia**, the General Nursing Council waged an intense advocacy campaign to include midwifery in its name and mandate. These efforts are continuing and likely to bear fruit. In **Ethiopia**, talks are under way between government authorities and the Medical and Nursing Council to allow for the creation of a direct entry midwifery programme.

Challenges: The biggest challenges facing midwifery regulation is the lack of a regulatory body in some countries and a standard practice code or well-defined scope of practice for midwives. The next big challenge facing midwifery regulation is seeking to empower midwives and to ensure that the profession has adequate supportive supervision. Midwives seldom play a role in policy making and programme development, and professional development of midwives and guidelines on continuous in-service education are weak.

Global Activities

ICM hosted a **Midwifery Services Technical Advisory Group Meeting in Geneva, on 2-3 February 2009**, at which 31 experts from different areas of maternal and newborn health participated. A number of these experts were independent; the rest came from ICM, UNFPA, WHO, PAHO, AMDD, JHPIEGO, American College and Sweden. The purpose was to develop a comprehensive and adaptable Midwifery Services Framework within which a midwifery workforce could be developed efficiently and effectively.

The **IX ICM Asia and Pacific Midwives Conference 2009** was organized by the Society of Midwives of India and the Academy for Nursing Studies and Women Empowerment Research (ANSWERS). Held in November 2009, in Hyderabad, India, the objectives of the conference — co-sponsored by ICM, Sweden, UNFPA and India, including the State Government of Andhra Pradesh — were to:

- ▶ Exchange information and skills to provide high quality midwifery services;
- ▶ Strengthen midwifery associations in the region;
- ▶ Formulate a vision for equitable access to midwifery services;
- ▶ Review the status of the profession in the countries of the region;
- ▶ Examine conditions needed for midwives to gain greater independence within the current “nursing and midwifery” concept. This latter objective was particularly relevant for the vast majority of South Asian countries.

The conference featured a combination of plenary discussions addressing issues of common interest, scientific presentations, thematic symposia, skills development sessions at the skills lab, and entertainment. The strongest feature of the conference, gathering 500 participants from 32 countries, was the opportunity for networking. It concluded with the release of two “manifestos”: one for India, calling for a policy change to develop an autonomous cadre of dedicated midwives with its own independent council, and the second for the regional approach, calling for more interaction among national associations.

Regional Networking Initiatives

ICM worked in the region to establish and strengthen collaboration with several regional institutions: West African College of Nursing (WACN); Eastern, Central and Southern African College of Nursing (ECSACON), Federation of Associations of Midwives (FASFACO) and regional offices of WHO. It also participated in the following meetings aimed at establishing synergies and partnerships with the UNFPA/ICM Midwives Programme:

- ▶ West African College of Nursing (WACN) meeting in March;
- ▶ WHO meeting in Kenya in April;
- ▶ WHO meeting in Ghana in July;
- ▶ The East, Central and Southern African College of Nursing (ECSACON) meeting in September in Lusaka;
- ▶ The September meeting in Lusaka, which aimed to foster collaboration between ECSACON, FASFACO and WACN;
- ▶ FIGO Congress in Cape Town in October.

The point of participating at such important meetings and events is to establish professional collaborative links with key partners in building midwifery networks in the sub-region as well as to gain a deeper understanding of existing curricula across Africa and what should be incorporated in a regionally standardized curriculum for basic midwifery training. These meetings also enable UNFPA and ICM to gain information about the midwifery work under way in the region and to develop broad-based support for the UNFPA/ICM Midwives Programme.

Programme Management and Coordination

Two core steering and programme management group meetings were organized in March and October 2009 in Accra, Ghana and New York, U.S., respectively. At these meetings, in addition to programme review and progress, the steering group members discussed programme management and strategic direction concerns. These included issues related to staffing, communication strengthening, team building, programme expansion, networking with partners (e.g WHO, JHPIEGO, WAHO, ECSACON and others), global programme advocacy, annual work plan/ technical events planning and reporting responsibilities and deadlines.

Two **newsletters** highlighting progress, achievements and challenges on the ongoing Midwives Programme were produced in April and September and widely disseminated to all programme staff, donors and stakeholders through UNFPA and ICM networks.

Programme Monitoring

The ICM International and Regional Midwife Advisors (**RMAs**) made regular field visits to the countries under their coverage to meet with all stakeholders, UNFPA technical RH staff and Country Midwife Advisors. The purpose of these visits was to guide the CMAs in their efforts to carry out quality needs assessments, strengthen midwifery curricula, associations and assess current midwifery regulations. The RMAs also participated in the formal launch of the programme in several countries, among them Sudan and Ghana. The IMA monitored the work of the CMAs and, in addition, a mid-year programme review was undertaken jointly by the UNFPA Programme Coordinator and the ICM advisors at the CMA capacity building workshop in Lusaka in September.

Key Challenges/Lessons Learned

The Midwives Programme is now firmly established on the ground: with the UNFPA Programme Coordinator, a senior maternal health advisor, the ICM International and Regional Advisors, and UNFPA Country and International Midwife Advisors have all taken up their positions at their respective duty stations. The key challenges in 2009 centered around hiring staff, team building, addressing communication flow challenges, and helping all personnel understand and develop a common perspective and vision on the UNFPA/ICM joint Midwives Programme. The First Inception Workshop organized in Accra, Ghana in March provided an opportunity for all members of the team to: understand organizational priorities, procedures and policies; become familiar with the key ICM midwifery competencies and linkages with gender, adolescent RH issues, PMTCT, etc.; develop project management skills; develop annual work plans in close collaboration with ICM advisors and the UNFPA Programme Coordinator; and learn from each other and network. The second workshop in Lusaka helped the Country Midwife Advisors to network with one another, share progress, seek guidance on specific country challenges, focus on issues of curriculum development and hone their advocacy skills.

The needs assessments and desk reviews undertaken have highlighted a number of challenges that need addressing if midwifery services are to be promoted and lives of mothers and children saved. In summary, achieving this goal requires: a supportive policy environment built through strong global, regional and country level advocacy and promoting stakeholder ownership; standards in midwifery education that include all essential ICM competencies; a midwifery training infrastructure that includes well-equipped skills labs and highly trained and experienced instructors; strong midwifery associations that are skilled in leadership, project management and advocacy; and functioning regulatory bodies. To adequately address the issues, more funds need to be raised at both the country and global levels. In fact, as the programme gains momentum on the ground, vast funding needs are emerging to strengthen midwifery. The ultimate challenge is securing national government ownership and including midwifery in national health sector human resource plans in all 60 high maternal mortality countries (MMR>300/100,000 live births).

Future Work Plan

As mentioned above, several challenges have been identified through the needs assessments and desk reviews relating to midwifery education, association and regulation; these will be systematically addressed in the work plans starting in 2010.

Key focus areas in 2010 will be:

- ▶ National strategic planning based on results of the desk reviews and needs assessments undertaken in 2009;
- ▶ Modifying and strengthening curricula to ensure that all essential ICM midwifery competencies, as identified in the needs assessments, are incorporated;
- ▶ Finalizing of standardized midwifery equipment and book lists for pre-service training; these lists, in turn, are to be vetted by WHO and the Global Programme on Reproductive Health Commodity Security Programme;
- ▶ Developing of country profiles and data fact sheets on midwifery;
- ▶ Collaborating with ICM to strengthen education, association and regulation standards around midwifery practice;
- ▶ Carrying out the second phase expansion of the Midwives Programme to five new countries in Asia — Laos, Nepal, Bangladesh, Afghanistan and India — as well as further expansion in select African countries; development of a midwifery services framework for South Asia as well as a South Asia strategy on midwifery prior to the programme launch in South Asia; leveraging on the International Day of the Midwife celebrations to promote global advocacy;
- ▶ Organizing of a Global Symposium on Strengthening Midwifery on 5-6 June 2010, immediately prior to the Women Deliver Conference in Washington, D.C., in collaboration with major partners like ICM, WHO, JHPIEGO, GHWA, FIGO, World Bank and UNICEF. This forum grants the midwifery profession high visibility and a major opportunity for global advocacy, which will help create a global movement around midwifery to address maternal mortality and morbidity;
- ▶ Organizing an inception forum for CMAs in Asia and capacity building workshops for all CMAs in select areas;
- ▶ Increasing ownership and integration of the Midwives Programme within UNFPA's ongoing country programmes to enhance synergies;
- ▶ Strengthening partnerships and harmonizing midwifery initiatives with partners like WHO, JHPIEGO, FIGO and others.

