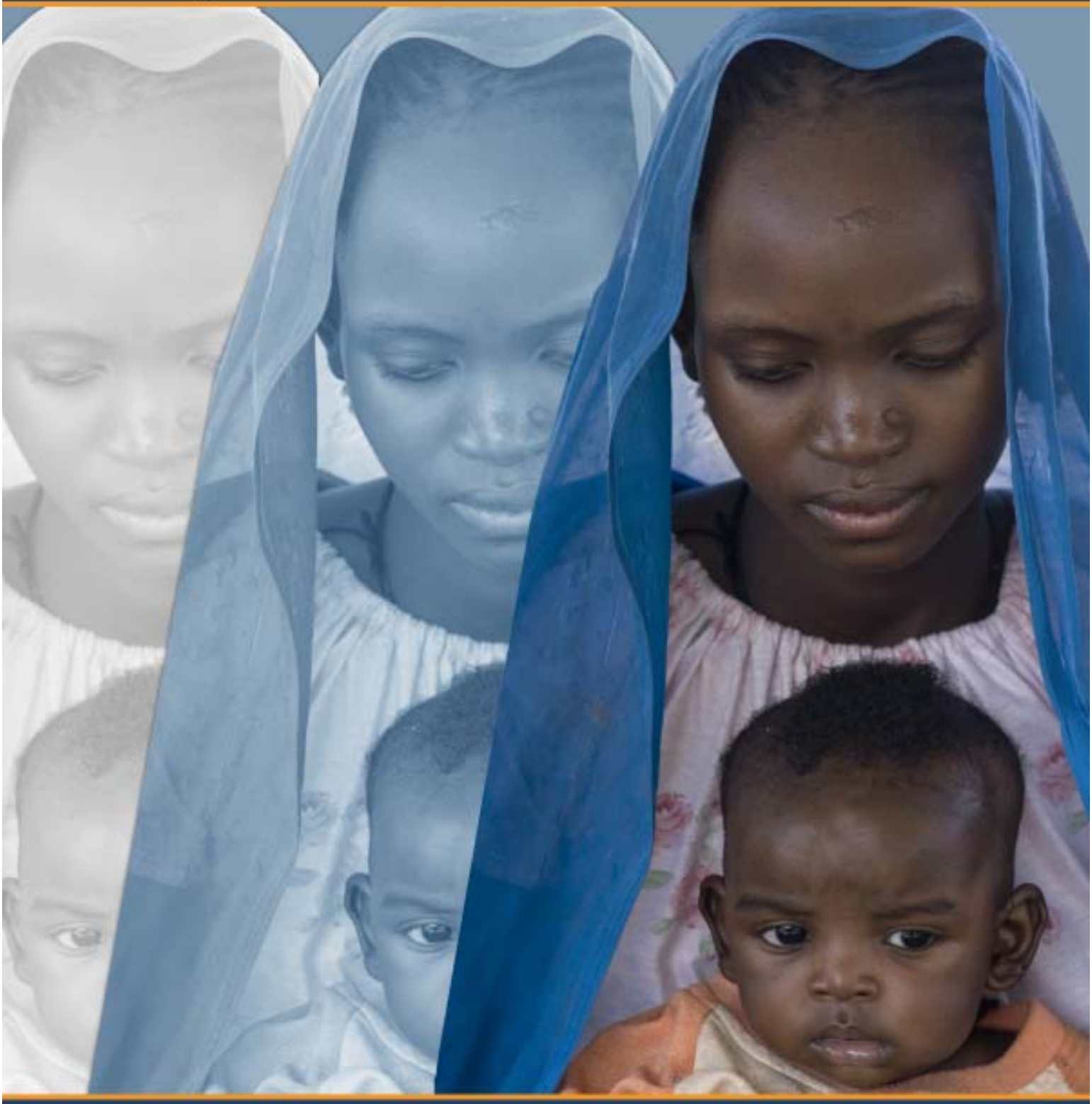
UNFPA

The Maternal Health Thematic Fund - Business Plan 2008 - 2011

UNFPA's Contribution to the Joint United Nations Accelerated Support to Countries in Maternal and Newborn Health



Accelerating Progress Towards Millennium Development Goal 5

No Woman Should Die Giving Life

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 for lack of quality care. Maternal mortality is the largest health inequity in the world, with 99 per cent of deaths occurring in developing countries–half of them in Africa. A woman in Niger faces a 1 in 7 risk of dying during her lifetime from pregnancy-related causes, while a woman in Sweden has a risk of 1 in 17,400, a greater than one thousand-fold difference. No other health indicator illustrates as starkly the global disparities in human development.

Though maternal mortality and morbidity 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 two 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 mortality and morbidity can be achieved by ensuring:

1) Access to family planning
2) A skilled health professional present at every delivery
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 sociocultural barriers will allow universal access to reproductive health and lead to a dramatic reduction in the number of maternal deaths.

On September 25th 2008, as world leaders gathered for the High-Level Event on the Millennium Development Goals (MDGs), the heads of the World Health Organization (WHO), the United Nations Population Fund (UNFPA),the United Nations Children Fund (UNICEF) and the Vice-President of Human Development of the World Bank issued a Joint Statement on Maternal and Newborn Health – Accelerating Efforts to Save the Lives of Women and Newborns (see Annex 2). The leaders jointly pledged to intensify their support to countries to achieve Millennium Development Goal 5, To Improve Maternal Health, and 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.

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.

As part of this effort, UNFPA, through the Maternal Health Thematic Fund (MHTF), aims to boost progress towards reducing maternal mortality and morbidity by supporting countries in working with civil society, the United Nations and other key partners to implement and scale up effective maternal and newborn health interventions as part of performance-driven national health plans and systems.

UNFPA aims to raise $500 million over four years for the MHTF, which will help save women's lives and prevent maternal morbidity such as obstetric fistula, one of the most devastating complications of childbirth. While this amount represents less than 2 per cent of the $7-8 billion needed annually to improve maternal and newborn health, it is a significant effort intended to be catalytic in leveraging resources for maternal and newborn health services.

