

# Maternal Health Thematic Fund Annual Report 2008





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# LIST OF ABBREVIATIONS AND ACRONYMS

AMDD	Averting Maternal Death and Disability Program – Columbia University
DHS	Demographic and Health Surveys
EmONC	Emergency obstetric and newborn care
GPRHCS	Global Programme on Reproductive Health Commodity Security
HMIS	Health management information system
ICM	International Confederation of Midwives
IHP+	International Health Partnership
IMMPACT	Initiative for Maternal Mortality Programme Assessment – University of Aberdeen
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
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

# EXECUTIVE SUMMARY

Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. 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 – half of them in Africa. A woman in Niger faces a 1 in 7 risk during her lifetime of dying of pregnancy-related causes, while the risk for a woman in Sweden is 1 in 17,400, a greater than one thousand-fold difference. No other health indicator as starkly illustrates global disparities in human development.

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted and every birth is safe. In early 2008 the United Nations Population Fund (UNFPA) launched the Maternal Health Thematic Fund (MHTF) to provide enhanced support to countries in working with governments, civil society, the United Nations and other key partners to implement and scale up effective maternal and newborn health interventions as a central component of their national health plans and systems.

The work of the Maternal Health Thematic Fund is a key UNFPA contribution to the joint United Nations work on maternal and newborn health. UNFPA has teamed up with the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the World Bank to provide accelerated support in 25 high maternal mortality countries before the end of 2009, working towards 60 high maternal mortality countries over the next five years. A Joint Statement was released on 25 September 2008 at the High-Level Event on the MDGs (See Annex 2: WHO-UNFPA-UNICEF-World Bank Joint Statement on Maternal and Newborn Health *Accelerating Efforts to Save the Lives of Women and Newborns*). A joint United Nations work plan is forthcoming.

A Business Plan was developed for the Maternal Health Thematic Fund based on an in-depth review of the scientific and programme literature to foster optimal use of resources towards achieving sustainable impact. The Business Plan calls for strategic and catalytic support to approximately 12 new countries each year, thus supporting 60 high maternal mortality countries within a five-year period.

In collaboration with UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, and the new Midwives Programme, the MHTF provides support to priority countries, those showing the least progress on Millennium Development Goal 5, in capacity development, technical assistance and the provision of life-saving equipment, supplies and drugs. Funding from the MHTF is intended to be very "strategic", to quickly identify and solve bottlenecks which are preventing progress in maternal health, and to be "catalytic" in stimulating donor collaboration at the national level.

Based on available and forecasted resources, a first wave of 11 countries with high maternal mortality, (maternal mortality ratio greater than or equal to 300 per 100,000 live births)<sup>[1]</sup>, was selected for support: **Bénin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi and Sudan**. Maternal mortality and fertility are both very high in all of these countries, thus leading to an extremely high lifetime risk of death due to pregnancy and childbirth.

<sup>[1]</sup> *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. October 2007. Geneva. WHO.*

In this first implementation year, inception missions took place in the first wave countries. As part of these missions, key stakeholders from governments and partner UN agencies gathered to complete an in-depth analysis of the maternal and reproductive health situation in order to determine priority areas for support. Following the analysis, countries submitted proposals for peer-review and funds had been allocated in nine countries at the time of this report. Funding should be provided to all 11 before the end of the second quarter of 2009. Funding from the Maternal Health Thematic Fund is not provided through a separate funding mechanism, but is integrated within the country programme and aligned with national strategies and plans for maternal and newborn health.

One of the fundamental principles underpinning the work supported by the Maternal Health Thematic Fund is country-owned and country-driven development and support to the one national health plan. Therefore, the specific outputs and activities in each country will be determined by the country. There will be, however, a set of seven essential outputs which the Maternal Health Thematic Fund will support with government and partners in every country unless otherwise fully supported (See Box 1 for these priority outputs).

Countries in the first wave have requested support from the Maternal Health Thematic Fund to implement initiatives related to a) family planning b) human resources for maternal health and in particular midwifery and c) Emergency Obstetric and Newborn Care (EmONC), three proven interventions for reducing maternal mortality and key focus areas of the Maternal Health Thematic Fund. Countries have also requested support for national advocacy efforts and community mobilization to increase the demand for reproductive health services and call national and global attention to the issues surrounding maternal and newborn health in the developing world.

National needs assessments of the accessibility and quality of EmONC have begun in Ethiopia, Haiti and Cambodia and are planned for the other countries. These assessments will provide valuable quantitative and descriptive information for advocacy and policy dialogue. They will also provide baselines against which progress can be measured. Most importantly, information collected through these assessments will contribute to solid national and district planning, allowing for a more targeted, results-focused strategy in each country. For example, the EmONC assessment in Ethiopia is providing valuable information on the current functioning of maternity services in over 800 facilities, thus forming the basis for solid district-by-district service delivery and human resource micro-planning and health system strengthening to achieve Millennium Development Goal 5.



**BOX 1: OUTPUTS FROM THE MATERNAL HEALTH THEMATIC FUND BUSINESS PLAN**

1. An enhanced political and social environment for Maternal and Newborn Health (MNH) and Sexual and Reproductive Health (SRH)
2. Up-to-date needs assessments for the SRH package with a particular focus on family planning, human resources for MNH, and Emergency Obstetric and Newborn Care (EmONC)
3. National health plans focus on SRH, especially family planning and EmONC with strong Reproductive Health / HIV linkages to achieve the health Millenium Development Goals
4. National responses to the human resource crisis in MNH, with a focus on planning and scaling up of midwifery and other mid-level providers
5. National equity-driven scale-up of family planning and EmONC services and maternal and newborn health commodity security
6. Monitoring and results-based management of national MNH efforts
7. Leveraging of additional resources for Millennium Development Goal 5 from government and donors

In Haiti, support from the Maternal Health Thematic Fund is also contributing to a nationwide campaign to promote family planning, focusing on the availability of all methods in every health facility and the provision of family planning as part of post-partum care.

In Madagascar and Malawi, funding will support an initiative to increase demand for sexual and reproductive health services and information, particularly for adolescent girls, by working with partner organizations to create youth-friendly services and conduct community outreach. Similarly, in Guyana, funding will support a strong effort to target women, and particularly adolescents, in the isolated hinterland regions where women suffer from very high rates of maternal mortality due to lack of access to health services and information.

Many countries have developed national plans (road maps) for the reduction of maternal death and disability. A recent assessment of these plans, supported by the Maternal Health Thematic Fund, has found that many have not been finalized, costed or implemented, thus further reinforcing the need for enhanced national health plans and stronger health systems.

Three of the countries included in the first wave, Cambodia, Ethiopia, and Madagascar, are active members of the International Health Partnership (IHP+). The other eight countries are each at different stages of strengthening their national health systems. By providing funding through the UNFPA country programme based on nationally identified priorities, the MHTF attempts to optimize results, ensure efficient implementation and reduce transaction costs for countries.

Within UNFPA, the Global Programme for Reproductive Health Commodity Security, the Campaign to End Fistula and the Midwives Programme are working together to provide integrated technical assistance, commodities and financial support to the countries on the full spectrum of reproductive health care.

There is unprecedented international commitment to achieve Millennium Development Goal 5. As part of translating this commitment to action, the Maternal Health Thematic Fund is operational and is beginning to achieve results in priority countries. It is said that maternal mortality is a litmus test for the functioning of a health system. The challenge now is to consolidate the work in the first wave of countries and to secure the required resources to expand the work to all 60 high maternal mortality countries over the next five years.

In 2008, UNFPA raised \$25 million in pledges from the following donors: Austria, Finland, Ireland, Luxembourg, The Netherlands and Spain; included is a contribution from Sweden for the Midwives Programme.

Based on a solid review of the scientific evidence and the results of programmes in countries which have tackled maternal mortality, we believe that much progress can be accomplished between now and 2015, with a community outreach and health systems approach of scaling up family planning, skilled attendance at delivery and emergency obstetric care, so that every pregnancy is wanted and every birth is safe. We could then envisage a world where maternal mortality has been eliminated as a public health problem and where the burden of suffering from maternal disabilities has been reduced considerably.

# INTRODUCTION

Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. And every year over one million newborns die within their first 24 hours of life from lack of quality care. Maternal mortality is the largest health inequity in the world; 99 per cent of deaths occur in developing countries – half of them in Africa. A woman in Niger faces a 1 in 7 risk during her lifetime of dying of pregnancy-related causes<sup>[2]</sup>, while a woman in Sweden has a risk of 1 in 17,400, a greater than one thousand-fold difference between the two countries. No other health indicator as starkly illustrates global disparities in human development.

Though maternal death and disability continue to be a major health problem in many parts of the world, notable progress has been achieved in over 100 countries. Unfortunately, this progress has been slow and unequal. During the 15-year period between 1990 and 2005, Asia experienced a 20 per cent reduction in maternal mortality ratio (MMR). During the same time period, MMR in sub-Saharan Africa decreased a mere 2 per cent.

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted and every birth is safe.