Conclusion

The joint UNFPA-ICM Midwives Programme is becoming the largest international programme aimed at strengthening midwifery in the world. The momentum created in 2008-09 is expected to gain strength in 2010-11, backed by support from development partners and donors. Midwives are now being invited to take part in policy and strategy meetings, whereby they are able to participate in decision-making at global and regional levels. One example of this is their prominence within the Partnership for Maternal Newborn and Child Health. However, much work remains to be done at country level, where MDG 5 has been neglected or insufficiently resourced. In some countries, midwifery is still not perceived to be a profession in its own right; it is often merged with nursing, and as such its potential to reduce maternal mortality is not recognized. And, although midwives represent the most competent health workforce to address all aspects of MDGs 4 and 5, they still lack an adequate voice at the policy table. The results of the needs assessments and desk reviews will provide vital information for national human resource planning for maternal health and will help guide policy dialogue.

During national discussions about maternal health policies and strategies, the programme's Country Midwife Advisors will serve as strong advocates for the midwifery profession and its potential impact on reducing maternal mortality. The year 2010 will be decisive in this respect, with major advocacy events and further expansion of the programme planned in the Africa and Asia regions.



Sangrend maternity hospital, Port of Spain, Trinidad. Photo by International Confederation of Midwives (ICM).



Fistula survivor Chantal Bukondu, 30, with her baby Winner. "I heard a woman on TV talking about how she was saved by UNFPA so that's why I came to Kinshasa to seek treatment. I know many other women's babies have died when they've had this problem. I am lucky that he is alive."

Photo: Campaign to End Fistula/ Robin Hammond/ Panos Pictures. Kinshasa, DRC, March 2010.

CAMPAIGN TO END FISTULA

Executive Summary

Obstetric fistula is a debilitating condition that has left millions of women suffering in solitude. Caused by prolonged and obstructed labour, it renders survivors incontinent, a condition that often results in stigma and ostracism by communities. Many women are abandoned by their husbands and their families. All but eliminated from the developed world, obstetric fistula continues to affect the poorest of the poor: women and girls living in some of the most resource-starved regions in the world.

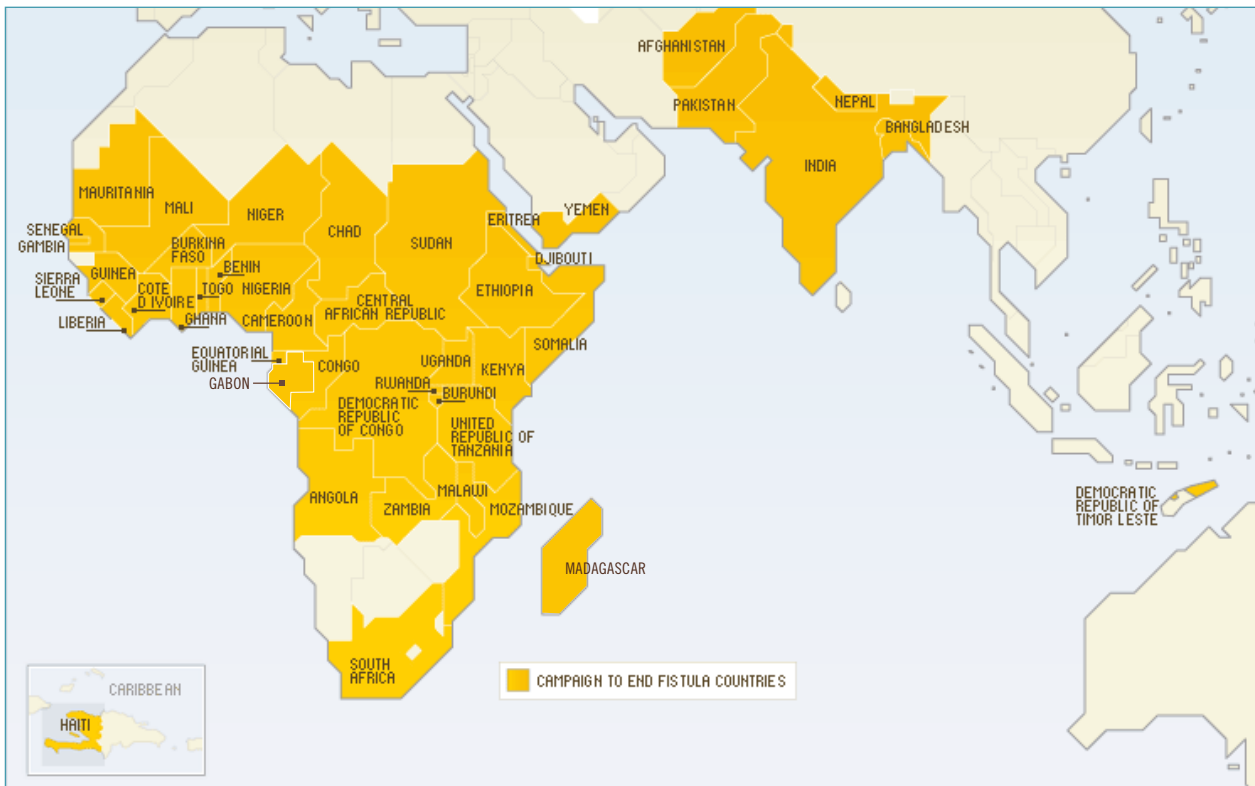
Obstetric fistula is a severe morbidity caused by prolonged obstructed labour unrelieved by timely medical intervention. It exposes the challenges that persist in reducing maternal mortality and morbidity. With timely access to skilled assisted delivery and emergency obstetric care, these injuries can be prevented. Unfortunately, the condition affects more than 2 million women and girls in developing countries, with as many as 100,000 new cases each year.

Obstetric fistula is a visible reminder of the inequity in maternal health. The highest rates of maternal mortality and morbidity are found in the least developed countries; the most striking evidence of this inequity is obstetric fistula, which affects women who are among the most marginalized.

In 2001, UNFPA identified obstetric fistula as a neglected reproductive health and human rights issue — one that is not addressed on a large scale by any other agency. Fistula touches on every aspect of the UNFPA mandate, including safe motherhood, reproductive rights, adolescent sexual and reproductive health, early marriage and childbearing, gender equity, and the link between access to quality reproductive health services and poverty reduction.

Launched by UNFPA and partners in 2003, the global Campaign to End Fistula is an integral component of UNFPA's overall strategy to improve maternal health, and includes interventions to prevent fistula from occurring, to treat women who are affected and to help women who have undergone treatment return to full and productive lives. The campaign's three strategic intervention points are flexible to allow for country context and designed to situate fistula within ongoing UNFPA country programmes and national maternal health strategies. The campaign's ultimate goal is to make fistula as rare in developing countries as it is in the industrialized world. The target for achieving fistula elimination is 2015, in line with the International Conference on Population and Development (ICPD) and Millennium Development Goal targets.

Figure 1: Campaign Map



Within six years, the campaign has quadrupled in size, spreading from its original 12 countries to include 47 countries in Africa, Asia and the Arab States. As a result of this growth, more and more women are able to access the care they need to prevent and treat fistula and return to full and productive lives after receiving fistula treatment with the support of UNFPA, governments and partners.

In publishing this report, UNFPA wishes to acknowledge with gratitude the donor support provided to the Campaign to End Fistula in 2009. In particular, we wish to thank the governments of Iceland, Luxembourg, New Zealand, Norway, Poland, Republic of Korea and Spain. We also wish to thank our partners from the private sector, including Americans for UNFPA, Johnson and Johnson, Women's Missionary Society of the African Methodist Episcopal Church, Virgin Unite, Zonta International and our many individual contributors. Since the campaign's inception in 2003, UNFPA has secured more than USD 36 million in contributions from generous supporters.

To illustrate the progress to date:

- ▶ At least 40 countries have completed a situation analysis on fistula prevention and treatment;
- ▶ More than 28 countries have integrated fistula into relevant national policies and plans;
- ▶ More than 16,000 women have received fistula treatment and care with support from UNFPA.¹

¹ Treatment services supported by UNFPA may have also received support from governments and other partners.

In 2009 alone, UNFPA:

- ▶ Supported fistula treatment for more than 4,400 women;
- ▶ Helped strengthen fistula prevention and treatment capacity in over 100 health facilities in 23 countries;
- ▶ Facilitated training of more than 1,000 healthcare personnel — including over 160 doctors, 245 nurses and midwives, and more than 600 community health workers.