One of the fundamental principles underpinning the work will be country-owned and country-driven development and support to the one national health plan. The specific outputs and activities supported by the MHTF in each country will be identified by the government through a consultative process with key partners and stakeholders and in close coordination with UNFPA's Global Programme on Reproductive Health Commodity Security and the Campaign to End Fistula.

In collaboration with government and key partners the MHTF will support:

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 EmONC
3. National health plans focus on SRH, especially family planning and EmONC with strong RH/HIV linkages to achieve the health MDGs
4. National responses to the human resource crisis in MNH, 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 MDG5 from government and donors

A detailed results framework is presented, anchored to MDG5 targets and indicators and to UNFPA's Strategic Plan 2008-2011. This includes the key outputs of UNFPA's Midwifery Programme, now a central component of the MHTF.

The MHTF Results Framework is linked to two other key UNFPA programmes and their respective results frameworks:

- The Global Programme on Reproductive Health Commodity Security, UNFPA, 2008
- The Campaign to End Fistula, Global Programme Proposal; Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010, UNFPA, 2006

UNFPA is currently examining how best to integrate the work of its three health thematic funds—Maternal Health, Fistula, and the Global Programme on Reproductive Health Commodity Security. The results framework for the MHTF is closely linked to those of the other two thematic funds. While maintaining the focus on specific results, it is envisaged that the thematic funds will move towards a joint country application, annual work-planning and reporting process in 2009.

Resources required for the MHTF are estimated at $25M, $72M, $138M and $269M each year from 2008 to 2011 respectively, for a total of $504M over the period. At the time of this writing in early 2009, the MHTF was in the process of supporting 11 countries, and had raised a total of $25M includ-

ing the resources for the Midwifery Programme.

A management structure and processes for the MHTF are presented, based on UNFPA thematic fund guidelines and closely coordinated with the other thematic funds, all housed within its Technical Division. A Maternal Health Inter-Divisional Working Group ensures strong representation from regional offices and other key units and meets regularly via teleconferencing.

The country-specific UNFPA outputs, activities and indicators will be prepared with the ministries of health (MoH) in close consultation with WHO, UNICEF, the World Bank and other key partners.

At the global level, the work of UNFPA, including the work supported by its thematic funds, will be closely coordinated with WHO, UNICEF and the World Bank through the UN-MNH Joint Support to Countries.

A consolidated annual report will be prepared with overall and country-specific results. This will also include financial reporting on income and on the use of resources.

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, in a not too distant future, a world where maternal mortality has been eliminated as a public health problem and where the burden of suffering from maternal morbidity has been reduced considerably.

List of Abbreviations and Acronyms

AMDD	Averting Maternal Death and Disability Program – Columbia University
AWP	Annual work plan
EmONC	Emergency obstetric and newborn care
FP	Family planning
GAVI	Global Alliance for Vaccines and Immunization
IHP+	International Health Partnership
HMIS	Health management information system
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
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
MVA	Manual vacuum aspiration
ODA	Official Development Assistance
OFWG	Obstetric Fistula Working Group
PMNCH	Partnership for Maternal Newborn and Child Health
PMTCT	Prevention of mother-to-child transmission (for HIV)
RHCS	Reproductive health commodity security
Sida	Swedish international development agency
SRH	Sexual and reproductive health
SWAp	Sector-wide approach
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VCT	Voluntary counselling and testing (for HIV)
WHO	World Health Organization

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Background and Strategic Vision

"Too many women die during pregnancy and childbirth because their right to sexual and reproductive health is denied."

– Ban Ki-Moon,
United nations Secretary-General
November 2007

1. The Goal, Vision and Mandate

Together as a global community, we have committed ourselves to achieve the fifth Millennium Development Goal (MDG)–*To Improve Maternal Health*–and to reduce the maternal mortality ratio (MMR) by three quarters by 2015 from a 1990 baseline. This goal was further strengthened in 2007 by the addition of a new target: *Achieve, by 2015, universal access to reproductive health*, enshrining in the Millennium Development Goal framework what had been agreed to by Member States at the International Conference on Population and Development (Box 1).

Making rapid progress towards this goal over the coming years will enable us to envision a world where maternal mortality has been eliminated as a public health problem and where women will enjoy their reproductive rights. As seen with so many public health successes, rapid progress can only be achieved when the global community unites under one common vision and strategy. Such a vision was recently announced by the Secretary-General for the elimination of malaria mortality. The same can be done for maternal health. The time is now to muster all of the world's creative energies to address maternal mortality, the greatest health inequity in the world.

We have an in-depth understanding of the problem and its causes. Progress has been made in well over 100 countries by strengthening national health systems to ensure near universal access to highly cost-effective maternal health interventions. With strong political commitment and improved management of health systems, similar progress can be made in even the world's poorest countries.

There is now unprecedented international commitment to make maternal health a global priority. The recent Women Deliver and Countdown to 2015 conferences reaffirmed this international mandate, as well as the need for rapid progress to reach the MDG5 targets. On 22 July 2008, the heads of WHO, UNICEF, UNFPA and the Vice President of Human Development of the World Bank pledged to accelerate joint support to all high maternal mortality countries. On 25 September they followed up on this pledge and issued a Joint Statement on Mater-

Box 1. Millennium Development Goal 5 [1]

Targets and Indicators

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

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

nal and Newborn Health during a high level MDG event (see Annex 2). This United Nations joint programme will provide enhanced support to 25 countries before the end of 2009 and all 60 high maternal mortality countries within five years.

Why a Thematic Fund for Maternal Health?

MDG5 may well be the most challenging Millennium Development Goal to achieve. The link between progress towards MDG5, newborn survival and child health (MDG4), and poverty reduction (MDG1) is inextricable. Improving maternal health is an urgent mandate that requires focused attention and support to save the lives of women, newborns and children.

In line with the UNFPA mission (Box 2) and Strategic Plan (2008-2011), the Executive Director announced the creation of a Maternal Health Thematic Fund (MHTF) at the Executive Board in September 2007 as part of a much needed global movement. The MHTF, focusing on 60 high maternal mortality countries, will complement UNFPA's core resources which are used to cover 140 programme countries and its entire mandate (population and development, gender and the whole of reproductive health).