Progress in many countries has led to a growing consensus in the maternal health field that reducing maternal and newborn deaths and disability can be achieved by ensuring 1) access to family planning, 2) a skilled health professional present at every delivery and 3) access to emergency obstetric and newborn care (EmONC), when needed. Mobilizing communities and governments to understand a woman's right to these resources combined with efforts to eliminate financial, geographic and socio-cultural barriers will allow universal access to reproductive health, in turn leading to a dramatic reduction in the number of maternal deaths.

Following the announcement by the Executive Director of the United Nations Population Fund (UNFPA) at its Executive Board meeting September 2007, UNFPA launched a Maternal Health Thematic Fund (MHTF) in early 2008. This Thematic Fund represents a focused effort in some of the poorest countries in the world with the greatest maternal health needs. The MHTF focuses on Outcome 2.2 of the UNFPA Strategic Plan (2008-2011) - *Access and utilization of quality maternal health services increased in order to reduce maternal mortality and morbidity* while also contributing to Outcomes 2.1 *Universal access to Sexual and Reproductive Health*, 2.3 *Access to and utilization of Family Planning* and 2.4 *Demand, access and utilization of quality HIV prevention services*.

In collaboration with UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, and the new Midwives Programme, the MHTF provides support to priority countries, those showing the least progress on Millennium Development Goal 5, in capacity development, technical assistance and the provision of life-saving equipment, supplies and drugs. Funding from the MHTF is intended to be very "strategic", to quickly identify and solve bottlenecks which are preventing progress in maternal health, and to be "catalytic" in stimulating donor collaboration at the national level.

<sup>[2]</sup> All estimates for maternal mortality ratio, lifetime risk of death during pregnancy or childbirth are from the following source: *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. October 2007. Geneva. The World Health Organization.*

This first year of preparatory activities included:

- the formal launch of the Thematic Fund
- the development of a business plan, based on an in-depth review of the scientific and programme literature to foster optimal use of resources towards achieving sustainable impact (see Annex 1)
- the elaboration of the business processes and the preparation of the basic documentation
- donor briefings and meetings to begin to mobilize the resources required
- the selection of a first wave of 11 countries among the 60 high maternal mortality countries (MMR >300 per 100,000 live births) based on available and forecasted resources

At the same time, inception missions took place in the first wave countries, in collaboration with Ministries of Health and partners, to assist these countries in an in-depth analysis of their maternal and reproductive health needs. Activities have started in countries that have completed the analysis and received their allocation.

A review of all national documents, assessments, policy statements, strategic plans and national programmes is undertaken as part of the inception mission process to ensure that funding from the MHTF is not a parallel or vertical project, but is an integrated component of the current national health plan and UNFPA country programme. Countries supported by the MHTF are encouraged to use the funding to boost support to strategic ongoing and new activities within their existing national programme for maternal and newborn health. The main strategy is to build capacity in countries at facility, district, national levels and regions as well as UNFPA's own country and regional capacity to respond to Millennium Development Goal 5.

The MHTF supports the process of mapping out existing maternal and reproductive health initiatives in order to identify gaps for subsequent strategic support from the Thematic Fund. Priorities in the first wave countries were defined by the country in alignment with the national strategy for maternal and newborn health and with a special focus on four areas: human resources for maternal health (skilled attendance at birth / midwifery), Emergency Obstetric and Newborn Care (EmONC), universal access to family planning and coordination and monitoring.

National needs assessments are also part of the required initial stages of the MHTF process: they cover various aspects of reproductive and maternal health: family planning and reproductive health commodity security, EmONC, and obstetric fistula prevention and treatment. The need for maternal / reproductive health human resources will also be identified as one component of the EmONC needs assessments, and as part of the national health and human resource planning process.

In many countries, major scarcities in health personnel have weakened the health system and limited the availability of midwives and other health workers with the skills to provide women with basic emergency obstetric care during labour and delivery (see Box 2).



# ON THE PATH TO RESULTS

The following 11 countries were identified by their respective Regional Offices for support in the first wave of the MHTF: **Bénin, Burkina Faso, Burundi, Cambodia, Djibouti, Ethiopia, Guyana, Haiti, Madagascar, Malawi** and **Sudan** (see Annex 4). These countries were selected based on maternal mortality ratio and the other Millennium Development Goal 5 indicators, as well as discussions with UNFPA's regional and country offices, participation in international initiatives and political will. The sequence of steps listed in Table 1 was initiated following the completion of preparatory activities. For nine countries the process has been completed at the time of writing this report (May 2009); the process is nearly finalized for the two other first-wave countries.

**TABLE 1: PROGRESS IN THE MATERNAL HEALTH THEMATIC FUND WAVE 1 COUNTRIES, AS OF 31 MAY 2009**

	<b>Inception Mission</b>	<b>Proposal Submitted</b>	<b>Peer Reviewed</b>	<b>Approved</b>
Haiti	10-19 July	17 Sept	9 Oct	17 Oct
Madagascar	22 July-1 Aug	21 Oct	28 Oct	20 Nov
Cambodia	20-25 Oct	9 Dec	17 Dec	17 Jan
Ethiopia	1-7 Oct	13 Oct	17 Dec	19 Feb
Malawi	29 Sep-3 Oct	17 Nov	17 Dec	19 Feb
Bénin	14-15 Nov	3 Jan	23 Jan	23 Mar
Guyana	9-16 Nov	19 Jan	13 Feb	8 Apr
Djibouti	17-23 Nov	9 Feb	8 Apr	
Sudan	1-11 Sep	12 May	28 May	
Burkina Faso	March	Being submitted		
Burundi	4-9 May	In preparation		

The Thematic Fund is designed to be a quick and flexible funding mechanism. The process leading up to the approval and allocation of funds is expected to move more rapidly as countries become more familiar with the application process and as proposals require fewer revisions following peer-review.

As with any programme in its implementation phase, one of the challenges was to adequately plan the level of initial support and the number of countries in the first wave of funding based on available resources. Donor funds were received or pledged at different times during this first year of operation.

# ANALYZING THE NEED

## HAITI

The MHTF mission in Haiti was the first inception mission for the Thematic Fund. The review of the current maternal and reproductive health situation was conducted jointly with the Director of Family Health (Directeur de la Santé Familiale – DSF) using the recently developed tool for assessing national maternal and newborn health plans, and involving key partners (WHO-PAHO, UNICEF, the country of Canada, USAID, the EU, and various NGOs).

One of the main issues revealed during the analysis process was the challenge of Haiti’s project-specific, rather than sector-wide, approach to improving health. To resolve this issue, a National Committee for Reproductive Health was constituted by the DSF with participation from other health directorates and partners. This committee assisted in the analysis of Haiti’s maternal health needs and the preparation of the proposal to the Maternal Health Thematic Fund.

The analysis highlighted some key indicators for Haiti. Half of Haiti’s population is below 24 years of age, and over 50 per cent of young people have never attended or did not complete primary school. Many people, particularly women in rural areas, live in absolute poverty. The maternal mortality ratio (MMR) is 670 deaths per 100,000 live births and three quarters of women deliver at home without a skilled attendant. The lifetime risk of dying from complications associated with pregnancy or childbirth is 1 in 44.

Given the high maternal mortality ratio, as well as the high adolescent fertility rate and unmet need for family planning (38 per cent), increasing access to family planning for the most vulnerable women (unmarried adolescents, women in slums, rural women, and those not attending the clinics) is an utmost priority for Haiti. As such, Haiti has requested support from the Maternal Health Thematic Fund for, among other activities, a nationwide campaign to promote family planning, focusing on the availability of all methods in every health facility and the provision of family planning as part of post-partum care.

Another key priority identified for Haiti is access to quality EmONC services for all women, as needed. The country requested support for a national EmONC assessment, which was initiated in late 2008. The assessment was carried out by the Institut Haitien de l’Enfance with technical and financial support from the Columbia University’s Averting



### KEY MH PRIORITIES IN HAITI

- Make contraceptive services accessible to all women in the pre- and post-partum periods by integrating family planning in all institutions providing delivery services.
- Human resources for maternal health (Nurse-Midwives) improved in quality, training, support, management and status.
- Assess all EmONC facilities in the country for a better identification of needs and gaps, with a focus on quality of care, regulation and monitoring through process indicators.
- Strengthen governance and management at the central and provincial levels, with a focus on Monitoring & Evaluation.

Death and Disability Program (AMDD) and the Maternal Health Thematic Fund. The country team is now in the final stages of data collection and analysis.

Haiti is also using funds from the MHTF to strengthen the National School of Midwifery. The country will recruit a national and international midwife adviser in 2009 through the MHTF Midwifery Programme. The Thematic Fund will allow an increase in the quantity and quality of new midwives. For a list of all key priorities in Haiti, see the box on page 8.



*A pregnant woman being weighed at a UNFPA-supported health centre in Ouanaminthe, Haiti.*

## MADAGASCAR

The analysis of maternal and reproductive health needs in Madagascar centred on the development, costing and implementation of the country's national plan for reproductive health which focuses on ensuring quality family planning and emergency obstetric care for all women, with particular attention to adolescent pregnancy. A team of key stakeholders was formed to review the country's priorities in the area of maternal and newborn health in the context of Madagascar's participation in the International Health Partnership (IHP+) and the process of establishing a Compact (memorandum of understanding) with all health partners.