Other major accomplishments in 2009 include:

- ▶ Conducting an **external, mid-term review** of the UNFPA-supported components of the fistula campaign, led by a team from the Health Research for Action (HERA) Consortium. The review assessed national programmatic efforts and regional/global support to national programmes;²
- ▶ Supporting the completion **and pilot testing of the internationally standardized training manual** for fistula treatment and care;
- ▶ Using public speaking engagements to promote the importance of fistula as an entry point to address maternal health. Sarah Omega, fistula survivor/maternal health advocate from Kenya, and Natalie Imbruglia, Campaign to End Fistula celebrity spokesperson, addressed the **High-Level Segment of the UN Economic and Social Council (July 2009)**;
- ▶ Supporting fistula survivors in 18 campaign countries to sensitize communities, **provide peer support and advocate for improved maternal health** at the community and national levels;
- ▶ Enabling national fistula surgeons from several countries (including **Benin, DRC, Senegal** and **Somalia**) to attend the International Society of Fistula Surgeons 2nd Annual Conference in Nairobi, **Kenya** (25-27 November 2009). Drawing thousands of participants, the conference allowed for knowledge exchange, professional development, and training in fistula prevention, treatment and reintegration;
- ▶ Integrating its thematic funds to reduce the reporting and programmatic burden on countries, to increase effectiveness and to foster a comprehensive approach to improving maternal health.

² The final evaluation synthesis report (Volumes I & II) are available on the End Fistula website: www.endfistula.org/publications.htm.

Campaign to End Fistula Mid-Term Review

The year 2008 marked the mid-point of the Obstetric Fistula Thematic Fund's current phase (2006-2010) and five years since the inception of the campaign. In 2009, an external, mid-term evaluation of the UNFPA-supported elements of the global Campaign to End Fistula was conducted. The evaluation assessed eight national level programmes and the global and regional support provided to countries.³ The evaluation, led by the HERA Consortium, had two main objectives:

- ▶ Assess the relevance, effectiveness and efficiency of the current strategies and approaches for national fistula programming;
- ▶ Assess the coordination, management and support from UNFPA global and regional levels to national level efforts. Areas of assessment were: internal coordination and management, capacity development, research, measurement, monitoring and evaluation, awareness raising and resource mobilization, and partnership building.

The evaluation contributed to the evidence base on fistula elimination programming and answered critical questions about the effectiveness of approaches used to date and their role in relation to maternal health programmes more broadly. It examined how effective the campaign approach — with its simultaneous strategies conducted at national, regional and global levels — has been in promoting the elimination of fistula. The evaluation team conducted extensive interviews with UNFPA staff and partners and reviewed global and regional documents, including financial reports, campaign annual reports, internal working group documents, and partner agreements. In collaboration with the evaluation team, the campaign has developed a detailed dissemination plan to ensure the recommendations are used effectively, and that they support countries in their efforts to address maternal mortality and morbidity.

Key Findings

1. The campaign has not only been a catalyst to mobilize countries to address fistula prevention, treatment and care, but it has had a positive impact on awareness building and service development;
2. The campaign needs to capitalize on its momentum to scale up efforts to eliminate fistula. There is an urgent need for greater focus on prevention. Treatment capacity is still far from sufficient; and more research/information is needed on the best approach to reintegration;
3. In order to ensure that fistula prevention and treatment becomes part of sustained service delivery at the national level, the campaign needs to be integrated into UNFPA country and national sexual and reproductive health (SRH) programmes. However, to preserve the campaign's continued influence on political commitment to and public awareness of fistula, it is necessary to maintain a specific focus on fistula in advocacy, monitoring and technical assistance at the global, regional and national level.

(continued on the next page)

³ The in-depth study countries were Bangladesh, the Democratic Republic of the Congo, Niger, and Nigeria. The desk review countries were Kenya, Pakistan, Sudan and Tanzania.

Campaign to End Fistula Mid-Term Review (*continued*)

Main Recommendations

1. Continue the UNFPA leadership and efforts within the global Campaign to End Fistula;
2. Clearly define the **revised vision and focus** of fistula programming for the next three years, including adjusted strategies and a clear monitoring and evaluation framework, with achievable targets;
3. Build on early progress to fully integrate obstetric fistula in UNFPA country programmes and SRH strategies/programmes, while maintaining a focus on fistula as an effective entry point to reduce maternal mortality and morbidity;
4. Increase targeted advocacy on the direct cause of fistula (obstructed labour) and fistula prevention;
5. Scale up treatment services and improve quality assurance and coverage; this includes training providers and working with governments to ensure these trained providers perform continuous service;
6. Support countries to define appropriate fistula treatment delivery and establish routine treatment in selected facilities;
7. Work with partners to provide technical assistance and develop quality assurance mechanisms;
8. Agree with ministries of health and partners to collect a minimum, agreed-upon set of routine data on obstructed labour and other pregnancy complications, and fistula diagnosis and treatment.

Next Steps and Dissemination

1. Act quickly on the main evaluation recommendations and utilize this tool to define the three-year vision for UNFPA efforts in the global Campaign to End Fistula;
2. Implement a comprehensive communication plan to ensure effective national, regional and global dissemination of the findings and recommendations;
3. Conduct a dissemination workshop with global partners (EngenderHealth, AMDD, FIGO, WHO, Centers for Disease Control and others) to review the recommendations and to identify key actions to be taken within the global partnership and by each individual partner;
4. Support national-level dissemination workshops within the countries engaged in the mid-term evaluation and share the key lessons and action steps from these workshops with countries engaged in the campaign for South-South learning.

National Leadership

Since its inception, a key focus of the Campaign to End Fistula has been advocacy and political support for the integration of obstetric fistula into national sexual and reproductive health (SRH) and maternal and newborn health (MNH) policies and plans. Many countries have made progress in this area: to date, more than 28 countries have included fistula in national SRH policies or plans. Additional countries have launched a revision of their existing RH national policy to ensure obstetric fistula is fully integrated. For example, in 2009 **Malawi** integrated fistula within its newly revised national SRH and RH policy, thereby increasing opportunities for national resource mobilization. Levels of integration vary, and countries continue to receive technical support to effectively include obstetric fistula in policies and plans, including implementation plans, budgets and monitoring, and evaluation frameworks.

The campaign strives to support countries to fight maternal mortality and morbidity by adhering to the Paris Declaration on Harmonization and Alignment, an international agreement with more than 100 signatories, among them ministers, heads of agencies and other senior officials. The aim is to increase efforts to harmonize, align and manage aid for better results.

In Africa, all campaign countries have developed a National Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity, and there are growing efforts to integrate fistula into MNH road map processes. One very important step toward integration is the revised emergency obstetric care situation analysis tool that includes a fistula module. Such analyses have been conducted in countries like **Gabon** and are envisioned in other countries to increase available data on fistula and to contribute to the more comprehensive understanding of maternal health. Since the same approaches to reduce maternal mortality also reduce maternal morbidity (including fistula), these efforts are contributing to the planning and programming processes for MNH.

Government commitment to addressing obstetric fistula as part of broader efforts to achieve MDG 5 is very important to sustain programmes and make effective progress. Promising examples include countries like **Eritrea**, where the federal government announced its commitment to eliminate obstetric fistula within the country by the end of 2011. While an ambitious goal, this type of commitment publicizes important national efforts under way to ensure women have access to fistula prevention and treatment. Another example from **Chad** illustrates the power of political engagement on this issue. The national government pledged a significantly higher amount of support overall to maternal health. The engagement of Chad's First Lady and her participation during a fistula outreach campaign also helps to raise community awareness.

National support for the delivery of fistula prevention and care is another area in which significant progress is being made. The majority of countries involved in the campaign have made fistula treatment free of charge, with support from UNFPA and other partners; many countries have also committed to the provision of preventive services, specifically Casarean sections (C-sections), free of charge. Another approach, as exemplified in **Ghana**, is the National Health Insurance Scheme, which covers the cost of fistula treatment. In 2009, the campaign supported outreach to women living with fistula in the country to ensure they were registered with the NHIS and were therefore entitled to free treatment.

Preventing Harm⁴

Detection of obstructed labour and access to Caesarian sections are crucial to prevent obstetric fistula, both of which require skilled attendance during birth and access to emergency obstetric care when complications arise. Professional midwives are trained to detect complications and to refer the patient to a hospital for emergency obstetric and neonatal care when needed.

Also, educating and empowering women is crucial in the prevention of obstetric fistula. Educated women will better understand the need for appropriate care during pregnancy and delivery. They will be more prepared to delay marriage, prevent early pregnancies and to act upon their reproductive health choices. Access to family planning services is another crucial element in fistula prevention, enabling women to space births and limit the number of pregnancies.

Prevention efforts are supported by core resources and other funds, such as the Thematic Funds (Obstetric Fistula, Maternal Health and Reproductive Health Commodity Security), as well as resources mobilized at country level. The programmatic integration of the Maternal Health and Obstetric Fistula Thematic Funds facilitates opportunities for strengthening the prevention of maternal mortality and morbidity.