Designed as a pro-poor, performance-based and MDG-driven mechanism, the MHTF will provide more focused capacity development, technical assistance, financial resources and life-saving equipment, supplies and drugs to those countries in greatest need, and thus further contribute to achieving national results.

Such funding, in support of national health plans and integrated within UNFPA's country programmes rather than as a separate funding mechanism, may circumvent the need for a multitude of parallel projects, and therefore reduce transaction costs for all concerned: donors, UNFPA, and most importantly, countries.

UNFPA foresees raising $500 million over the four-year period from 2008 to 2011 for the MHTF. While this is not an insignificant sum, it represents only two per cent of the funding required to achieve MDG5. WHO estimates that at least $6 billion a year will be needed to improve maternal health with an added $1.5 billion annually to meet the unmet need for family planning. Therefore, the MHTF is intended to be catalytic in leveraging major MDG5 resources by strengthening the capacity of national health systems to achieve results towards reducing maternal mortality and morbidity. MDG5 will only be achieved with both a major effort by high maternal mortality countries, including the allocation of 15 per cent of their national budget to health, and a significant increase in donor funding for maternal and newborn health and health system strengthening. As maternal health is a litmus test for the functioning of a health system, maternal health programmes should be a priority entry point for health system strengthening in the context of primary health care for every district and every community.

Box 2. UNFPA's Mission

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

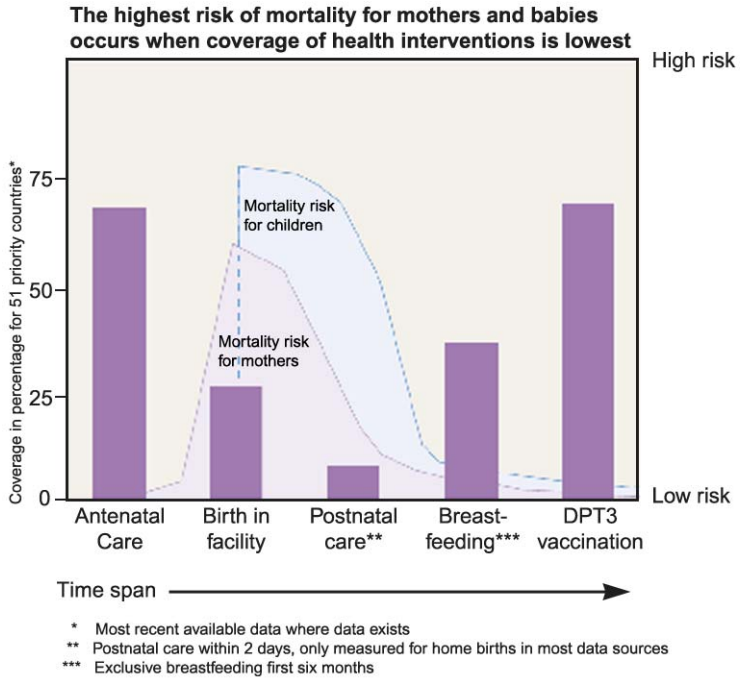
2. Challenges

Maternal Mortality: the greatest health inequality in the world

Maternal mortality represents the greatest health inequity in the world. No other health indicator as starkly illustrates global disparities in human development. Each year more than 500,000 women die during pregnancy or childbirth–one every minute. Nearly all of these deaths occur in developing countries with a greater than one thousand-fold difference in lifetime risk between parts of Africa and more industrialized countries. A woman in Niger has a 1 in 7 risk of dying from maternal causes as compared to a 1 in 17,400 risk for a woman in Sweden. Half of the maternal deaths that occur each year are in Africa–a continent which represents 11 per cent of the world's population.[2] It is no wonder that maternal and newborn mortality have remained so high when the time around delivery is such

[2] *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. October 2007. Geneva. WHO.*

Box 3. Risk of Mortality and Coverage



* Most recent available data where data exists
** Postnatal care within 2 days, only measured for home births in most data sources
*** Exclusive breastfeeding first six months

Source: The Global Campaign for the Health Millennium Development Goals. First year report 2008. Published by the Office of the Prime Minister of Norway, Oslo, September 2008.

The graph shows estimates of care coverage for the 51 most indebted countries along a continuum from pregnancy through to birth and the care of the child through newborn care, breastfeeding and immunisation. Superimposed is an illustrative diagram of the risk of mortality for mothers and children loosely based on Demographic and Health surveys and selected studies. The diagram shows that health care is accessed least where the risks are highest for women and their babies–at the time of birth.

a risky period for both mother and newborn and when coverage of health interventions has remained so low (Box 3).

Though maternal mortality and morbidity 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 MMR. During the same time period MMR in sub-Saharan Africa decreased a mere two per cent.[3]

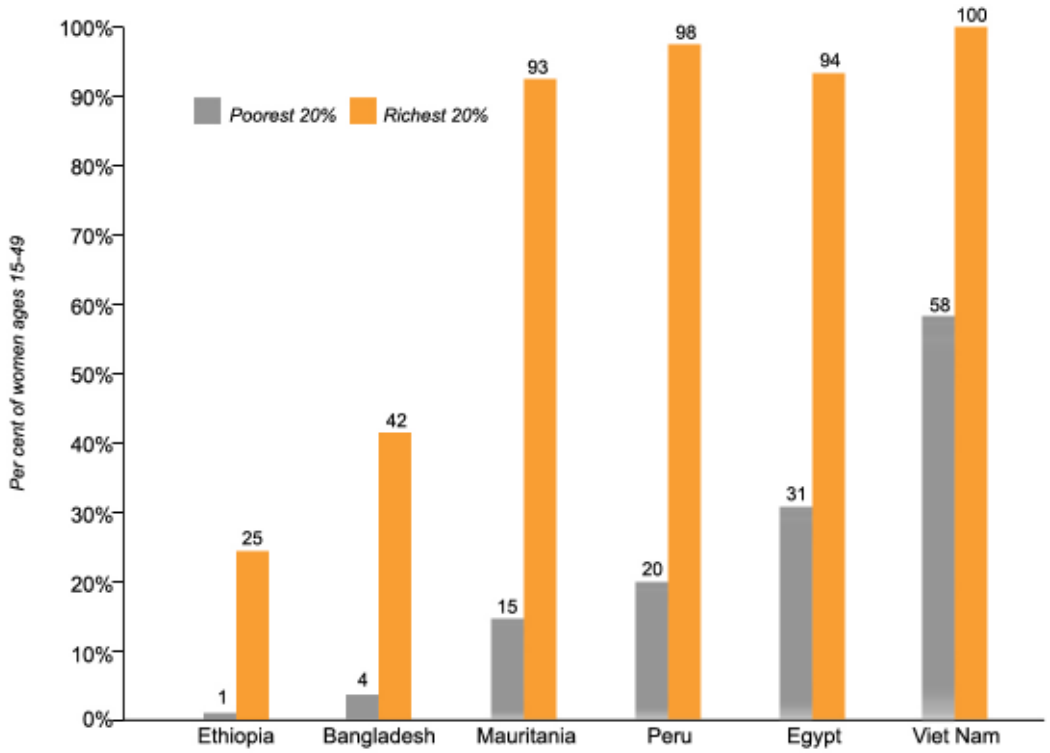
Poor women often lack access to the life saving interventions provided by skilled health personnel (emergency obstetric and newborn care). Figure 1 shows the tremendous difference in the proportion of births attended by skilled personnel among the poorest and richest wealth quintiles in six developing countries. In countries such as Ethiopia, Bangladesh and Mauritania the proportion of women giving birth with a skilled attendant in the highest wealth quintiles is between 7 and 25 times greater compared to those in the poorest wealth quintiles.[4]