The maternal mortality ratio in Madagascar is 510 deaths per 100,000 live births and the lifetime risk of death due to pregnancy or childbirth is around 1 in 38. The unmet need for family planning is close to 25 per cent, and only slightly more than half of the women give birth with a skilled birth attendant.

In Madagascar, one-third of all births are to adolescent girls; the adolescent fertility rate is around 150 births per every 1,000 girls. Given the high rate of maternal mortality and the vast reproductive health needs of adolescent girls, Madagascar has requested support from the MHTF for work in the expansion of demand for services. This work will be carried out in collaboration with UNFPA's Global



### KEY MH PRIORITIES IN MADAGASCAR

- Make contraceptive services accessible and available in all institutions receiving women, with a focus on long-term methods.
- Improve human resources for maternal health (midwives and other providers in obstetrics) in quality, training and support, recognition and status regulations.
- Identify and analyze EmONC priorities, needs and gaps in view of improving coverage and quality of care. This will also be useful for the process indicators.
- Better manage, coordinate and monitor the health system by strengthening national and regional capacities, including health management information system (HMIS) performance.

Programme on Reproductive Health Commodity Security (GPRHCS) and in partnership with local non-governmental and community-based organizations.

Madagascar's proposal to the MHTF also includes, among other activities, an analysis of the effects of the government's recent policy to provide caesarean sections free of charge. The inception mission analysis also revealed that the country does not have a recent national EmONC assessment and as such they have requested funding to start one in mid-2009. While political unrest has slowed the process considerably for a period of time, programming is now moving at a better pace.

## CAMBODIA

The inception mission was made jointly between the Technical Division and the Asia and Pacific Regional Office, and in collaboration with local partners. The mission visited several maternity and health centres, as well as a large training centre for human resources for health in Kampot. Maternal mortality in Cambodia is 472 maternal deaths per 100,000 live births and the lifetime risk of dying due to pregnancy or childbirth is 1 in 48. The contraceptive prevalence rate stands around 27.2 per cent and approximately one quarter of the women of reproductive age would like access to family planning services, but are unable to get it.

Cambodia is also an active member of the IHP+ partnership, and has demonstrated significant progress in child survival. The Government has made public a strong political commitment to address maternal survival and to expand access and utilization of improved maternal and reproductive health services. The country is currently testing and scaling up an innovative Equity Fund to improve financial accessibility to maternal health services.

The analysis in Cambodia focused on mapping out these existing initiatives to determine those areas not already covered that could benefit from MHTF support without creating parallel structures. The resulting proposal selected strategic activities within four main categories: 1) human resources for maternal health (with support to Cambodia's Midwifery Council), 2) EmONC services and information systems, 3) linkages with family planning and 4) financing for equity funds.

One priority activity in Cambodia relates to the anticipated increase in institutional deliveries associated with the introduction of performance-based support schemes to encourage women to give birth in a facility. In response, Cambodia has requested funding to increase the quantity of midwives trained and the quality of training through support to the Cambodian Midwives Association, midwifery schools and regional training centres. Support will also contribute to an on-site refresher training in emergency obstetric and newborn care for doctors in district hospitals. An EmONC national assessment is also ongoing in Cambodia. Results will be released in 2009. The country will seek support from the MHTF to support the implementation of the EmONC Improvement Plan from 2010 onwards.



UN/PS Sudhakaran

Woman carrying her child in Cambodia.

## ETHIOPIA

Senior maternal health and reproductive health advisers gathered in Ethiopia for the inception mission in September of 2008. Ethiopia is characterized by a predominantly rural population, with little education and poor access and utilization of health services. The population of 74.6 million (2007 Census Report) is growing rapidly, with concerns about poverty, employment, and the capacity of social services to respond to the needs. The Ministry of Health has embarked in an ambitious Health Extension Programme that will reach all communities in all districts with a focus on prevention. This programme aims to tackle the high unmet need for family planning (34 per cent) in order to decrease the lifetime risk of dying from pregnancy or childbirth which now stands at 1 in 27.

In addition, the Ministries of Health and of Education have recently established an ambitious Masters of Sciences (MSc) programme aimed to train high numbers of non-physician clinicians (NPCs) to perform essential surgery including emergency obstetric surgery at district levels. The MSc training program in integrated emergency obstetrics and surgery (IEOS) was officially launched in 4 April, 2009, at national level, in the presence of H.E. Minister of Health and Minister of Education, ambassadors, donors, trainers, trainees and a number of invited guests. The program was started in three universities: Jimma, Hawassa and Mekelle.

Supporting the training of professional midwives by the regional midwifery schools is the next step to be implemented. Activities include placing an international midwife advisor in the country office, undertaking a capacity assessment of training institutions and strengthening the midwifery association.

In Ethiopia, the Government gives priority to aid effectiveness and donor coordination, and is an active member of the International Health Partnership (IHP+). As a result, the inception mission and analysis were very participative, with all partners and donors involved. Ethiopia was the first country to sign the IHP+ Compact in August of 2008. As such, it was decided that a portion of funding from the MHTF will be channelled through the IHP+ Millenium Development Goal Performance Fund, which has a four-year plan focusing on basic and comprehensive EmONC, human resources for health, and the Health Extension Programme.

The team in Ethiopia also determined the need for a national EmONC needs assessment, which was conducted with support from UNFPA, UNICEF, WHO, and Columbia University (Averting Maternal Death and Disability or AMDD). This needs assessment will provide detailed information on the current functioning of over 800 health facilities (health centres and district hospitals) providing maternal health services.

The preliminary analysis shows astonishing results such as the fact that only 25 out of the 636 health centres function as basic EmONC centres and only 58 out of the 115 hospitals function as comprehensive EmONC facilities. The majority of the facilities do not have adequate supplies, including important drugs like magnesium sulphate and oxytocin. The next step is to develop a joint work plan for 2009/10 with the Ministry of Health, WHO and UNICEF to come up with steps and activities towards report finalization, dissemination and use of data for planning.



### KEY PRIORITIES IN ETHIOPIA

- Improve access and utilization of quality EmONC
  - National EmONC Assessment
- Health Systems Strengthening
  - Human resources: Midwifery Programme
  - MSc programme for non-physician clinicians
  - Health Financial System
- Reproductive Health Commodity Security (RHCS)
- Sector-wide support through IHP+ and participation in MDG Performance Fund

Among the planned outputs, there will be a presentation of the needs assessment district by district, so that district health authorities have a clearer view of the needs at their level. The information gained from this needs assessment will contribute to national and district planning processes around EmONC service delivery, fistula programming and human resources for health. This is a significant contribution to the ongoing efforts of the Ethiopian Ministry of Health to scale up the coverage and quality of maternal health services in the country. The main priorities for Ethiopia are outlined in the text box on page 11.

## MALAWI

The inception mission in Malawi was carried out in July of 2008 with participation from UNFPA's country team and key partners in the region. Malawi's maternal mortality ratio remains one of the highest in the world at 807 deaths per 100,000 live births. And for every maternal death, 30 more women are left with serious disabilities as a consequence of pregnancy or delivery. A woman's risk of dying from complications associated with pregnancy or childbirth is very high in Malawi at 1 in 18. The unmet need for contraception in Malawi is 28 per cent and the contraceptive prevalence rate is 28 per cent (MDHS 2004).

A national EmONC assessment in 2005 showed that only 2 out of 94 health facilities targeted for delivering basic EmONC services were actually able to deliver this service. In response to these findings, and others from the assessment, Malawi developed a national road map for reducing maternal and neonatal mortality and morbidity. The number of health facilities providing basic EmONC has now increased to 67. This is due to a change in policy to allow enrolled nurse/midwives to provide basic EmONC, increased funding from development partners for training health workers in basic EmONC and renovation of health facilities to provide space for basic EmONC services. UNFPA has been a key partner in this process, and this work will be accelerated with support from the MHTF.

As in many African countries, the major challenge facing Malawi is one of human resources for health and in particular skilled midwives and others with midwifery skills. Recruitment and retention of staff has become a major challenge. Support was requested from the MHTF to assist in the implementation of the national road map, focusing on five main strategies: 1) strengthen the provision of family planning services, 2) promote skilled attendance at birth, 3) promote quality EmONC, 4) strengthen youth friendly health services, and 5) support community mobilization for maternal and newborn health. The community mobilization work will include the implementation of a community package which includes training of outreach workers and village health committees, establishing safe motherhood task forces to aid in the referral of pregnant women with complications, working with women groups to advocate for maternal health, involving men in maternal health, creating youth groups and training community based distributors of contraceptives.

## GUYANA

The inception mission to Guyana took place in November 2008. Major stakeholders came together to discuss Guyana's national strategy for the reduction of maternal mortality and morbidity. The discussion and analysis focused on targeting hard to reach rural populations. Guyana's maternal mortality ratio is estimated by the United Nations at 470, but thought to be significantly higher in the isolated hinterland rural regions. The lifetime risk of dying from pregnancy or childbirth is 1 in 90, and the contracep-

tive prevalence rate is 36 per cent. Guyana faces serious difficulties with the migration of midwives, and other health personnel, to more developed countries. This issue was discussed at length with the Minister of Health, who is committed to taking measures to reduce the brain drain by improving the quality of life and the working conditions of the workforce. To address this challenge, Guyana's proposal to the MHTF includes structural and functional support to midwifery schools, associations and training sites as well



as support for in-service EmONC training. The schools of midwifery will also receive support to modernize the knowledge and improve the quality of the teaching.