Scaling up Quality EmOC Services and Skilled Birth Attendance

Adequate and qualified management of obstructed labour is key to the prevention and elimination of obstetric fistula. Building human resource capacity is a major focus of UNFPA programming, an investment that will not only prevent obstetric fistula (OF), but also prevent the possible occurrence of iatrogenic fistula due to poor quality Caesarian sections, inappropriate use of forceps, and other causes. In **Liberia**, a fistula education programme for medical students has been launched, bringing together five schools to discuss causes, prevention and management of fistula, with an emphasis on the role of students in the elimination of the condition. In **Cameroon**, 391 health providers were trained in the different aspects of reproductive health — including 145 who were trained in EmOC and 9 in obstetrical surgery and anesthesia. In the **Central African Republic (CAR)**, 162 health providers were trained in the new EmOC and family planning national procedures. UNFPA in **Gambia** supported the training of over 200 service providers in antenatal and newborn care, while **Guinea** trained 131 health providers on prenatal counseling.

Bringing Services Closer to Women and Bringing Women to Services

Access to services remains an important issue in the prevention of maternal mortality and morbidity. In **Eritrea**, maternity waiting homes (MWH) were vital to bridge the geographical 'gap' in accessing obstetric care. In **Zimbabwe**, UNFPA procured equipment, building materials and nutrition packs to improve conditions of pregnant women at maternity waiting homes. In **Guinea-Bissau**, efforts to decentralize EmOC services have reinforced EmOC health centers and subsidized C-section kits for marginalized and poor communities; nearly 90 per cent of health centers throughout the country now offer the minimum package of reproductive health interventions, including assisted delivery and basic EmOC. In **Somalia**, to increase geographical distribution of EmOC, the backbone of maternal mortality reduction, UNFPA supported partners to conduct an 18-month training workshop for 20 community midwives selected from remote districts. In 2009, six doctors were trained in comprehensive EmOC to broaden service availability and to build up a referral system. In addition, 56 midwives from all regions were trained in basic EmOC.

⁴ The data included in this section was collected from both country Thematic Fund Reports and the UNFPA Country Offices Annual Report (COAR), which include activities funded by the Thematic Funds and other sources.

Strengthening the referral system is also an important step to prevent obstetric fistula, as is facilitating safe and easy transport for women in need. UNFPA provided ambulances and motorbikes to many countries, including **Benin, Chad, Guinea, Guinea-Bissau, Kenya, Rwanda, Senegal, Tanzania, Uganda** and **Zambia**. In **Niger**, UNFPA equipped districts with communication equipment, including 18 radios BLU.

Lowering Costs

Cost is a serious barrier to access and utilization of prevention services. Countries have taken serious steps to lower the cost of health services. In **Chad, Eritrea, Ghana, Liberia, Mali, Nepal, Pakistan, Senegal, Sudan, Tanzania, Uganda** and **Zambia**, EmOC services are free of charge. In **Niger**, free antenatal care and Caesarean sections were introduced in 2007. Fees for EmOC services vary according to country. For example:

- ▶ About 70 per cent of health care costs in **DRC** are financed through user payments;
- ▶ In **Kenya** patients have to pay for comprehensive EmOC services, but not for basic EmOC services;
- ▶ In **Burundi** user fees for EmOC services are charged in private health facilities, but not in public ones;
- ▶ Free deliveries are offered in **Rwanda** to women who have attended at least four antenatal visits;
- ▶ In **Senegal**, solidarity funds are encouraged at the community level to collect money for women who require emergency referrals;
- ▶ In order to introduce free Caesarean sections (Initiative de Gratuité des Opérations Césariennes) for all women in need, **Madagascar** developed a protocol specifying the content and estimated cost of C-section kits, as well as the financing and advocacy required to make these kits available to all women by 2012.

Improving Access to Reproductive Health Commodities and Family Planning Services

Ensuring proper procurement of RH commodities is one of the major goals of UNFPA programming. The agency's efforts in this sphere include: equipping EmOC services, including teaching materials (**Benin, Ethiopia, Gambia**); aiding governments in the creation of a RH Commodities Security Plan and national coordination mechanisms (**Kenya, Lesotho**); facilitating the training for logistic management of all RH commodities (**Burkina Faso, Cote d'Ivoire**); and delivering of contraceptives, products and maternal health kits (**Ghana, Guinea**).

In **Chad**, for example, procuring contraceptives, together with the training provided to health providers and information offered at the community level to advertise services, led to an increase in the distribution of family planning. In a health center in Doba, out of 168 visits within a three-month period, 128 represented new female clients who came in for RH counseling. The recent increase of contraceptive coverage in **Madagascar** is associated with free access to contraceptives at public health centers and the improved commodity security.

In **Burkina Faso**, where nine NGOs and associations play an important role in community-based distribution, 553 regional health staff received training on family planning (including the female condom, IUD, etc.). In **Swaziland**, UNFPA expanded family planning options by introducing new commodities, such as norplant and IUD. In **Cameroon**, 140 health providers received training

on family planning, and in **Liberia**, a series of trainings to promote the use of condoms were conducted, benefitting 120 mid-level service providers and 150 community health volunteers.

Working with Communities

Community-based intervention and communication help to increase awareness to overcome the three delays, namely the delay in 1) deciding to seek medical help in the case of obstetric emergency; 2) reaching an appropriate obstetric facility; and 3) receiving adequate care once a facility has been reached. Communication is also vital to educate the community about obstetric fistula prevention and to identify solutions that are culturally accepted. Over the last few years, the involvement of fistula survivors to mobilize communities is one example of an innovative and successful approach. In **Ghana**, 18 fistula survivors were trained not only to educate their peers about the causes, prevention and treatment of obstetric fistula, but also in advocacy, communication and counseling skills.

In **Cote d'Ivoire**, ten 'ambassadors' are working to demystify obstetric fistula in rural areas. Successful community sensitization programmes were organized in **Liberia** with the active participation of fistula survivors. In **Zambia**, the UNFPA country office supported the recruitment and orientation of community mobilizers, such as Safe Motherhood Action Groups (SMAGs), peer educators and counselors, and other community-based groups to galvanize communities to elevate reproductive health services and the status of women.

Empowering Women and Girls and Promoting Male Participation

Empowering women and girls cannot take place in an insecure environment. All countries, therefore, must alter or reinforce national policy to create a protective environment in favor of women and girls. In **Pakistan**, UNFPA is partnering with selected civil society organizations and women's groups to highlight harmful cultural practices (including child marriage) through media, advocacy and dialogue, as well as to support initiatives aimed at promoting the Women's Protection Bill. In **Burkina Faso**, UNFPA is working with the government to reduce the incidence of early marriage.

Empowering women and girls and preventing early marriage and pregnancy are key for the reduction of maternal mortality and morbidity. In **Ethiopia**, for example, a programme targeting adolescent girls and the general community in Amhara Regional State has had tangible results, delaying marriage and improving the reproductive health status of girls. More specifically, this comprehensive programme has assisted 7,348 girls to attend formal school, while established non-formal educational centers reached another 1,134 girls. These efforts not only enable girls to receive an education, but help prevent early marriage while enhancing life skills and self-esteem. And through Married Adolescent Girls Clubs, 2,782 girls gained knowledge about their reproductive health, enabling them to make informed decisions about the use of family planning services.

Encouraging the involvement of men, boys and religious leaders in the empowerment of women and girls is another important focus of UNFPA programming. In **Chad**, a men's network was created to promote gender equality and reduce maternal mortality. In **Kenya**, UNFPA partners approached boys and men to promote gender equality and reproductive health. Farmers were sensitized about the negative aspects of harmful practices, including early marriage. In **Madagascar**, 72 leaders joined the fight against harmful practices, helping to launch a national 'Yes, We Can' campaign to encourage girls to stay in school and delay marriage. Gender equality, reproductive rights and the empowerment of women and adolescent girls were promoted in **Uganda** through the participation of men and the elimination of harmful practices. In close collaboration with the Government

of **Afghanistan**, UNFPA was able to identify religious groups in several target provinces to secure their proactive participation in addressing some of the critical gender related issues; these include domestic violence, reproductive rights, birth spacing (family planning) and early marriage.

Healing Wounds

In 2009, more than **4,400 women received fistula treatment** with support from UNFPA. Many countries exhibited an increase in treatment capacity, such as **Democratic Republic of the Congo**, where more than two times the number of women received treatment in 2009 as compared with 2008. Other countries (**Bangladesh, Chad, Cote d'Ivoire, Niger, Nigeria, Pakistan, and Zambia**) have shown steadily increasing figures over the last year. These increases in capacity and provision of care are encouraging, but there remains a tremendous backlog of patients; sustainable scale-up of existing treatment approaches is urgently needed.