As can be seen in Figure 2, women in the poorest quintile may have more than double the risk of maternal death when compared to the wealthiest quintile.[5]

For each woman who dies during pregnancy or delivery, there are many more who suffer complications resulting in disability. An estimated two million women and girls around the world are living with obstetric fistula, a devastating, and potentially lifelong injury, caused by prolonged, obstructed labour.[6] When mothers die or face serious illness, their children suffer; over one million newborns and children die each year because of poor maternal and neonatal health services.[7]

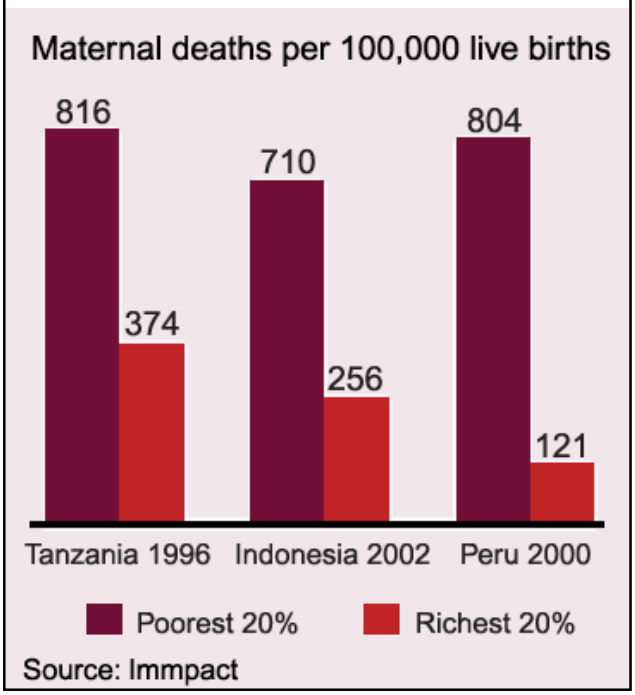
[1] *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World Bank. October 2007. Geneva. WHO.*
[2] *Round II Country Reports on Health, Nutrition, and Population Conditions Among the Poor and the Better-Off in 56 Countries. 2004. Washington, D.C. the World Bank.*
[5] *Measuring Maternal Mortality. Challenges, Solutions, and Next Steps. Impact. Population Reference Bureau. February 2007. http://www.prb.org/pdf07/MeasuringMaternalMortality.pdf. Accessed 4 June 2008.*
[6] *Murray C and Lopez A (1998). Health Dimensions of Sex and Reproduction. Geneva. WHO.*
[7] *State of the World's Children 2008: Child Survival. December 2007. UNICEF.*

FIGURE 1. BIRTHS ATTENDED BY SKILLED PERSONNEL* AMONG THE POOREST AND RICHEST WOMEN



* Defined to include a doctor, nurse or trained midwife.
Source: World Bank, 2004, Round II Country Reports on Health, Nutrition, and Population Conditions Among the Poor and the Better-Off in 56 Countries.

FIGURE 2. MATERNAL DEATHS BY SELECTED WEALTH QUINTILES



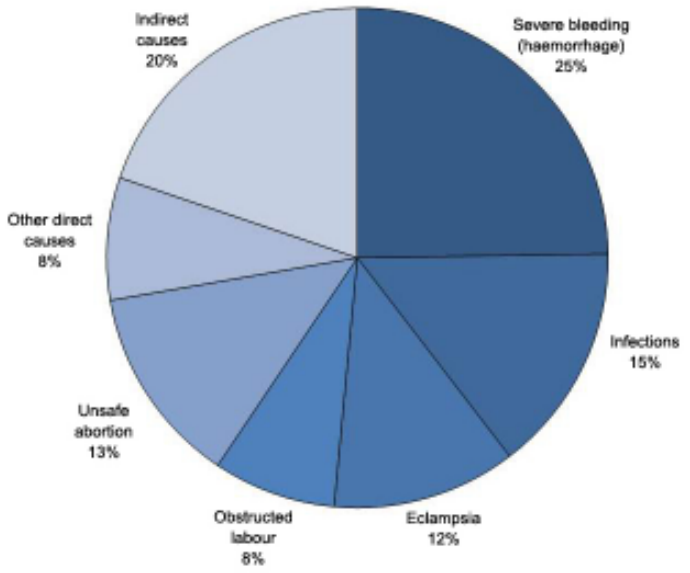
FEW CAUSES ACCOUNT FOR THE MAJORITY OF MATERNAL MORTALITY

Figure 3 shows that a small number of direct causes account for around 80 percent of maternal deaths.[8] Fortunately, we have cost-effective and proven interventions for each of these causes.