The analysis also revealed that most of the investments made by the government until now focused on the central referral hospital in Georgetown. The proposal to the Maternal Health Thematic Fund focuses on reaching isolated and vulnerable populations in the hinterland with family planning and obstetric services while building strong national commitment to maternal and reproductive health. In addition to a plan for a national EmONC needs assessment, there will be a strong focus on expanding access to sexual and reproductive health services for adolescents, decreasing adolescent pregnancy rates, preventing STIs and eliminating death and disability from unsafe abortion. A partnership with local non-governmental organizations will be established to help reach adolescents.

## BÉNIN

**B**énin has a high maternal mortality ratio of 840 deaths per 100,000 live births and a lifetime risk of death during pregnancy or childbirth of 1 in 20. The inception mission brought together key partners with members of the Ministry of Health to discuss existing initiatives and new strategies for reducing maternal mortality. One priority identified by the team was the need for an integrated and comprehensive communication and community mobilization strategy for Millennium Development Goal 5 to meet the need for family planning and improve reproductive and maternal health. The contraceptive prevalence rate (modern methods) is less than 10 per cent despite an unmet need for family planning of 27 per cent.

Bénin's proposal to the MHTF includes support for the repositioning of family planning through advocacy and outreach initiatives in the community and with Government leaders. The proposal also requests support for analyses of both EmONC and human resources for health in order to develop a comprehensive national strategy. Human resources will also be strengthened through participation in the Midwives Programme.

## DJIBOUTI

The inception mission to Djibouti took place in November of 2008. The Minister of Health fully supported the idea that strategic and multi-sectoral investments supported by strong political commitment could lead Djibouti to substantive reductions in maternal mortality in the coming seven years, and committed himself to this effort. Djibouti is a relatively small country that faces high rates of maternal mortality (MMR= 650) and a lifetime risk of 1 in 35. There are major shortages in health personnel with only 3 obstetrician-gynecologists and 60 midwives in the entire country. About 60 per cent of women give birth in a health facility, but poor quality of care and lack of health workers leads to large number of maternal deaths and cases of disability. There is also a large nomadic population which does not have access to care and is difficult to reach.

The analysis in Djibouti included meetings with key members of government and partner United Nations agencies. It was decided that a main priority for the country is to recruit more obstetrician-gynecologists to ensure 24 hours coverage in referral health facilities and to reinforce midwifery training. Support from the MHTF will also contribute to the recruitment of a midwife adviser through participation in the Midwives Programme and the building of a strong referral system to make sure women with pregnancy complications receive timely care. The country team has also requested funding for a study of women's perceptions in the community on sexual and reproductive health services to determine a strategy for community mobilization.

## SUDAN

The maternal mortality ratio in Sudan averages 1,107 deaths per 100,000 live births, with southern Sudan having the highest maternal mortality ratio in the world (2,037 deaths per 100,000 live births). The total fertility rate is high, close to 6 children per woman in northern Sudan and almost 7 children per woman in southern Sudan. The contraceptive prevalence rate is extremely low and only 57 per cent of births in northern Sudan and 5 per cent of births in southern Sudan are assisted by a skilled attendant. The country also faces specific humanitarian challenges in certain regions due to civil and political unrest. Infrastructure is very minimal in many states with limited road networks for transportation, making it very difficult for pregnant women to reach facilities and receive timely care.

The inception mission and analysis in Sudan highlighted the critical shortage of human resources for SRH and in particular midwives, the limited access to EmONC for the majority of pregnant women and poor access to family planning services. The unmet need for family planning is estimated to be 26 per cent. The training of professional midwives in Sudan is very limited relative to the needs, in particular in southern Sudan, and the poor geographic distribution of midwives leads to a very high proportion of women giving birth without a skilled attendant. In southern Sudan, all the training institutions that were once providing various levels of health training are now either not functioning optimally or not functioning at all. Except for the community midwives training program currently offered at Yei Medical Training School, there is no other formal/accredited reproductive health-training program in southern Sudan. A proposal for Sudan has been submitted to the Maternal Health Thematic Fund and has been favourably peer-reviewed.

## BURKINA FASO

**W**omen in Burkina Faso face a lifetime risk of dying of maternal causes of 1 in 22, due to very high maternal mortality (MMR = 700), very high fertility and unmet need for family planning. The contraceptive prevalence rate with modern methods is less than 10 per cent and the unmet need for family planning is 29 per cent. While the reported figure of skilled attendance at delivery is 38 per cent, the effective proportion of deliveries being offered the life-saving signal functions of EmONC is probably far lower, as not all health facilities provide the needed combination of health workers with the required skills to perform the seven signal functions and the necessary equipment, supplies and drugs to deliver the life-saving interventions.

Burkina Faso is in the process of strengthening its maternal health programming as part of its sector-wide approach and with support from UNFPA, UNICEF, WHO and modest resources from a grant from the Bill & Melinda Gates Foundation. Key priorities include meeting the unmet need for family planning, including post-partum family planning, strengthening EmONC and human resources for maternal health, especially in rural areas. A proposal for the MHTF has been finalized with the Ministry of Health and partners and is in the process of being submitted.



UN/  
r/Isaac

*Women and her child in Burkina Faso.*

## BURUNDI

**B**urundi was selected for support from the MHTF due to its very poor maternal health indicators and its commitment to address them. The inception mission is scheduled for May of 2009. Burundi has a maternal mortality ratio of 1,100 deaths per 100,000 live births and one of the highest lifetime risks of death from maternal causes (1 in 16). Again, this very high lifetime risk is due to the combination of extremely high maternal mortality ratio and high fertility despite high unmet need. The contraceptive prevalence rate is less than 10 per cent and the unmet need for family planning is close to 30 per cent. In Burundi, only one quarter of women gives birth with a skilled birth attendant and in many cases this skilled health worker does not have the needed maternal health commodities to deliver life-saving care.

UNFPA supported Burundi in developing its Memorandum of Understanding in the context of its Sector-Wide Approach to foster greater alignment of partners around the national health plan in the spirit of the Paris Declaration. A proposal to the MHTF should be finalized before the end of the second quarter of 2009.

# NATIONAL PLANNING FOR MATERNAL AND NEWBORN HEALTH

Support from the MHTF contributed to a review of the Maputo Plan of Action, and particularly national maternal and newborn health road maps in 30 African countries, including all of those supported as part of the first wave of the MHTF. The tool was adapted for non-African countries to assess their existing national plans for maternal and newborn health (MNH). The main objective of the study was to determine the stage of implementation of national MNH plans and therefore identify the gaps and priority areas for the upcoming years. This review is providing vital information for over half of the 60 high maternal mortality countries (MMR > 300 per 100,000 live births). The preliminary findings from the study revealed that a number of the countries are still in the development or finalization stage of their national plan. Support from the MHTF will assist countries in moving this planning process forward at the national and district levels. Details are included in Box 3.



UNFPA/Ken Opprann

*Woman with her child in Mozambique.*

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**Box 3: Selected Findings: Assessment of National Plans for Maternal and Newborn Health**

In September 2006 in Mozambique, African ministers of health endorsed the integrated Sexual Reproductive Health and Rights Plan of Action, known as the Maputo Plan of Action (MPoA), proposed by the African Union with UNFPA, International Planned Parenthood Federation and European Union support. The MPoA includes, as one of its key outputs, the development of Maternal and Newborn Health Road Maps.

A participative assessment of the progress made by African countries in developing their Maternal and Newborn Health Road Maps and operational plans was conducted by the UNFPA Technical Division and Regional Office for Africa, collaboratively with national MNH teams (Ministry of Health, UN and additional partners). The findings are currently in the final stages of analysis. The methodology provided the national MNH teams with an opportunity to self reflect, assess strengths and weaknesses and benefit from best practices of other countries. The findings will be used to assist countries in the development and the implementation of such plans.

Of the 30 African countries who responded, almost all had developed a national MNH Road Map. Countries varied in the stage of implementation: 25 countries have finalized the plan and 22 countries costed the plan as a key step towards implementation. Only 12 countries have developed an operational plan at district level.

The scale of financial resources already mobilized for the first phase of the national plan implementation is a challenge to most countries. Among the 30 countries responding, only 3 have mobilized more than half of the necessary funds to implement their plans.

Eleven components have been identified as main components of an MNH programme, namely, individual, family and community strategy; human resources strategy and plan; infrastructure, emergency obstetric and neonatal care strategy and plan; family planning, abortion/post-abortion care; youths and adolescent sexual reproductive health strategy; HIV/AIDS strategy and reproductive health commodity security strategy. Only four countries have included all the mentioned components in their Road Map. The most often missing elements of a comprehensive MNH plan are EmONC plan, infrastructure plan, human resources plan and strategy. Six countries have not included family planning activities as a component of their MNH plan.