Several countries that have developed decentralized treatment approaches have reported this to be an effective means of increasing women's access to care. Decentralization varies from country to country, but often calls for the treatment of complex fistula cases at a referral hospital in the capital city, while lower level facilities in the districts have the responsibility of treating simpler cases. Additionally, many countries, among them **Bangladesh, Liberia, DRC, Kenya, and Zambia**, also deliver fistula care through outreach campaigns. These campaigns facilitate increased access for women who do not live in close proximity to facilities offering fistula treatment, and provide training opportunities for medical personnel in more remote areas. In countries such as **Bangladesh**, where there are many geographic barriers, the provision of care outside of the capital has facilitated increased access for many women.

Ensuring that well-trained medical personnel are available to deliver needed care is an integral part of fistula treatment. A newly created professional society, the International Society of Fistula Surgeons (ISOFS), promotes knowledge sharing, professional development and oversight of fistula surgeons. The Campaign supported the participation of several fistula surgeons from **Benin, DRC, Senegal and Somalia** at the ISOFS 2nd Annual Meeting from 25 to 27 November 2009 in Nairobi, Kenya. This proved to be an important forum for medical professionals to share knowledge, address issues related to clinical care, and to develop a database of experts to be drawn upon to support national efforts. UNFPA's support increased representation from West Africa and the Arab States, facilitating more regional participation and greater opportunity for South-South cooperation.

UNFPA also supported the completion and pilot testing of a standardized, fistula competency-based training manual. Developed by the Treatment and Training Committee of the Obstetric Fistula Working Group, the manual received important inputs from numerous partners, including ISOFS, EngenderHealth, GFMER, UNFPA and others. Coordinated by the International Federation of Gynecology and Obstetrics (FIGO), the process resulted in a major contribution to the field, satisfying a long-standing demand from countries for guidance on quality training.

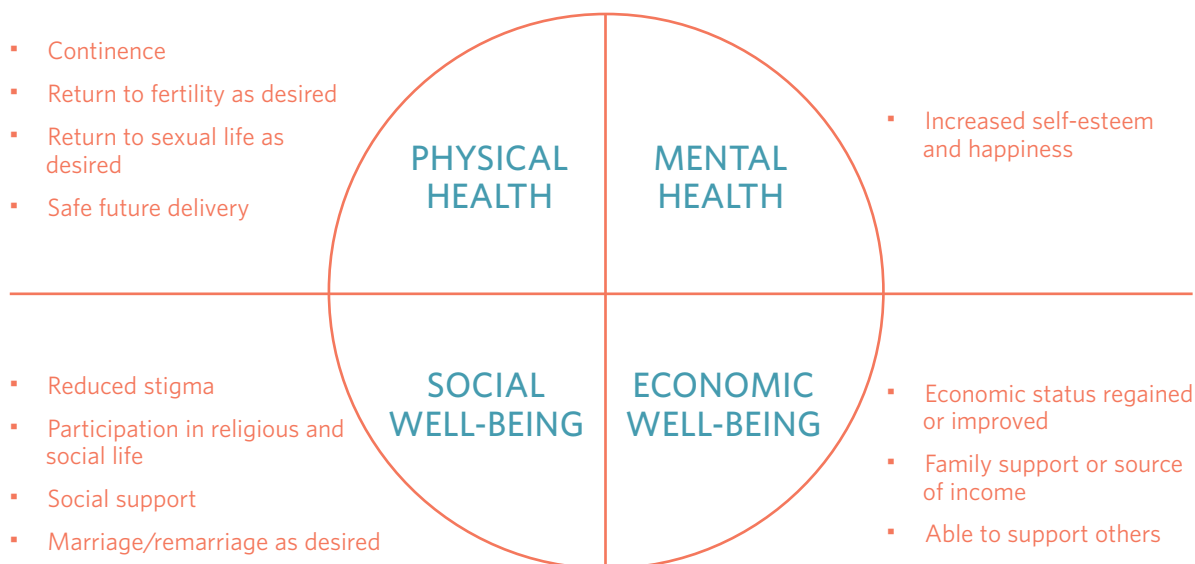
The campaign routinely supports countries in their development of facilities that can deliver quality fistula treatment and care. **In 2009, the campaign provided more than 100 health facilities in 23 countries with equipment, supplies and renovation services.** As part of the overall capacity strengthening for fistula treatment, **the campaign facilitated the training of more than 1,000 healthcare personnel in fistula prevention and management, benefitting over 160 doctors, 245 nurses and midwives, more than 30 social workers and paramedical staff, and more than 600 community health workers.**

South–South training and knowledge exchange continues to be an integral part of the campaign. Both **Liberia** and **Cote d’Ivoire** engaged in South–South exchanges with **Mali**, thereby increasing the number of women who received treatment — particularly for complicated fistula cases — and ensuring national capacity strengthening. Experts from **Chad** traveled to the **Central African Republic**, a country that just started its fistula programmatic efforts, to provide South–South training and knowledge exchange. The campaign will continue to facilitate and develop efforts to connect countries to share and learn from each other.

Renewing Hope

Experience shows that healing fistula requires more than just surgical intervention — survivors may also require psychosocial and economic support to heal the damage. Nonetheless, there remains a lack of clarity about exactly what reintegration means and the types of interventions and stakeholders that can best facilitate it. Full healing requires four inter-related components: physical health, mental health, and social and economic well-being. Survivors themselves can contribute to the full definition of what constitutes reintegration and speak to those services best suited to their needs.

Figure 2: Needs of Women in the Reintegration Process



Adapted from DIRG/OFWG, 2006

More than 25 per cent of campaign countries are now working to ensure women have access to rehabilitation and reintegration. Several other countries have plans to engage in this area in the coming year. Increasingly, countries are documenting the number of women who receive some kind of social reintegration and/or rehabilitation services following fistula treatment. In 2009, at least six countries (**Bangladesh, Burkina Faso, Cote d’Ivoire, Chad, Liberia** and **Niger**) reported on the number of treated women who had access to social reintegration/rehabilitation services. This is indicative of the increased attention given to the delivery of these services as well as of the move toward more data collection of this important component of the continuum of care. For example, **Cote d’Ivoire** reported that 27 of 119 women who received treatment in 2009 were fully reintegrated into their communities. These data must be viewed with the awareness that there may not

be follow-up on all women after treatment. Prior to this year, very few countries reported on the percent of treated women who had access to reintegration/rehabilitation, and therefore this information can be utilized as a baseline for the countries reporting in the future.

Countries are working with civil society and non-governmental organizations to ensure fistula survivors have increased access to reintegration/rehabilitation services. In **Kenya**, two faith-based organizations were supported to provide the community/hospital linkage, increase demand, and assist in the reintegration of those who were successfully treated. The reintegration involves two components: one concentrates on counseling both the survivor and close relatives, while the second equips the survivor with income-generating skills.

Countries are employing a mix of community and center-based reintegration approaches to help women transition smoothly back into society. A key mid-term evaluation finding in this area points to the potential for fistula reintegration and rehabilitation services to be delivered at the community level. It is recognized that facilities play an important role in the referral and initial rehabilitation services, such as preliminary RH and family planning education. However, for those women who need or may need more intensive rehabilitation services, preliminary findings indicate they benefit most when the services are delivered at the community level through existing networks and/or organizations with experience in the provision of these types of training and support. Community-based rehabilitation and reintegration can facilitate increased access to health services.

The work of fistula survivors to help women in their reintegration process is gaining recognition as a very effective method to reduce maternal mortality and morbidity. The mid-term evaluation recommends scaling up training of fistula community advocates (women who have survived fistula and received treatment) to provide community level education and peer support and identify fistula cases. Such efforts also present the opportunity for community advocates to address underlying root causes of obstetric fistula, maternal mortality and harmful traditional practices, such as early marriage and childbearing, within the context of outreach and education.

Reintegration is still a relatively new development within fistula programming, and thus requires greater documentation to understand what is working and what needs to be changed. Toward this end, the campaign will continue to work with national stakeholders — including health and other relevant ministries, civil society organizations, non-governmental organizations and health facilities — to collect data on the provision and effective modalities for reintegration/rehabilitation.

Broadening the Knowledge Base & National Data and Research

Many countries have conducted needs assessments in order to move toward national strategy development and implement fistula programmes. A total of 41 countries have been supported to carry out needs assessments for obstetric fistula — significantly more than the 17 initially planned in the budget for the second phase of the campaign. The needs assessments vary from country to country. Some countries have concentrated on analyzing the situation in a selected number of districts or states, while others have concentrated on issues related to access and availability of EmONC, fistula treatment and rehabilitation services.