Other contributing causes of maternal mortality include malnutrition, HIV, malaria and violence against women. All of these factors are linked to larger health determinants including gender inequality, poverty and low education level, and when combined can have catastrophic results. Cultural norms and religious beliefs may also interact with socio-economic status and gender to restrict a woman's access and right to the full continuum of reproductive and sexual health services including maternal health services, as discussed below.

[8] *The World Health Report 2005: Make every mother and child count. 2005. Geneva. World Health Organization.*

Figure 3. Direct Causes of Maternal Mortality



*Total is more than 100% due to rounding

Source: The World Health Report 2005, WHO

Maternal morbidity: often severe, long-lasting with high burden of suffering

Maternal morbidity affects millions of women each year often with severe and long-lasting physical and mental suffering. In 2003, UNFPA and partners launched a global Campaign to End Fistula with the goal of making obstetric fistula as rare in developing countries as it is in the industrialized world. The reader is referred to the website of this highly successful campaign.[9]

Complications of unsafe abortion leave women with long-lasting problems such as infertility. Perinatal depression is another severe, and often neglected, pregnancy related condition responsible for high numbers of suicides and disability in many countries.[10]

Gender and Socio-cultural norms and practices

Maternal mortality and morbidity are, at their core, a consequence of gender inequality and health inequity. Data from national surveys reveal that access to maternal health services is highly inequitable, with the lowest socio-economic quintiles and rural populations having the least access. Other marginalized groups, such as adolescents, minorities and indigenous groups, face similar barriers to access. Gender inequality further contributes to poor maternal health on various levels from the prioritization of women's health by governments in their health plans and budgets to gender norms within villages and communities. Women, and particularly poor women, are often unable to access care because they lack the decision-making power, the financial resources, and the empowerment to obtain a full range of reproductive health services and information, including family planning, skilled attendance at birth and emergency obstetric care.

Cultural norms and practices may severely restrict or enhance maternal health. The perceptions of health and risks during pregnancy, birth and the postpartum/newborn period strongly influence both health-seeking behaviour and appreciation of the quality of the available services. For adolescents in particular, high levels of maternal mortality and morbidity stem from gender norms that force them into child marriage and to drop out of school, and deprive them of basic knowledge and decision-making about reproductive health, as discussed further below. Meeting the challenge of MDG5 will rely heavily on efforts to reduce health and gender disparities and improve access to primary and secondary education for girls.

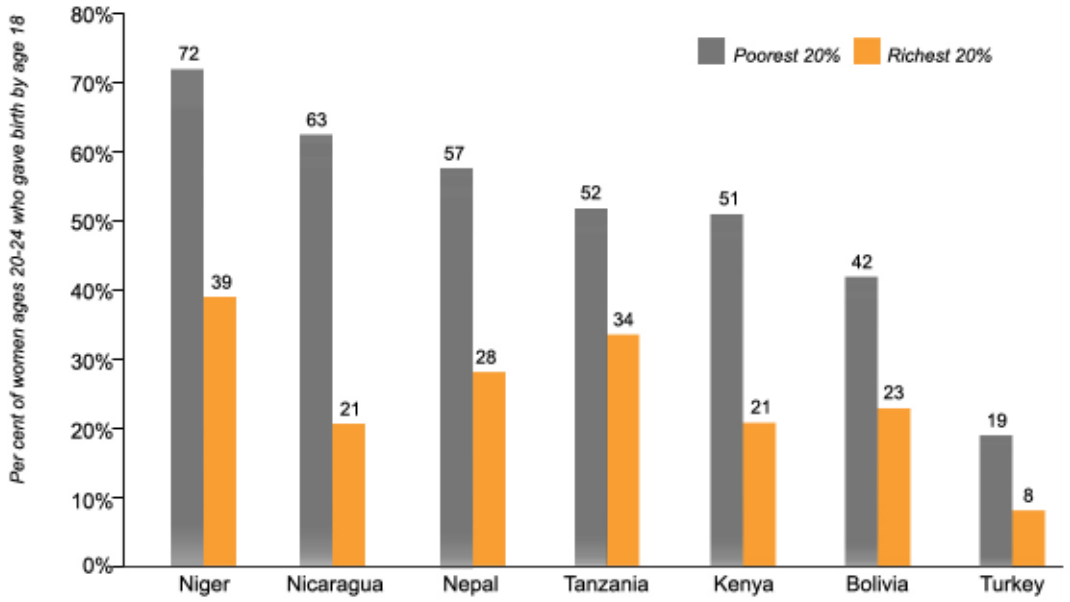
Adolescents

Pregnancy and childbirth-related deaths are the number one killers of 15-19 year old girls worldwide. Each year, nearly 70,000 die. At least two million more are left with chronic illness or disabilities that may bring them life-long suffering, shame and abandonment. Pregnancy rates among adolescents are high in many countries, particularly among the poor (see Figure 4). In 2004 in Niger, for example, 72 per cent of adolescents in the poorest quintile had given birth by age 18, compared to 39 per cent in the richest quintile. High fertility rates among adolescents are associated with higher maternal mortality due to complications from pregnancy and de-

[9] *www.endfistula.org*

[10] *UNFPA Emerging Issues: Mental, Sexual and Reproductive Health. 2008. UNFPA.*

FIGURE 4. CHILDBEARING AMONG THE POOREST AND RICHEST ADOLESCENTS



Source: Rani, M. and E. Lule, 2004, "Exploring the Socioeconomic Dimension of Adolescent Reproductive Health: A Multicountry Analysis" International Family Planning Perspectives 30 (3): 112.

livery as well as from unsafe abortions. Adolescent girls are twice as likely to die during pregnancy or childbirth as women in their 20s. For those under 15, the risks are five times higher.

In many countries girls are married at a young age, often against their will, and are expected to have children soon after to prove their fertility. Globally, the overwhelming majority of adolescents who become pregnant are married. Married adolescent girls often lack awareness of their rights and have limited access to family planning. Unmarried adolescent girls face a different set of challenges. They are more likely than married girls to suffer unplanned, financially unsupported and socially unsanctioned pregnancies. An unmarried adolescent mother may face the social stigma of single motherhood and lack the financial means to take care of herself and her child. Adolescent girls confronted with unplanned pregnancy are more likely to resort to unsafe abortions than older women.