The questionnaire proposed, at the end of the self-assessment process, that the country team formulate recommendations to the MoH and partners based on the findings of the review. A substantial number of countries have used this opportunity to formulate recommendations regarding the national MNH Road Map finalization, improvement and/or implementation.

# WORKING TOGETHER TO ACHIEVE MILLENNIUM DEVELOPMENT GOAL 5

## THE HEALTH 4 (H4)

**D**uring this first year of the MHTF, a great deal of effort was also put forth to foster joint maternal and newborn health support with other United Nations agencies. As a result, a joint statement was developed by UNFPA, UNICEF, WHO and The World Bank outlining a pledge by the four agencies to enhance support in 25 countries before the end of 2009 working towards all 60 high maternal mortality countries over the next five years. These four agencies are often referred to collectively as the H4. The Statement was released along with a more detailed technical document at the 25 September High Level Event on the Millennium Development Goals (See Annex 2: WHO-UNFPA-UNICEF-World Bank Joint Statement on Maternal and Newborn Health *Accelerating Efforts to Save the Lives of Women and Newborns* and Annex 3: WHO-UNFPA-UNICEF-World Bank Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care - 22 July 2008). A draft UN-MNH joint work plan has been submitted to the management of the four agencies for their consideration and feedback as to the way forward. The MHTF, a unique and specific funding mechanism for MNH, has an important role to play in the near future in contributing to the implementation of this joint workplan.

The four agencies are also working together in the area of MNH commodities to update essential lists of equipment, supplies and drugs, promote international standards for quality procurement, support national capacity building in supply chain management and provide international procurement and procurement services when needed and requested. This important work is advancing rapidly and should be completed during the second quarter of 2009.

## DELIVERING EMERGENCY OBSTETRIC AND NEWBORN CARE AT SCALE: A UNFPA, UNICEF AND COLUMBIA UNIVERSITY/AMDD ALLIANCE

**N**ational EmONC assessments are planned for all MHTF-supported countries as part of an alliance between UNFPA, UNICEF and Columbia University's Averting Maternal Death and Disability Program (AMDD). The heads of the three agencies signed a Memorandum of Understanding on 17 July 2008 to build a technical support network to strengthen regional and national capacity in the area of EmONC (see Annex 7). Training for master trainers and facilitators has started in Anglophone and Francophone Africa and in the Asia-Pacific Region, in collaboration with WHO and UNICEF, and planning for Latin America and the Caribbean Region has been initiated.

A tool for EmONC needs assessment has also been finalized in collaboration with UNICEF, WHO and Columbia University (AMDD), and is in the final stages of publication. The tool is comprised of the "Monitoring Emergency Obstetric Care: A Handbook" and the accompanying modules. This will guide the national EmONC needs assessments in countries



supported by the MHTF. The tools have been translated into French, and soon will also be translated in Spanish. The handbook is expected to be officially launched at the Africa regional meeting on Human Resources for Maternal Survival in Ethiopia in June 2009.

EmONC needs assessments are being completed in Ethiopia, Haiti and Cambodia and are being planned for the other countries. It is expected that over 20 countries during 2009 and 2010 will initiate these EmONC needs assessments to guide their maternal health service delivery and human resource planning and implementation as part of their national health plans.

As part of the process of providing maternal health tools to countries within a larger integrated package of sexual and reproductive health (SRH) resources, advisers in UNFPA's Technical Division have compiled situation analysis tools on sexual and reproductive health into a toolkit. As this work continues, we hope to develop one tool kit that encompasses key SRH tools to be used by countries, partners and UNFPA country offices.

## **IMPACT (UNIVERSITY OF ABERDEEN) COLLABORATION**

**D**iscussions are nearly completed to partner with the University of Aberdeen in critical activities of the MHTF, in particular in the area of national capacity strengthening for monitoring and evaluation. With funding from the MHTF, teams from UNFPA country offices will participate in extensive training courses, on monitoring and evaluating maternal health. These trainings will take place through regional institutions whose capacity will be developed so that they may continually replicate courses in the future and contribute to the network of regional institutions developed in support of national capacity development.

# UNFPA COORDINATION AND INTEGRATION

## INTERNAL

UNFPA's Maternal Health Thematic Fund and the Midwives Programme are now fully integrated in order to provide more coordinated support at the country and regional levels. The MHTF and the Midwives Programme receive integrated proposals from countries, allocate funds together and share one results framework for monitoring and reporting.

Similarly, UNFPA's Obstetric Fistula Thematic Fund and Campaign as well as the Global Programme on Reproductive Health Commodity Security (see Annex 1 for information on the latest Annual Reports) are planning to integrate with the MHTF to reduce the burden on the countries and ensure more seamless support for reproductive health as a whole. Thematic funding will be requested through one common proposal template that includes all aspects of sexual and reproductive health (commodities, human resources, etc.). The countries will also report on Thematic Funding through an integrated template that includes data for the MHTF, Midwives Programme, Obstetric Fistula Thematic Fund and Global Programme on Reproductive Health Commodity Security.

Internally, the MHTF process is steered by the Inter-Divisional Working Group on Maternal Health (IDWG-MH). The IDWG-MH is a coordinating body made up of members who represent UNFPA's regional offices and the various divisions at Headquarters, including the Resource Mobilization and Media Communications Branches, the Humanitarian Response Branch, the Commodity Security Branch and the Sexual and Reproductive Health Branch. The IDWG-MH meets to peer-review proposals from the countries and regions and to provide guidance and coordination of the activities of the MHTF. The group met nine times at the working level and once at the policy level in 2008. The working level team has been a great example of coordination around maternal health across the regional and Headquarters divisions. The Group acknowledged the changes in its composition over the year due to the regionalization process and the relocation of regional offices. Moving forward, the greater number of staff members in the region will bring to the group a better perspective on how activities supported by the MHTF are being implemented on the ground.



UNFPA/Sven Torfinn/Panos

*A midwife examining a pregnant woman in a UNFPA-supported clinic located in Darfur.*





As part of its commitment to universal access to reproductive health, UNFPA launched a global Campaign to End Fistula with partners in 2003 aiming to prevent and treat fistula, and to rehabilitate and empower women after treatment. The Campaign has grown from 12 countries to over 45 countries in Africa, Asia and the Arab States. The Campaign has helped to spotlight the need to reduce morbidity as well as mortality in order to improve maternal health. In addition, a focus on fistula has contributed to promoting equitable access to maternal health care that responds to women's needs.

Significant progress is being made toward this goal, as shown by some of the following results to date:

- At least 38 countries have completed an analysis of the situation regarding fistula prevention and treatment.
- More than 25 countries have integrated fistula in relevant national policies and plans.
- More than 12,000 women have received fistula treatment and care with support from UNFPA.<sup>3</sup>
- More than 2,000 professionals received training in fistula prevention, treatment and reintegration.
- 104 health facilities in 20 countries were supported to strengthen capacity to manage and treat fistula.
- The Campaign to End Fistula received an award of excellence for championing south-south collaboration from the United Nations Development Programme (UNDP).

The Campaign to End Fistula emphasizes coordination and partnership building. Global efforts to eliminate fistula are coordinated among partners via the international Obstetric Fistula Working Group, for which UNFPA serves as the Secretariat. Established in 2003, the group is comprised of approximately 25 institutional members including international and regional NGOs, universities, health facilities and United Nations agencies. While UNFPA and partners provide support, the Campaign emphasizes locally-driven solutions, south-south collaboration addressing communities' awareness of fistula and women's access to care, and building on existing capacities.

Now, the voices of women who have lived with fistula are joining the global call to urgently make maternal health care accessible and affordable for all. In recognition of the unique perspective fistula survivors lend to the maternal health dialogue, UNFPA sponsored the first-ever fistula advocate delegation to attend the Women Deliver Conference in 2007. Following the conference, countries engaged in the Campaign have also begun efforts to create platforms for women to dialogue at community and national levels.

The Campaign has made remarkable progress, but the needs are great. Ending fistula worldwide will demand political will, resources, and strengthened collaboration between governments, civil society and health professionals. Support for governments' efforts to improve maternal health, including the Campaign to End Fistula, can help bring the world closer to the day when safe and healthy childbirth is a reality for all women, not just the lucky few. See Annex 6 for details on the latest Annual Report.

<sup>1</sup> Wall, L. 2006. "Obstetric Vesicovaginal fistula as an international public-health problem." *Lancet* 368 (9542): 1201-1209.

<sup>2</sup> Abou Zahr, C (2003). "Global Burden of Maternal Death and Disability," *British Medical Bulletin* 67 (1).

<sup>3</sup> Treatment services supported by UNFPA may have also received support from governments and other partners.

# GLOBAL AND NATIONAL ADVOCACY AND POLICY DIALOGUE

In 2008, maternal health and Millennium Development Goal 5 gained momentum and moved up the international agenda. While just three years ago there was little talk about maternal health as a development priority, in 2008 the issue was discussed at major national, regional and international political events and has since been recognized as the MDG that has made the least amount of progress. It has become widely understood that unless reproductive health and the rights of women becomes a political and financial priority for donors and national governments, MDG5 will not be met and progress towards the other seven MDGs will falter.