In 2009, **Zimbabwe** conducted a needs assessment for obstetric fistula using both qualitative and quantitative methods. The findings of the assessment not only revealed obstetric fistula as a significant health problem, but also revealed the shortage of health staff and lack of necessary skills to treat afflicted women. Some of the health care institutions surveyed lacked the basic equipment required for obstetric fistula repair as well as the necessary anesthetic equipment and supplies. More

than 90 per cent of the central, provincial and district hospitals lacked protocols for the care of OF patients in the post-operative period. Following the needs assessment, recommendations were made to address these gaps. In 2010, UNFPA will use core resources to disseminate the results of the needs assessment to stakeholders and focus on strategy development and programme implementation.

As the campaign continues to integrate fistula programming into maternal health initiatives, many countries conducted EmONC needs assessments that include fistula and family planning issues. In **Haiti**, the EmONC survey conducted in 2009 revealed that 10 per cent of obstetric health facilities reported treating at least one case of obstetric fistula during the previous three-month period. This was followed up with a second study to assess the socio-economic impact of obstetric fistula.

As part of efforts to standardize national fistula data collection, UNFPA and partners developed a standardized fistula module for inclusion in country Demographic Health Surveys (DHS). This standard module has been incorporated into the DHS of **Burkina Faso, Kenya and Nigeria**. The Nigeria DHS of 2008 was the first to use this module, the reports of which were published in 2009. The main findings revealed:

- ▶ 31 per cent of women surveyed in Nigeria have heard of obstetric fistula symptoms. Knowledge of obstetric fistula is higher among rural women (33 per cent) than women residing in urban areas (27 per cent);
- ▶ Three-quarters of women with fistula in the country reported that their symptoms began after a difficult labour. 44 per cent reported that their symptoms occurred following a difficult labour resulting in the birth of a live infant, while 30 per cent reported their symptoms started following a very difficult delivery of a stillborn child;
- ▶ One in four women reported that symptoms began 2-4 days after delivery, while 16 per cent reported that symptoms began on the same day or the day following the delivery. Around one in five women reported the symptoms began 5-7 days or 8 days or more after delivery.

It is important to note the DHS fistula module has not yet been fully validated with a clinical exam to confirm women reporting fistula symptoms actually have the condition. Presently, there are efforts to support other interested countries to include the standardized fistula module in their DHS.

Analysis of country level indicators reporting for 2006-2008 and efforts to increase integration within the Maternal Health Thematic Fund led to the inclusion of a short set of fistula-specific questions in the Country Office Annual Report (COAR) tool. These questions are based on the agreed upon global campaign indicators (developed in collaboration with national and regional colleagues in 2005) and aim to support integrated data collection, thereby reducing the reporting requirements for countries. This is an internal process, but illustrates ongoing and intensified efforts to increase effective fistula programme monitoring.

A final important step to broaden the knowledge base around fistula elimination programming is to capture the magnitude of obstetric fistula. In response to recognized data limitations, Johns Hopkins University, UNFPA and the World Health Organization, in collaboration with medical and national institutions in up to seven countries, are conducting a study to examine the links between surgical prognosis and treatment for long-term health, psycho-social status and reintegration outcomes following the surgery. A full roll-out of the multi-country research study was delayed in 2009 due to financial constraints. However, data collection commenced in Bangladesh in 2010 and is moving forward in the other countries. The results of the study will be instrumental for

advocacy purposes as well as to devise programmes and national strategies that are appropriate, cost-effective and feasible.

Partnership Building

Effective and collaborative partnership is the cornerstone of the campaign's efforts at all levels. UNFPA serves as the Secretariat of the International Obstetric Fistula Working Group (OFWG), which now includes more than 25 global and regional partner agencies. This global coordination mechanism facilitates partner dialogue and joint projects. Divided into four working committees, focused groups concentrate on: partnership and advocacy; treatment and training; data and indicators; and research and reintegration. In September 2009, the OFWG met in Dar es Salaam, Tanzania. A key recommendation that emerged from this meeting was the importance of translating the activities and work of the global coordination body at country level.

Global coordination efforts are increasingly mirrored at country level, with growing numbers of effective national partnerships. Several countries, such as **Bangladesh, Chad, DRC, Niger** and **Pakistan**, have created national coordination bodies on fistula prevention, treatment and reintegration, which facilitates interaction and coordinated planning among partners. Typically these coordination teams include the Ministry of Health, international and national NGOs, civil society organizations, medical providers and UN agencies to ensure better coordination, reduce duplication of efforts, and to promote common goals, strategies and plans.

The influence of an effective partnership is perceived in many levels. For example, a partnership between the Ministry of Health, Ministry of Religious Activities and UNFPA resulted in the successful completion of the Fistula Rehabilitation Center in Khartoum, **Sudan**. In **Bangladesh**, the Government, UNFPA and Bangladesh Women's Health Coalition (BWHC) worked together to supervise newly trained community fistula advocates to raise awareness and mobilize communities on fistula prevention and treatment.

The engagement of multiple national ministries to address obstetric fistula is a promising partnership approach, as it recognizes the cross-cutting influences that cause fistula — including poverty and gender inequity. For example, in **Congo Brazzaville**, the Minister for the Promotion of Women and Integration of Women in Development is actively engaged in the campaign, resulting in increased governmental support for fistula reintegration services.

Media partnerships are also very important, illustrating the opportunities presented by collaboration between media professionals and technical experts. In **Guinea**, training for rural radio broadcasters led to greater public awareness of obstetric fistula and helped break the isolation of women living with the condition. And in both **Guinea** and **Niger**, following radio host training, rural radio stations signed contracts to ensure they would disseminate standardized fistula prevention messages.

Raising Awareness

Fistula at ECOSOC

In July 2009 fistula survivor Sarah Omega Kidangasi and singer, along with actress and Virgin Unite Ambassador Natalie Imbruglia, addressed the Economic and Social Council (ECOSOC) of the United Nations to call attention to maternal health and obstetric fistula. The 400 attending health and foreign affairs ministers and ambassadors at the ECOSOC High-Level Segment were confronted with grim facts: every minute a woman dies needlessly in pregnancy or childbirth, and for every woman who dies, 20 to 30 women suffer a serious birth injury, one of the more devastating being obstetric fistula.



Fistula survivor and activist Sarah Omega joined singer, actress and campaign celebrity spokesperson, Natalie Imbruglia, to call for action on maternal health and obstetric fistula. Economic and Social Council (ECOSOC) meeting of the United Nations, July 2009. UN Photo.

Raising Awareness through Film

"Outcasts No More", a UNFPA video news report on obstetric fistula in Afghanistan's remote Badakshan province, was aired on CNN's World Report programme in March 2009. It features the testimony of two fistula survivors and the UNFPA-trained doctor who performed their successful surgeries. Apart from being available on YouTube and the UNFPA Online Video Channel, the video has since received more than 50 requests for broadcasting throughout the world. Natalie Imbruglia invited a representative of the Campaign to speak about obstetric fistula at the launch of her last film, "Closed for Winter", in Australia. A portion of the ticket sales went to the campaign.

VIP Event in Brussels Supports Fistula

Media support goes beyond publicizing stories about issues related to fistula: it includes direct support to initiatives to fight the problem. In November 2009, ELLE Belgium magazine hosted its anniversary party in support of the Global Campaign to End Fistula. The event attracted more than 1,000 members of Belgium's media, fashion and arts worlds and featured an exhibition of UNFPA's awareness campaign images, developed by RKCR/Young and Rubicam UK. UNFPA was invited by ELLE Belgium as part of a long-term partnership to raise awareness on obstetric fistula, which started in 2007.

Congo Women

In 2009, the Campaign to End Fistula supported the organization of the exhibition “Congo/Women Portraits of War: The Democratic Republic of Congo”. The exhibition featured astonishing photographs and essays documenting the bravery of women and their families throughout the atrocities they have had to endure in recent years. The nearly total collapse of the health system, an extreme lack of both general and reproductive healthcare, and the common occurrence of brutal sexual violence against women and girls has had devastating consequences in the country, including the increased occurrence of obstetric and traumatic fistula. The exhibit, which premiered at Chicago’s Columbia College in February 2009, was also presented at the U.S. Congress in Washington, and the United Nations Headquarters in New York, Yale University and USAID, before traveling to 40 colleges in the U.S. and the UN Palais in Geneva in 2010.