Both married and unmarried pregnant adolescents are likely to face poverty, ill health and abuse, and to have frequent pregnancies, engage in unprotected sex carrying HIV risk, lack education and have few positive life options. Their children are more likely than those of older mothers to be malnourished and have developmental problems. One million babies born to adolescent mothers will not make it to their first birthday. Several hundred thousand more will be dead by age five.[11]

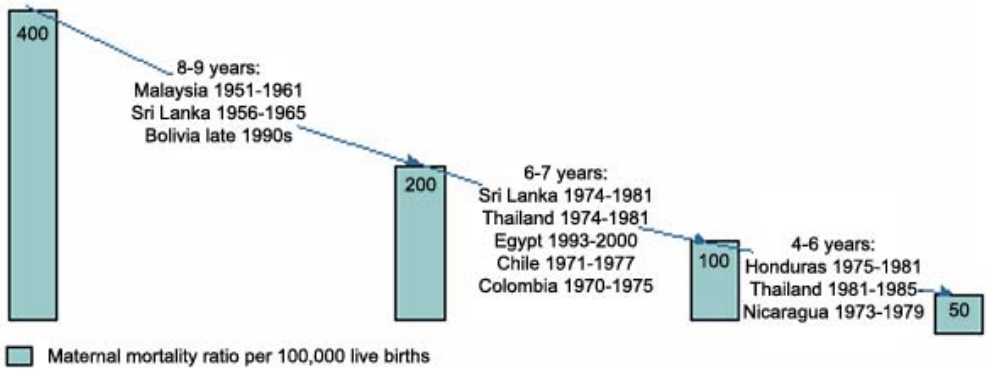
HIV/AIDS

Around 2.2 million HIV positive women give birth every year.[12] In areas of high prevalence, HIV is the cause of a significant number of maternal deaths. In a scientifically robust cohort study in rural Rakai District, Uganda, the MMR was 5.4 times greater in HIV-positive women as compared to HIV-negative women.[13]

The HIV/AIDS epidemic is increasingly more prominent among women; over 60 per cent of people living with HIV in sub-Saharan Africa are women. HIV and AIDS have also had a devastating effect on health systems in many high prevalence countries by depleting the health workforce. In these areas, women are less likely to be accompanied by a skilled attendant at the time of delivery leading to an increased risk of maternal death or disability.

[11] *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy. UNFPA. 2007*
[12] *WHO, World Health Report, 2005*
[13] *Sewankambo NK et al. Mortality associated with HIV infection in rural Rakai District, Uganda. AIDS, 2000, 14:2391-2400.*

FIGURE 5. NUMBER OF YEARS TO HALVE MATERNAL MORTALITY, SELECTED COUNTRIES



Source: The World Health Report 2005, WHO

3. OPPORTUNITIES

PROVEN INTERVENTIONS

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven, highly cost-effective interventions to ensure that every pregnancy is wanted and that every birth is safe. First, we must tackle the root causes of maternal mortality, including gender inequality, low access to education—especially for girls—child marriage and adolescent pregnancy. Many countries with limited resources have been able to reduce maternal mortality by half in less than 10 years (see Figure 5). Progress in these countries has led to a growing consensus in the global health community on three sets of interventions most effective in reducing maternal mortality and morbidity:

1) universal access to family planning
2) a skilled health professional present at every delivery
3) access to emergency obstetric and newborn care, when needed

Working towards the elimination of financial, geographic and sociocultural barriers will allow universal access to these interventions. Community mobilization and communication for social change will empower individuals to demand services and enhance political support. In successful countries, this increased demand together with universal access has resulted in high utilization and thus rapid declines in maternal mortality.

Family planning

World leaders reaffirmed their commitment to achieving universal access to reproductive health at the World Summit in 2005. Despite these renewed pledges, an estimated 137 million women around the world still had an unmet need for contraception in 2008.[14] In sub-Saharan Africa, the proportion of married women using modern family planning–the contraceptive prevalence rate–remains under 20 per cent while unmet need stands at 27 per cent.[15] Despite declines in global fertility, lack of access to resources and information about family planning, particularly among adolescents, has contributed to total fertility rates of more than 5 children per woman in over 30 countries is sub-Saharan Africa. In Gambia, 1 in 5 adolescent girls (aged 15-19) becomes pregnant compared to 1 in 140 adolescent girls in Sweden.[16] Meeting the need for family planning could reduce maternal mortality by at least 33 per cent.[17]

The recent adoption of a new MDG5 target—to achieve universal access to reproductive health—recognizes the importance of family planning in improving maternal health as part of the greater sexual and reproductive health continuum. Empowering women with the resources they need to exercise their right to plan the number of children they have will significantly reduce the number of unintended pregnancies and unsafe abortions. Meeting the unmet need for family planning will thus have a profound impact on a woman's risk of dying from pregnancy-related complications over the course of her lifetime.

[14] *Guttmacher Institute, UNFPA. Contraception: An Investment in Lives, Health and Development. November 2008.*
[15] *UNFPA – UN Population Division 2008.*
[16] *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank. October 2007. Geneva. WHO.*
[17] *UNFPA 2007.*

It will be important to insure a judicious mix of family planning policies, advocacy and communication, client education and quality service delivery to ensure optimal impact with available resources.

To help meet the unmet need for family planning, particularly in isolated rural areas, many countries have enlisted community health workers to provide basic primary care including family planning education and services at the community level. For example, the Government of Ethiopia has decided to accelerate its successful community health worker program to cover the entire country by 2009. The Health Extension Program is working towards universal access to primary care through the training and deployment of over 30,000 health extension workers to deliver services at the community level. For the first time in Ethiopia's history, every community should have access to family planning information, education and services.