With this recognition and understanding came intensified communications work. In 2008, the Maternal Health Thematic Fund, in partnership with multiple organizations and initiatives, supported advocacy and media outreach activities at the global level, supporting resource mobilization and building momentum around the need to improve maternal health.

UNFPA also engaged in a series of advocacy and communication initiatives to ensure that universal access to reproductive health was understood as a critical element to achieving MDG5 and reducing maternal mortality and morbidity. This was addressed in both political and public outreach. The MHTF supported a full-time communication and advocacy expert to coordinate activities for the year.

Activities for 2008 included:

- Ensuring that the High-Level Meeting at the United Nations on the MDGs addressed maternal health and highlighted MDG5. UNFPA and more than 100 governments, NGOs and international organizations participated in a special, exclusive side event on mothers and children. The High-Level meeting on the MDGs led to \$2 billion in pledges of support for MDGs 4 and 5.
- UNFPA and The White Ribbon Alliance for Safe Motherhood extended their global advocacy collaboration to include working in partnership at the national level in 13 countries including: Bangladesh, Burkina Faso, India, Indonesia, Malawi, Nepal, Pakistan, Rwanda, South Africa, Tanzania, Uganda, Yemen and Zambia.
- Tracking Progress in Maternal, Newborn & Child Survival, a report released at the 2008 Countdown to 2015 conference, revealed that few of the 68 developing countries that account for 97 per cent of maternal and child deaths worldwide are making fast enough progress to prevent maternal, infant and child deaths. The UNFPA-backed report offered a wake-up call to governments and others, with information on the latest trends in life-saving interventions to reduce maternal and child deaths.

There were also high profile media pieces that focused on maternal health issues. UNFPA worked closely with The Washington Post on a maternal health story out of Sierra Leone, which ran a front page story in the Sunday edition. With support from UNFPA, United Nations Television produced stories focusing on maternal health in Nepal and Haiti, which were distributed globally via UN in Action to over 50 broadcasters and transmitted on CNN International.

# RESOURCES AND FINANCIAL IMPLEMENTATION

**R**esources were provided through pooled contributions by donor governments to the MHTF. It is envisaged that the vast majority of the funding will go to countries, keeping a very lean team at Headquarters, while contributing to strengthen regional capacity and regional advocacy for MDG5.

The Maternal Health Thematic Fund received \$25 million in pledges and/or contributions for 2008 from the following donors: Austria, Finland, Ireland, Luxembourg, The Netherlands and Spain; included is a contribution from Sweden for the Midwifery Programme which is now fully integrated within the MHTF (Please see separate annual report of the Midwives Programme). The funding target for 2008 has thus been met. Sweden announced at the January 2009 UNFPA Executive Board that they would provide additional support. Active discussions with other key donors are underway.



UNFPA

*Executive Director, Thoraya Obaid and fistula recovery patients at the Women Deliver Conference in November 2007. The conference raised awareness for the fistula campaign as well as maternal health.*

# GOING FORWARD: PROSPECTS FOR 2009

Progress in the first wave countries is moving rapidly. Support is expected to be fully implemented in all 11 countries in the first half of 2009, to continue at least until 2011 and in all likelihood until 2015. Many additional country requests have been received from UNFPA's country and regional teams for support from the MHTF for 2009. Subject to funding, a second wave will be selected in the coming months, in the spirit of the target by the joint United Nations agencies to accelerate support in 25 countries by the end of 2009 on the way to providing enhanced support to all 60 high maternal mortality countries within five years.

As of February 2009, the list of countries recommended by their respective Regional Office to be included in the second wave, subject to sufficient funding, is as follows:

<b>Africa</b>	Chad, Congo (Brazzaville), Côte d'Ivoire, Liberia, Mauritania, Niger, Rwanda
<b>Asia and the Pacific</b>	Bangladesh, Lao PDR, Nepal, Pakistan

See Annex 4 for a full list of Maternal Health Thematic Fund countries in wave one and requested for wave two. Please note that the African Union is currently examining the issue of maternal mortality and is developing the Campaign to Accelerate Maternal Mortality Reduction in Africa (CARMMA). This may lead to an increase in the number of additional priority countries to be supported by the MHTF in Africa in 2009. This should be clarified with the Africa Regional Office in the second quarter of 2009.

In addition, requests have been received by the Regional Offices for support through the MHTF for their regional activities: the Latin America and Caribbean Office has submitted a proposal to cover a number of strategic activities as part of the Regional Task Force on Maternal Mortality Reduction. Activities for 2009 fall into the following three main areas: facilitating interagency cooperation and coordination to avert maternal death and disability, systemizing of existing information gathered through EmONC needs assessments conducted in countries in the region, and support to national and sub-regional advocacy strategies to strengthen and increase the financial sustainability needed to reach Millennium Development Goal 5.

Proposals from the Asia Pacific and the Africa Regions are under development and expected to undergo the peer-review process during the second quarter of 2009.

## CONCLUSION

The Maternal Health Thematic Fund represents a focused effort by UNFPA to accelerate progress towards Millennium Development Goal 5 in countries with the greatest reproductive and maternal health needs. This first year involved implementation of the Thematic Fund and development of an evidence-based and results-focused business plan. It included preparatory work and in-depth analysis in a first wave of countries to strategically plan activities to be carried out as part of the country programme and in line with existing national plans and strategies for maternal health as part of the full spectrum of reproductive health care. As we move forward in 2009, implementation will continue in the first wave, and once additional funding has been received, support for a second wave of countries will be initiated.

Far too many women and newborns continue to die from complications associated with pregnancy and childbirth in the developing world. Funding needed to improve maternal health in all of the high priority countries is around \$7 billion annually with an added \$1-2 billion for family planning.<sup>[3]</sup> The MHTF aims to raise a modest amount comparatively, but represents a strategic effort to remove obstacles contributing to high rates of maternal death and disability by working within existing country programmes and national strategies, thus avoiding the creation of parallel funding mechanisms and increased transaction costs to for the countries.

There is unprecedented international commitment to achieve Millennium Development Goal 5. As part of translating this commitment to action, the MHTF is operational and is beginning to achieve results in priority countries. It is said that maternal mortality is a litmus test for the functioning of the health system. The challenge is now to consolidate the work in the first wave of countries and to secure the required resources to expand the work to all 60 high maternal mortality countries over the next five years, as UNFPA's contribution to the Joint UN Accelerated Support to Countries in Maternal and Newborn Health and to an evolving global delivery framework for Millennium Development Goal 5.

Based on a solid review of the scientific evidence and the results of programmes in countries which have tackled maternal mortality, we believe that much progress can be accomplished between now and 2015, with a community outreach and health systems approach of scaling up family planning and skilled attendance at delivery and emergency obstetric care, so that every pregnancy is wanted and every birth is safe. We could then envisage, in a not too distant future, a world where maternal death has been eliminated as a public health problem and where the burden of suffering from maternal disabilities has been reduced considerably.

<sup>[3]</sup> *The Global Campaign for the Health MDGs. First Year Report, 2008.*

# ANNEX 1:

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For copies of the following documents, please visit our website at <http://www.unfpa.org/public/global/publications> or contact UNFPA's Information and External Relations Division through email at the following address: [publication@unfpa.org](mailto:publication@unfpa.org).

- Maternal Health Thematic Fund Business Plan
- Maternal Health Thematic Fund Annual Report 2008
- The Global Programme on Reproductive Health Commodity Security Annual Report 2008
- Midwives Programme Progress Report 2008
- The Campaign to End Fistula Annual Report 2008

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# **ANNEX 2: WHO-UNFPA-UNICEF WORLD BANK JOINT STATEMENT ON MATERNAL AND NEWBORN HEALTH**

## JOINT STATEMENT ON MATERNAL AND NEWBORN HEALTH

### Accelerating Efforts to Save the Lives of Women and Newborns

Today, **25 September 2008**, as world leaders gather for the High-Level Event on the Millennium Development Goals (MDGs), we jointly pledge to intensify our support to countries to achieve Millennium Development Goal 5 *To Improve Maternal Health* — the MDG showing the least progress.

During the next five years, we will enhance support to the countries with the highest maternal mortality. We will support countries in strengthening their health systems to achieve the two MDG 5 targets of reducing the maternal mortality ratio by 75 per cent and achieving universal access to reproductive health by 2015. Our joint efforts will also contribute to achieving MDG 4 *To Reduce Child Mortality*.

Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. And every year over one million newborns die within their first 24 hours of life for lack of quality care. Maternal mortality is the largest health inequity in the world; 99 per cent of maternal deaths occur in developing countries — half of them in Africa. A woman in Niger faces a 1 in 7 chance during her lifetime of dying of pregnancy-related causes, while a woman in Sweden has 1 chance in 17,400.

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted and every birth is safe.

We will work with governments and civil society to strengthen national capacity to:

- Conduct needs assessments and ensure that health plans are MDG-driven and performance-based;
- Cost national plans and rapidly mobilize required resources;
- Scale-up quality health services to ensure universal access to reproductive health, especially for family planning, skilled attendance at delivery and emergency obstetric and newborn care, ensuring linkages with HIV prevention and treatment;
- Address the urgent need for skilled health workers, particularly midwives;
- Address financial barriers to access, especially for the poorest;
- Tackle the root causes of maternal mortality and morbidity, including gender inequality, low access to education — especially for girls — child marriage and adolescent pregnancy;
- Strengthen monitoring and evaluation systems.