Around the World Wide Web

In 2009, several articles and feature stories appeared on the UNFPA and the Campaign to End Fistula website (www.endfistula.org). These features offer hope, illustrating the efforts of fistula champions in their daily fight against this humiliating condition. In **Somalia**, for instance, surgeons and medical teams surrounded by political instability, violence and chaos continue their work, dedicated to ending the misery of women living with obstetric fistula. And in **Liberia**, 17 fistula survivors are now ready to return to their communities, having undergone successful surgery, counseling and skills training through the Liberia Fistula Rehabilitation and Reintegration Programme.

In the Media

Throughout the year, many stories on obstetric fistula were published in the media, particularly in West and Central Africa, including in **Burkina Faso**, **Congo Brazzaville**, and the **Democratic Republic of the Congo**. One of the media outreach highlights in the region was a fistula media trip to remote regions of **Senegal** in November 2009. The media trip with national journalists was organized by the UNFPA Senegal country office and resulted in significant media coverage on fistula in print media and on national radio and television, and a global interview on Voice of America. The BBC World also placed obstetric fistula in the global spotlight when it repeatedly featured a story from the Fistula Hospital in Addis Ababa, **Ethiopia**. In **Germany** a radio feature on fistula won a journalism prize and was later used for a story in Die Zeit. The campaign’s celebrity spokesperson, Natalie Imbruglia, did a couple of high-level interviews about obstetric fistula with leading media outlets in the **UK**. These are only a few examples of the many stories featured in major media outlets in 2009, which covered different aspects of obstetric fistula, emphasizing the need to engage opinion leaders to prevent new cases as well as to fight against the stigma faced by survivors. The stories also shed light on what has been done as part of the UNFPA Campaign to End Fistula to prevent and treat afflicted women.

Mid-term Evaluation – Awareness Raising and Advocacy Findings

According to the mid-term evaluation of national programmes, global advocacy and awareness raising activities have contributed to greater visibility and knowledge of the fistula problem worldwide. They have also led to greater resource mobilization for fistula programmes. The campaign has increasingly supported the advocacy work of fistula survivors to convince communities and decision makers of the right to treatment and the importance of preventing maternal death and disability. Key examples of the findings and contributions in this area include:

- ▶ An improved political and social environment focused on reducing maternal mortality and morbidity, including obstetric fistula, is the result of advocacy and awareness raising activities with

policy makers, religious and traditional leaders, communities, service providers, administrative officers, and government officials;

- ▶ Efforts targeting service providers, administrative officers and government officials enhance their knowledge and understanding of obstetric fistula and encourage them to increase their efforts to provide fistula prevention services to prevent obstetric fistula, actively identify obstetric fistula patients and refer to them for treatment at the appropriate level;
- ▶ The awareness raising efforts within communities are usually carried out by local CSOs and NGOs before and during treatment/training camps in order to help identify women living with OF in the community and to give them access to surgical repair. A number of strategies are used for this purpose: radio announcements, booklet distribution to local level service providers, publication of articles in newspapers, and distribution of flip charts and posters for use at community level. Mobilization, sensitization and awareness raising activities carried out in several countries to increase knowledge and understanding of obstetric fistula and identify its sufferers have also contributed to increased knowledge and understanding of other maternal health issues.

Communication and Advocacy as part of Programming

Communication and advocacy are essential tools for programming. Incorporated into Annual Work Plans, these tools can make a difference in terms of raising awareness and funds, and strengthening partnerships and cooperation at national, regional and global levels. To support country offices, the Media and Communications Branch (MCB/IERD) reviewed a sample of Maternal Health and Fistula Thematic Trust Funds Country 2009 Reports and 2010 Annual Work Plans, looking for communication and advocacy components.

Out of the 34 country reports reviewed, approximately 69 per cent included at least one communication or advocacy component as part of their programmes. Out of those, 35 per cent reported the implementation of strong communication and/or advocacy components, 16 per cent demonstrated some underlying strategy for communication and/or advocacy, and 9 per cent reported the use of indicators or some monitoring mechanism in place for communication and/or advocacy.

In the case of the Annual Work Plans, about 23 per cent of the countries reviewed have an average representation of communication and/or advocacy components, while 6 per cent have an above average presence, incorporating solid and innovative proposals.

Challenges

The Campaign to End Fistula has achieved a lot in a relatively short time. Currently 47 countries have initiated interventions and strengthened their fistula elimination efforts. However, challenges remain and need to be highlighted and discussed to improve future campaign efforts.

More than 10 countries have developed national programmes or strategies. However, implementing these strategies is often limited, due, in part, to poor or non-existent costing of these national plans, minimal coordination, unclear division of tasks and responsibilities, and a lack of resources and mobilization plans. Monitoring and evaluation of national strategies are often weak and limited. All these limitations have a negative impact on the implementation and scale-up of initiatives. They also hinder efficient planning and make it more difficult to identify new directions for national programming. With such shortcomings, countries risk losing money as well as motivated staff who are involved in the early stages of the fight against obstetric fistula.

There is a need for an increased and ongoing focus on fistula prevention within the context of maternal mortality and morbidity reduction. **It is clear that the same interventions that reduce maternal death are also effective in reducing maternal disability, including obstetric fistula.** While an ongoing emphasis on fistula treatment is needed to ensure that women living with the condition have access to services, it is only through increased prevention efforts that eliminating fistula can be achieved. As part of the increased focus on prevention, it is important for national programmes to increasingly integrate obstetric fistula into MNH policies and strategies to ensure a comprehensive approach to fistula. More focus should also be put on young people and their specific reproductive health needs, including the particular needs of young mothers.

The existing treatment services do not yet meet the needs of all women living with fistula. There is an urgent need to scale up available treatment services and determine the best delivery mix in each country. For example, many countries still rely on outreach campaigns and/or international expertise. While these campaigns are important to increase access to treatment for women, there is also a need to increase routine treatment provision. The campaign needs to support countries to assess their specific 'best' service delivery approach, as well as to train at least one national team to ensure fistula treatment on a routine basis.

In order to ensure better quality assurance and harmonious training, it is important that standards and protocols are put in place and endorsed by partners. An important step to ensure synergies and better quality assurance is to validate, disseminate and encourage ownership of the standardized, competency-based manual that was developed through the Treatment and Training Working Committee of the international OFWG. This process is under way and will continue to be supported by UNFPA and partners.

The appropriate modality for delivering reintegration and rehabilitation services needs further study and analysis. As part of this effort, it would be useful to consider addressing this work from a strong gender perspective, with more emphasis on linking fistula programmes with national gender policies and programmes. In order to prevent the discrimination associated with long-term sufferers of obstetric fistula, it is important to provide **psychosocial support and family counseling as soon as the first symptoms are detected.** Midwives and other health professionals represent an untapped resource to counsel women on fistula symptoms and refer them to available services when they are experiencing obstructed labour. In addition to early diagnosis, this will allow early guidance and support to women and their family members.

Women living with fistula whose condition excludes them from society require services and support to reintegrate them into their community and family. While the form these services take may vary from country to country, they are currently reaching too few women, and are often too costly to be sustainable. It is time to evaluate and assess the initiatives that are used throughout different contexts. More research and data are required on quality of life after surgery and rehabilitation efforts. The multi-country research study (conducted in partnership with Johns Hopkins University and WHO) will contribute to the available data on quality of life outcomes following fistula treatment, but additional research by national stakeholders should also examine these issues.

In many countries, the capacity to monitor programme activities and evaluate programmatic efforts (M&E) is limited. Many campaign countries are working to build M&E capacity, but it is an ongoing process that requires government investment. Fistula treatment is usually not tracked at the national level, limiting the ability to gather and analyze data, and thus to improve service provision and fill in the gaps.

Lessons Learned

An important part of an annual review is the documentation and use of lessons learned to adjust approaches and invest more in areas where promising lessons emerge. The lessons gathered for this report from national and global sources are used to support ongoing campaign efforts and to improve future ones.

One important lesson is that women's voices and experiences must increasingly be part of the maternal health dialogue, since advocacy efforts by fistula survivors help to harness policy support.

The work of fistula survivors has had an incredible impact from the global to the community level. With appropriate advocacy training, women's voices are joining the maternal health dialogue and being heard. While continuing to strengthen their capacity as advocates, it is important to support their empowerment by involving them in planning and programming processes and to encourage them to consider their own personal goals and commitment.

The existence of a national coordination body facilitates the organization of fistula efforts within the national plan. Several countries with existing national coordination mechanisms in place reveal how this body facilitates dialogue amongst partners and an increasingly comprehensive approach to fistula programming. Additionally, at least four countries in 2009 reported that the absence of such a body impeded coordinating efforts and expressed interest in developing such a mechanism. This presents an important opportunity for South-South learning; plans are under way for countries with effective mechanisms to document and share their experiences with other countries.