A skilled health professional present at every delivery: towards quality facility-based deliveries

Prevention of death and disability during labour and delivery is greatly increased by the presence of a skilled health professional. Life threatening complications occur in around 15 per cent of deliveries and cannot be predicted. In regions with high maternal mortality and morbidity, such as sub-Saharan Africa and Asia, the proportion of births attended to by a skilled professional are as low as 47 and 61 per cent, respectively. In the least developed nations in Eastern Africa, only 34 per cent of women give birth with the help of a skilled attendant.[18] These proportions fall significantly short of the ICPD+5 target of 85 per cent by 2010, and are thought to be overestimates due to methodological problems in determining the skill level of birth attendants as well as their lack of supplies and/or an enabling environment.[19]

Countries face serious challenges in ensuring skilled attendance at birth due to major global shortages in the health workforce and in particular, midwives. Midwives have an essential role in providing normal pregnancy, delivery and post-partum care; in managing complications and providing basic emergency obstetric and newborn care; and in referring women, when needed, for comprehensive emergency obstetric newborn care (EmONC).

These human resource challenges are compounded by poor training, unequal geographic distribution and decreasing retention of health professionals. The Global Health Workforce Alliance estimates the deficit of trained health providers to be over four million in 57 countries.[20] In Afghanistan, a country with one of the highest MMR, there were less than 500 midwives in the entire country in 2002.[21] In many countries shortages are increasing due to "brain drain" caused by skilled health-care providers leaving their countries to seek more advantageous opportunities elsewhere. Health workforce shortages have also been exacerbated by the death and illness of many professionals due to AIDS.

In 2007, WHO developed global recommendations for task-shifting to create more effective health systems through the redistribution of tasks among health-workers. By allocating tasks to health professionals with less training and fewer qualifications through standardized protocols, facilities can more optimally use existing human resources to improve service delivery.[22] If health providers work in teams and are effectively supervised, task-shifting can help to relieve overburdened health systems and rapidly improve coverage. To this end, great emphasis has been placed on the need to scale up the training and deployment of non-physician providers, such as midwives and surgical technicians. Several countries have developed national human resource strategies to increase the number of mid-level providers and improve their retention, particularly in more isolated, rural areas. These providers are essential to increasing coverage of family planning services and EmONC, through direct provision or through referral systems, as is the case with comprehensive EmONC.[23], [24], [25]

Given the importance of the issue of skilled health professionals for maternal health and in particular midwives, UNFPA has developed the Midwives Programme (See Box on Midwives Programme next page).

[18] *Proportion of births attended by a skilled attendant- 2008 updates. WHO Factsheet. Department of Reproductive Health and Research.*

[19] *Ibid.*

[20] *The World Health Report 2006- Working together for health. 2006. Geneva, World Health Organization.*

[21] *Ronsman C, Graham WJ. Maternal mortality: who, when, where, and why. Lancet 2007;368:1189-200.*

[22] *Task Shifting: Global Recommendations and Guidelines. World Health Organization 2007.*

[23] *Freedman et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. Lancet 2007; 370: 1383-1391.*

[24] *Global Health Workforce Alliance Forum, Kampala, 2008. www.ghwa.org.*

[25] *Global Health Workforce Alliance and Health Systems for Equity Project. Report of a meeting. London 10 November 2008 (forthcoming).*

The Midwives Programme

Jointly implemented by UNFPA and the International Confederation of Midwives (ICM), the Midwives Programme was officially launched in April 2008 with the slogan "The world needs midwives now more than ever to save the lives of mothers and babies". It was conceived as UNFPA's response to the growing need for human resources for health in many countries. UNFPA chose to focus on midwives as they are a key component to reducing maternal and newborn deaths and are in critical demand in most high maternal mortality countries.

The Midwives Programme calls for a global effort to promote the work and role of midwives and others with midwifery skills in order to accelerate progress towards MDG5. The Programme is aligned with the ICPD agenda and the international call for investing in sexual and reproductive health and rights. The aim is to develop national capacity in high maternal mortality countries, ensuring skilled attendance at all births. Increasing the number and capacity of midwives will also contribute to the other health MDGs: reducing neonatal mortality (MDG4), promoting gender equality and empowering women (MDG3) and combating HIV/AIDS, malaria and other diseases (MDG6).

With initial funding received from Sida in 2008, support was provided to an initial group of 11 high priority countries through the posting of national midwife advisors in each country who are supervised by regional midwife advisers. An international UNFPA Programme Coordinator and an international ICM Midwife Adviser were also brought on board to coordinate the global efforts of the two partners—UNFPA and ICM. The countries involved in this first wave are in Francophone Africa (Benin, Burkina Faso, Burundi, Côte d'Ivoire, Madagascar), in Anglophone Africa (Ethiopia, Ghana, Uganda, Zambia) and in the Arab region (Djibouti and Sudan). UNFPA country offices in Haiti and Cambodia have also initiated midwifery activities.

The Midwives Programme aims at building a critical mass of midwife advisers in all regions who will lead country level efforts in capacity building on four focus areas: strengthening regulatory mechanisms; developing/strengthening education and accreditation mechanisms; promoting the development of midwifery associations and promotion of midwives as a key health workforce for the achievement of MDGs 4 and 5. These advisers will also have the necessary capacity to participate in policy level discussions and decisions concerning maternal and reproductive health. Working in full coordination with the ministries of health and national training institutions, the advisers will receive technical support from international and regional midwifery schools or universities, as well as from international training programmes.

The Programme is initially planned for three years and aims at addressing at least 20-25 priority countries that will also be supported under the Maternal Health Thematic Fund. The two programmes will thus harmonize with aligned financial flows, monitoring frameworks and reporting procedures. This will create synergies with the three key pillars of safe motherhood (family planning, skilled attendance at birth and emergency obstetric care) and ensure a concerted response in addressing maternal mortality and morbidity and neonatal survival.

Emergency Obstetric and Newborn Care (EmONC)

Basic and comprehensive EmONC represent a set of interventions that address each of the direct causes of maternal death. The term has been broadened recently to include life-saving newborn care such as newborn resuscitation (Figure 6).

Access to basic and comprehensive EmONC greatly increases a woman's chance of survival during childbirth. Lack of access to simple interventions such as oxytocics to prevent or treat haemorrhage or antibiotics to treat infection often leads to death or severe disability. Many countries lack the health infrastructure to provide emergency care to women, particularly poorer women and women living in isolated, rural areas.

Even in areas where adequate basic and comprehensive EmONC facilities exist, significant barriers prevent women from reaching facilities or receiving care upon arrival. The three major delays in obtaining EmONC are a delay in 1) deciding to seek care 2) identifying and reaching a medical facility and 3) receiving adequate and appropriate treatment. Many factors influence the delays at each stage in a woman's path to obtaining EmONC (Figure 7).