In the countdown to 2015, we call on Member States to accelerate efforts for achieving reproductive, maternal and newborn health. Together we can achieve Millennium Development Goals 4 and 5.



Margaret Chan  
Director General, WHO



Thoraya Ahmed Obaid  
Executive Director, UNFPA



Ann M. Veneman  
Executive Director, UNICEF



Joy Phumaphi  
Vice President Human Development, World Bank

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**ANNEX 3: WHO-UNFPA-UNICEF  
WORLD BANK JOINT COUNTRY SUPPORT  
FOR ACCELERATED IMPLEMENTATION OF  
MATERNAL AND NEWBORN CONTINUUM  
OF CARE - 22 JULY 2008**



## WHO-UNFPA-UNICEF-World Bank Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care 22 July 2008

### Objective

To harmonize approaches by UN agencies towards improving maternal and newborn health (MNH) at country level and jointly raise the necessary resources.

### Background

The year 2007 represented the mid-point for the Millennium Development Goals (MDGs). While there has been some progress in the health-related MDGs, MDG 5 is the one with the least progress.<sup>1,2</sup> It represents the greatest inequality in health and one that affects women, with a life-time risk of maternal death of one thousand times greater in parts of sub-Saharan Africa and Asia (as high as 1 in 7) than in some industrialized countries. Complications of pregnancy and childbirth leave 10-20 million women with physical and mental disabilities every year.

Maternal mortality has root causes in gender inequality, low access to education, especially for girls, early marriage, adolescent pregnancy, low access to sexual and reproductive health, including for adolescents, and other social determinants.

**Maternal mortality can be effectively reduced by addressing the above determinants and by ensuring universal access to a) family planning, b) skilled attendance at birth and c) basic and comprehensive emergency obstetric care.**

Maternal and newborn health is also intrinsically related to health programmes such as HIV and AIDS, in particular primary prevention and prevention of mother-to-child transmission, malaria prevention and treatment, nutrition and immunization.

Taking into consideration the comparative advantage, core expertise/experience, and collective strengths in MNH, WHO, UNFPA, UNICEF and The World Bank undertake to accelerate our joint support to countries to improve maternal and newborn survival by strengthening the continuum of care. The agencies will coordinate their support at country level guided by the national health plan and according to each agency's respective country-specific strengths and capacities. Support to these activities will be embedded within the strengthening of national health systems. The agencies will jointly contribute to **national capacity strengthening, building of sustainable national health systems and costing and financing of MNH national plans** whilst ensuring **national and global advocacy**.

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<sup>1</sup> Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. October 2007. Geneva. WHO. Africa and the Millennium Development Goals. United Nations. 2007 Update.

<http://www.un.org/millenniumgoals/docs/MDGafrika07.pdf>

<sup>2</sup> The Millennium Development Goals Report. United Nations. 2007.

[http://millenniumindicators.un.org/unsd/mdg/Resources/Static/Products/Progress2007/UNSD\\_MDG\\_Report\\_2007e.pdf](http://millenniumindicators.un.org/unsd/mdg/Resources/Static/Products/Progress2007/UNSD_MDG_Report_2007e.pdf)

## Core functions of the UN agencies based on their comparative advantage:

- **WHO:** policy, normative, research, monitoring & evaluation
- **UNFPA:** reproductive health commodity security, support to implementation, human resources for sexual and reproductive health including MNH, technical assistance on building M&E capacity
- **UNICEF:** financing, support to implementation, logistics & supplies, monitoring & evaluation
- **The World Bank:** health financing, inclusion of MNCH in national development frameworks, strategic planning, investment in inputs for health systems, including fiduciary systems and governance, taking successful programmes to scale

## Focal agencies

*Focal agencies – (or shared focal agencies) – have been identified for each component of the MNH continuum of care and related functions to ensure and facilitate coordinated, optimal support to countries and clear accountability (Table 1). While these provide global guidance, the work of each agency at country level will be determined by existing situations in countries where agency strengths and experience differ as well as by arrangements such as sector-wide approaches (SWAps), or other sector plans, within the context of support to the national health plan/compacts.*

Being a focal agency would imply accountability at global and national level for facilitating and ensuring coordinated optimal support to countries for scale-up of the agreed programme components including:

- ensuring knowledge of the situation, inventory (mapping) of existing activities and resources, including human resources;
- ensuring support for the inclusion of MNH continuum of care concept in the development of detailed national plans/compacts and district plans;
- ensuring availability of technical support (tools and people);
- identifying relevant partners and supporting government coordination;
- supporting resource mobilization; and
- ensuring that a strong monitoring and evaluation system and the required skills are in place and used.

Being a focal agency does not mean that other agencies are not involved; on the contrary, the focal agency should help coordinate a strong UN response in support of the national health plan and national leadership, and foster the involvement of other key partners. The government should always lead and coordinate the process.

**Table 1 Proposed focal agency per building blocks, i.e. core areas within the continuum of care**

Area	Focal agency	Partners
<b>Family Planning</b>	UNFPA, WHO	UNICEF, WB
<b>Antenatal Care</b>	UNICEF, WHO	UNFPA, WB
<b>Skilled Attendance at Birth</b>	WHO, UNFPA	UNICEF, WB
<b>B-EmONC<sup>3</sup></b>	UNFPA, UNICEF	WHO, WB
<b>C-EmONC<sup>4</sup></b>	WHO, UNFPA	UNICEF, WB
<b>Post-partum</b>	WHO, UNFPA	UNICEF, WB
<b>Newborn care</b>	WHO, UNICEF	UNFPA, WB
<b>Maternal and Neonatal Nutrition</b>	UNICEF, WHO, WB ( for maternal nutrition)	UNFPA

<sup>3</sup> B-EmONC Basic Emergency Obstetric and Newborn Care

<sup>4</sup> C-EmONC Comprehensive Emergency Obstetric and Newborn Care

Table 2 lists additional issues and functions to be considered for maternal and newborn health programming.

**Table 2: Focal and partner UN agencies in additional areas of MNH work**

Area	Focal Agency	Partners
Girls education	UNICEF	UNFPA, WB
Gender/culture/male involvement	UNFPA, UNICEF	WHO, WB
Gender-based violence	UNFPA, UNICEF	WHO
Adolescent sexual reproductive health - young people	UNFPA, UNICEF, WHO	WB
Communication for development	UNFPA, UNICEF	WHO, WB
Obstetric fistula	UNFPA	WHO
Prevention of unsafe abortion/ post-abortion care	WHO	UNFPA
Female genital mutilation	UNFPA, UNICEF, WHO	WB
MNH in humanitarian situations	UNFPA, UNICEF, WHO	WB
Sexually transmitted infections	WHO	UNFPA, UNICEF
HIV/AIDS and integration with family planning	As per <i>UNAIDS Technical Support Division of Labour</i>	
Pre- and in-service training of human resources for MNH	WHO, UNFPA	UNICEF, WB
Regulation/legislation for human resources for health	WHO	UNFPA, UNICEF, WB
Essential drug list	WHO	UNFPA, UNICEF
Road maps' development and implementation	WHO, UNFPA, WB	UNICEF

## ANNEX 4: LIST OF MATERNAL HEALTH THEMATIC FUND COUNTRIES - 11 WAVE ONE COUNTRIES AND 11 REQUESTS (TO DATE) FOR WAVE TWO

Wave One Countries	MMR (maternal deaths per 100,000 live births)	Lifetime Risk 1 in:
<b>Africa Region</b>		
Bénin	840	20
Burkina Faso	700	22
Burundi	1100	16
Ethiopia	720	27
Madagascar	510	38
Malawi	1100	18
<b>Asia Pacific Region</b>		
Cambodia	540	48
<b>Arab States Region</b>		
Djibouti	650	35
Sudan	450	53
<b>Latin America and Caribbean Region</b>		
Guyana	470	90
Haiti	670	44
<b>Wave Two Countries</b>		
<b>Africa Region</b>		
Chad	1500	11
Liberia	1200	12
Rwanda	1300	16
Congo (Brazzaville)	740	22
Côte d'Ivoire	810	27
Niger	1800	7
Mauritania	820	22
<b>Asia Pacific Region</b>		
Nepal	830	31
Lao PDR	660	33
Bangladesh	570	51
Pakistan	320	74

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**ANNEX 5: MEMORANDUM OF UNDERSTANDING  
UNFPA, UNICEF AND COLUMBIA UNIVERSITY'S  
AVERTING MATERNAL DEATH  
AND DISABILITY PROGRAM**



Columbia University  
MAILMAN SCHOOL  
OF PUBLIC HEALTH



## MEMORANDUM OF UNDERSTANDING

### **Contributing to Millennium Development Goal 5 to Improve Maternal Health Delivering Emergency Obstetric and Newborn Care at Scale: A UNFPA, UNICEF and Mailman School of Public Health/AMDD Alliance to develop technical support capacity in the countries and regions**