Making fistula treatment free of charge and securing funding for reintegration support will lead to more and more fistula sufferers seeking out treatment. The majority of campaign countries reported the importance of cost as both a barrier and an opportunity in the delivery of fistula treatment and care. When treatment fees were removed from the equation through subsidized care or insurance coverage, more women sought treatment.

The absence of adequate, robust fistula treatment data is an ongoing concern. **It has been found that OF is not considered in the existing data collection.** As a starting point, UNFPA must support countries to integrate a minimum set of data points to collect at the facility level. Specific data collection tools have been developed and are available (Geneva Foundation for Education and Research). Beyond that, there needs to be a national data collection point to compile facility-level data. Such data centers could be developed and operated by a national coordination body.

To raise community awareness, community dialogue must be an integral part of the fistula prevention programme. This not only enables community members to have an intimate discussion with health service providers regarding the importance of skilled delivery at birth, but it also promotes awareness of fistula among those who continue to have home deliveries. Improving the dialogue within the community strengthens healthcare delivery. Toward this end, many countries are training community health workers to disseminate information on obstetric fistula. Local media, health personnel, civil society and fistula survivors all play important roles in the effective delivery of these messages.

In order for these valuable lessons learned to be translated into action at the community level, UNFPA relies on the committed support of its donors. Multi-year commitments are particularly important to help ensure sustainable and continued programming to eliminate the devastating effects of fistula.

Moving Forward

Only by evaluating our work can UNFPA adapt our efforts to more effectively support our partner countries. The external mid-term evaluation has provided very important tools to revise strategies, address weaknesses and scale up effective approaches.

As stated in the mid-term evaluation, **“The Campaign to End Fistula has achieved much in terms of awareness building and service development and has been a catalyst to mobilize countries towards addressing fistula prevention, treatment and care.”** However, there is much more to do — as the ambitious goal of fistula elimination in the regions most affected has not yet been achieved.

UNFPA will work to increasingly integrate obstetric fistula within its country programmes and national SRH policies and plans. However, it will also maintain an advocacy and technical focus on fistula so as not to jeopardize the progress made to date. Fistula continues to be an effective entry point to raise awareness and inspire action on maternal health overall.

UNFPA will use the mid-term evaluation results and recommendations to determine the short- and longer-term vision for the Campaign’s next phase. We will continue to build the campaign’s emphasis on South-South cooperation so that countries that are making rapid progress and have innovative approaches can support newer countries in their learning and programmatic development.

Ultimately, UNFPA — together with its partners — will persist in its role to ensure the continuity of the global Campaign to End Fistula.

CONCLUSION

THE WAY FORWARD: 2010 AND BEYOND

Building on the solid foundation made in 2008, the MHTF is supporting over 30 countries, plus an additional 12 supported for the fistula programme only; this effectively doubles the number of countries supported by MHTF. In addition to our key partners (WHO, UNICEF and the World Bank), partnerships have been formed with many national and regional institutions and a limited number of strategic global organizations to support the programme (see box).

Countries, regions and global partners supported by MHTF as of early 2010

Africa Region: Benin, Burkina Faso, Burundi, Cameroon*, CAR*, Chad, Cote d'Ivoire, Congo*, DRC, Eritrea*, Ethiopia, Ghana, Guinea*, Guinea-Bissau*, Kenya*, Liberia, Madagascar, Malawi, Mali, Mauritania*, Mozambique, Niger, Nigeria, Rwanda, Senegal*, Sierra Leone, Uganda, Zambia

Arab States Region: Djibouti, Somalia, Sudan (support to North and South), Yemen

Asia and Pacific Region: Afghanistan, Bangladesh, Cambodia, Lao PDR, Nepal, Pakistan, Timor-Leste

Latin America & Caribbean Region: Guyana, Haiti

Regional Offices: Africa, Latin America and the Caribbean, Asia-Pacific

Global Partners receiving MHTF support : ICM, Columbia University AMDD, Aberdeen University, FIGO, FCI, Johns Hopkins University, JHPIEGO

**Countries enjoying fistula support only*

The MHTF is thus supporting nearly all of the 25 H4 UN-MNH countries, and will do so in the coming year. Before further increasing the number of countries, it will be important to consolidate work in the countries currently supported and to secure a sufficient and more predictable funding base.

The process of peer reviewing country Annual Work Plans has contributed significantly to South-South learning and the sharing of good practices. In particular, the January 2010 planning meeting convened jointly by the MHTF and the GPRHCS, which involved staff from 20 key countries, was an excellent opportunity to learn how to accelerate efforts towards MDG 5 targets: reducing maternal mortality and jointly providing universal access to reproductive health.

Priorities for 2010 include:

- ▶ Strengthening national capacity and UNFPA's own CO capacity;
- ▶ Strengthening family planning efforts by supporting a conducive policy environment, service delivery and demand creation;
- ▶ Working more closely with midwifery schools, midwifery trainers and governments to put in place a recommended curricula for midwifery; UNFPA will also focus on expanding enrollment in midwifery schools, recruiting graduates to serve where they are most needed, and motivating midwives;
- ▶ Building on the success of the Campaign to End Fistula and its external evaluation, and developing a three-year vision based on the findings of this evaluation while mainstreaming fistula programming into national programming;
- ▶ Continuing communication, media and advocacy efforts to raise awareness and promote commitment;
- ▶ Mobilizing resources to consolidate and expand the programme.

Some of the key challenges to overcome include:

- ▶ Boosting national commitment to health and to MDG 5, and increasing resources commensurate to the commitment and disbursement of funds for health;
- ▶ Basing district-based service delivery plans on EmONC needs assessments;
- ▶ Advocating for national recognition of the need to scale up quality clinical training, better management, and deployment and retention of human resources for maternal and neonatal health;
- ▶ Scaling up evidence-informed communication and advocacy;
- ▶ Scaling up quality family planning in priority countries to cover the unmet need.

At the global level:

- ▶ Ensuring sufficient, predictable financing for MDG 5; as part of this, support to UNFPA's MHTF;
- ▶ Ongoing advocacy to promote greater awareness and commitment.

The global landscape for maternal health is changing rapidly, with unprecedented political commitment and recognition of the issue. The challenge will be to translate this commitment into adequate financing and then to scale up the interventions which save and improve the lives of women and newborns.

2009

FINANCIAL TABLES

Maternal Health Thematic Fund: Contributions 2009

DONOR	AMOUNT IN USD
Austria	576,757
Luxembourg	1,496,063
The Netherlands	2,425,000 ¹
Private	2,109
Spain	6,903,353
Sweden	3,217,503 ²
TOTAL	14,620,785 *

¹ Total contribution USD 4,950,000 over three years (2010–2012)

² Total contribution USD 12,146,000 over four years (2009–2012)

Maternal Health Thematic Fund: Expenditures 2009

ACTIVITY	AMOUNT IN USD	PERCENTAGE
Country Level	6,797,024	61.12%
Regional Office Level	673,021	6.05%
Global Level (including Implementing Partners)	3,651,415	32.83%
TOTAL	11,121,460 *	100.00%

Figures are provisional, subject to certified financial statements issued by UNFPA.

* Donor funds are received throughout the year. Contributions are thus calculated as income for that year, but are available for the operating budget of the following year. It is thus important to distinguish between income to the TF for a given year and its operating budget with country-specific allocations, the latter based on funds received and in hand (or committed through multi-year agreements with donors).

The Campaign to End Fistula: Contributions 2009

DONOR	AMOUNT IN USD
Americans for UNFPA	109,680
Iceland	200,000
Luxembourg	756,726
New Zealand	101,932
Norway	1,683,431
Poland	50,000
Private Contributions	3,208
Republic of Korea	500,000 ¹
Spain	3,451,677
Women's Missionary Society of the African Methodist Episcopal Church	25,000
Zonta International	100,000 ²
TOTAL	6,981,654 *

¹ Total contribution USD 1,500,000 over three years (2007-2009)

² Total contribution USD 450,000 for over three years (2008-2010)

The Campaign to End Fistula: Expenditures 2009

ACTIVITY	AMOUNT IN USD	PERCENTAGE
Country Level	2,634,670	83.90
Regional Office Level	248,149	7.90%
Global Level (including Implementing Partners)	257,284	8.20%
TOTAL	3,140,103 *	100.00%

Figures are provisional, subject to certified financial statements issued by UNFPA.

* Donor funds are received throughout the year. Contributions are thus calculated as income for that year, but are available for the operating budget of the following year. It is thus important to distinguish between income to the TF for a given year and its operating budget with country-specific allocations, the latter based on funds received and in hand (or committed through multi-year agreements with donors).



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