- BETWEEN:** UNFPA, the United Nations Population Fund (“UNFPA”) having its headquarters office at 220 East 42<sup>nd</sup> Street, New York, New York, 10017, USA
- AND:** UNICEF, the United Nations Children’s Fund (“UNICEF”), having its headquarters office at 3 UN Plaza, New York, New York, 10017, USA
- AND:** **The Trustees of Columbia University in the City of New York**, specifically the Averting Maternal Death and Disability Program (“AMDD”) in the Department of Population and Family Health, Mailman School of Public Health (“Mailman School”), having its office at Columbia University, 60 Haven Avenue, Suite B3, New York, New York, 10032, USA

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**THIS MEMORANDUM OF UNDERSTANDING** (this “MoU”) is dated 17th of July 2008 and is effective as of the same date. This MoU is entered into between UNFPA, UNICEF and the Mailman School/AMDD (“the Alliance”);

**WHEREAS**, UNFPA works with governments, civil society organizations and other partners worldwide to advance people’s access to reproductive health, promoting the right of every woman, man and child to enjoy a life of health and equal opportunity, and is guided by the Programme of Action of the 1994 International Conference on Population and Development;

**WHEREAS**, UNICEF works with governments, civil society organizations and other partners worldwide to advance children’s rights to survival, protection, development and participation, and is guided by the Convention on the Rights of the Child;

**WHEREAS**, the Mailman School of Public Health's AMDD program has expertise in Emergency Obstetric and Newborn Care (EmONC) and works with multi- and bi-lateral agencies, governmental and nongovernmental organizations, research institutions, community groups and the private sector to improve lives worldwide through research and programs in public health, including the reduction of maternal and newborn mortality;

**WHEREAS**, UNFPA and UNICEF are ready to play a key role in supporting countries to reach Millennium Development Goal 5 to Improve Maternal Health (MDG5) including its two targets and specifically for EmONC within a joint UN approach; and UNFPA and UNICEF are both committed to assist governments as they implement their national health plans, and AMDD shares that commitment;

**WHEREAS**, UNFPA, UNICEF and AMDD, reflecting their shared commitment to women and their families, now wish to develop a strengthened relationship to save maternal and newborn lives by developing technical support and expanded programming responses to reduce maternal and newborn mortality while strengthening health systems and building capacity.

**NOW THEREFORE**, UNFPA, UNICEF and AMDD are entering into this Alliance, guided by this MoU, to strengthen their relationship and their shared commitment to reduce maternal and newborn mortality through their support to country-led processes aimed at improving health services and strengthening health systems to meet UN Millennium Goal 5, and to contribute to MDG4.

## **1. Background and Purpose of the Alliance**

UNFPA, UNICEF and AMDD have been working collaboratively since 1999 to help countries move forward on their national health plans. UNICEF received AMDD funding and technical support for large country projects in Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka as part of UNICEF's Women's Right to Life and Health program. In Africa, AMDD provided funding and technical support to UNICEF for needs assessments in Angola, Benin, Chad, Guinea, Mali, Malawi, Namibia and Uganda as the first steps in improving emergency obstetric and newborn care. UNFPA received AMDD funding and technical support for large field projects in four countries: Morocco, India (State of Rajasthan), Mozambique and Nicaragua as part of UNFPA's Making Safe Motherhood a Reality program. In addition, AMDD-supported needs assessments were initiated by UNFPA in multiple countries in West Africa and Central America.

Building upon our past collaborative work, the three parties propose to build an Emergency Obstetric and Newborn Care Technical Support Network of individuals and institutions at national and regional level. Through this Alliance, UNFPA, UNICEF and AMDD will jointly improve technical capacity and programming responses for the reduction of maternal and newborn mortality worldwide in line with the UN Millennium Goal targets, the new global architecture of funding for health and development, and countries' strategic plans and health system roadmaps. This Alliance puts a premium on technical coordination aimed at facilitating country ownership and leadership, and will have important collateral benefits for the UN coordination agenda at local, regional and global levels. With capacity development as the driving goal, we anticipate focusing first on 60-75 high maternal and newborn mortality countries declared as priorities by the UNFPA Maternal Health Thematic Fund, the UNICEF Catalytic Initiative to Save a Million Lives, and the International Health Partnership Plus.

It is envisaged that this Alliance will foster the development of a larger consortium – a network of regional institutions, academia, private sector and bilateral partners to further enhance the level of effort towards MDG5, thus also contributing to MDG4.

There is widespread commitment to the UN Millennium Development Goals, as well as a new coherence in the global health financing architecture, potentially backed by unprecedented levels of financial support for countries to implement national plans to meet the UN Millennium Development Goals 4 and 5. Yet, even in this favorable global environment, capacity within countries to implement EmONC at scale remains woefully inadequate. To develop within countries this kind of systemic capacity itself requires a level of technical support that is not now available. That technical support must be locally grounded and politically savvy, gender- and rights-sensitive, evidence-based, problem-solving and outcome-oriented, EmONC-specific yet health systems-based, and closely linked with national and health sector processes. Creating the platform and deepening the capacity within the regions to deliver such technical support is the aim of the Alliance.

The value of this partnership lies in combining complementary strengths of the three organizations to achieve greater impact and synergy than when operating separately. The partnership will actively support country-led processes that include aligning behind national strategies and plans to achieve the goals of universal access to Emergency Obstetric and Newborn Care and will support and contribute to the achievement of the UN Millennium Development Goals 4 and 5. A partnership approach implies collaboration based on comparative advantages and resources in-country during all phases of the partnership, including during assessment, identification of expected results, strategic planning and programme design, and support of implementation, monitoring and evaluation in-line with country-led processes. For maximum success, this partnership will encourage and plan for open and ongoing communication at all levels that includes harmonizing with existing coordination processes at the country level and will align activities with agreed ongoing and planned country assessments and monitoring activities.

## **2. The Work of the Alliance**

The Alliance will respond in a coherent and coordinated manner to expressed country needs and requests for technical support on Emergency Obstetric and Newborn Care within the broader framework of national Maternal and Newborn Health (MNH) plans. Our aim is to develop a cross-country network that will advance the maternal and newborn health movement to improve health outcomes, engaging in a health systems development approach. The job of the Alliance is to identify national individuals and institutions to work with us in creating a network to strengthen capacity for consistent, high-quality technical support in EmONC and connected to maternal and newborn health and the continuum of care for women and children. We anticipate expanding expertise on multiple areas of health systems development needed to deliver EmONC at scale including, but not limited to, needs assessments, human resources planning including updating skills-based curricula and planning for quality scale-up of health workforce for MNH, implementation of home-to-hospital continuum of care, costing, governance and accountability within a framework of a human rights approach. The competencies we will develop in countries will support and be integrated into those countries' health and development plans. A longer term goal is to strengthen the capacity for delivering EmONC in the regions. Our work will be coordinated with and support UN and bi-lateral initiatives as well as the aid architecture articulated in the Paris Declaration on Aid Effectiveness.

## **3. Resources**

The amount of resources to be mobilized and managed by UNICEF, UNFPA and AMDD will be specified in separate project cooperation agreements around specific activities. The scope of these activities will be dependent on availability of resources.

We estimate that the activities described in this MoU will require major funding in the order of several tens of million dollars per year to provide support to the 60-75 high maternal and newborn mortality countries in-line with national processes. The vast majority of funds mobilized will be spent at the country level, strengthening the network, implementing technical support, building capacity, contributing to the development and dissemination of practical guidelines and other tools, documenting and sharing lessons learned in-line with country-led processes.

UNFPA and UNICEF will use some portion of the funds mobilized to strengthen the technical capacity within key UN offices at country and regional level. AMDD will use some portion of its mobilized funds to build the network of individuals and institutions in the regions and to design, adapt and/or implement tools and methodologies needed for developing systemic capacity in countries to implement EmONC.

#### 4. Obligations

The Parties agree and understand that this MoU shall not create or give rise to any legally binding obligations upon UNFPA, UNICEF and AMDD in the absence of a separate specific written agreement signed on behalf of each of the Parties.

#### 5. Term and Termination

This MoU will become effective once UNFPA, UNICEF and AMDD sign it. It will continue until 31 December 2011 with a view to a potential extension to 31 December 2015. However, any of the Parties may withdraw from this MoU (and terminate this MoU) at any time prior to the above date by informing the other Parties of its withdrawal, with written notice of three months of any such termination.

Signed in New York, this 17th day of July 2008



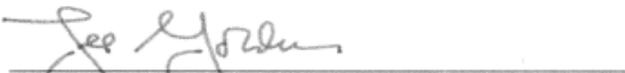
Thoraya Ahmed Obaid  
Executive Director, UNFPA



Ann M. Veneman  
Executive Director, UNICEF



Linda P. Fried, MD, MPH  
Dean and DeLamar Professor of Public Health  
Mailman School of Public Health  
Senior Vice President, Columbia University Medical Center  
Columbia University



Lee Goldman, MD, MPH  
Executive Vice President for Health and Biomedical Sciences  
Dean of the Faculties of Health Sciences and Medicine  
Columbia University