Figure 6. Emergency Obstetric and Newborn Care

In Primary Health Care Facility	In District Hospital
Basic EmONC	**Comprehensive EmONC**
• Antibiotics IV • Oxytocics IV • Anticonvulsivant • Manual removal of placenta • Post abortion care (MVA) • Assisted vaginal delivery (vacuum extraction) • Newborn care	**All Basic EmONC +** • Surgery (caesarean section) • Blood transfustion • Care to sick and low birth weight newborns

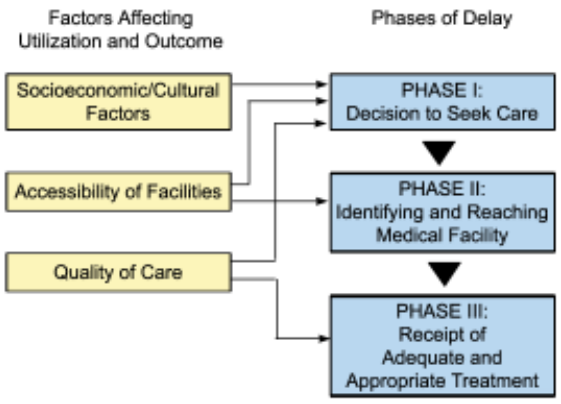
Women often fail to recognize labour complications; they may not have the means for timely transportation to facilities or the money to afford quality care once they have arrived; and the cost of EmONC can be catastrophic for households.[26] Preventing delays in obtaining EmONC can only occur when solid health infrastructure is combined with outreach and education as part of a functioning national health system.

There is now universal agreement that countries should move as rapidly as possible to ensure that every woman has access to a quality, facility-based delivery:

> "The advantages of facility-based deliveries–both from a technical perspective and from systematic analysis of mothers' experiences–are many. They enable teamwork, so that midwives can attend far more births than if would be possible in home deliveries. They also enable non-professionals, such as assistants and auxiliaries, to help, making care more cost-effective. This allows a single midwife to attend up to 220 deliveries per year, compared with less than 100 for a single-handed midwife visiting mothers at home. In addition, the mixture of professionals in a facility means that life-saving emergency care can be given quickly. Skilled care at facilities also ensures safety, cleanliness and the availability of supplies. Other work can be performed, and referrals are easier, as is emergency transport."
>
> — Margaret Chan,
> Director General, WHO[27]

UNFPA's Campaign to End Fistula is intended to address the devastating childbearing injury caused by prolonged obstructed labour (See box on the Campaign to End Fistula next page).

Figure 7. The "Three Delays" Framework



Source: UNFPA Website: http://www.unfpa.org/mothers/obstetric.htm

[26] *Renaudin P, Prual A, Vangeenderhuysen C et al. Ensuring financial access to emergency obstetric care: Three years of experience with Obstetric Risk Insurance in Nouakchott, Mauritania. Int J of Gynecol and Obstet (2007), doi: 10.1016/j.ijgo.2007.07.006.*

[27] *The Global Campaign for the Health Millennium Development Goals. First year report 2008. Published by the Office of the Prime Minister of Norway, Oslo, September 2008.*

The Campaign to End Fistula

Obstetric fistula is a devastating childbearing injury caused by prolonged, obstructed labour that is unrelieved by medical intervention. Women with fistula constantly leak urine and/or faeces and suffer life shattering consequences—the baby usually dies and the smell associated with fistula combined with misperceptions about the condition often causes women to be stigmatized within their communities and abandoned by their husbands. Left untreated, fistula can lead to medical problems such as bladder infections, painful genital ulcerations, kidney failure and infertility. This physical and emotional suffering is frequently accompanied by a loss of financial support and inability to work.

It is estimated that at least two million women are currently living with obstetric fistula and 50,000 to 100,000 more are affected each year—almost all in sub-Saharan Africa and parts of Asia and the Arab World.[1, 2] The chronic incidence of obstetric fistula in low-resource settings highlights the enormous disparities in maternal health care between the developed and the developing world. The women affected are among the most marginalized—young, poor, illiterate and rural—and as a result, they have remained invisible and the issue has been largely neglected.

Fortunately, the means to prevent and treat fistula are well understood. Prevention is the ultimate goal, through universal access to high quality and accessible maternal health care services, including family planning, skilled birth attendance and emergency obstetric care, particularly caesarean section. Reconstructive surgery can mend the injury, and with comprehensive care to address the social consequences, most women can resume full and productive lives.

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. The target for achieving fistula elimination is 2015, in line with ICPD and MDG targets.

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

- Thirty-six countries have now assessed the national need to address fistula
- At least 16 countries have integrated fistula in relevant national health policies and plans
- More than 7,800 women have received fistula treatment [3]

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 (OFWG), 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 and South-South collaboration, addressing communities' awareness of fistula and women's access to care and building on existing capacities.

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 engage in dialogue at community and national levels for the reduction of maternal mortality and morbidity.

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.

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[1] *Wall, L. 2006. "Obstetric Vesicovaginal fistula as an international public-health problem." The Lancet 368 (9542): 1201-1209.*

[2] *Abou Zahr, C (2003). "Global Burden of Maternal Death and Disability," British Medical Bulletin 67 (1).*

[3] *Treatment services supported by UNFPA may have also received support from governments and other partners.*

Scaling-up coverage of effective interventions through MDG-driven, performance-based health systems strengthening

Maternal mortality is increasingly accepted as a litmus test of a functioning health system. Strong national health systems are necessary for making progress towards MDG5 and the other health MDGs. To achieve universal access to the interventions needed to prevent maternal death, national health systems must be strengthened to improve overall functioning, coverage and quality. Investments in maternal health must be fully integrated into, and in line with national strategies, plans and budgets as they relate to health systems and services. Initiatives must support country-led processes that bring together important stakeholders to develop, cost and implement national plans and strategies for improving maternal health services within a larger health systems framework.

WHO has identified six building blocks of the health system: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).[28] Identifying the problems and bottlenecks within each building block will help countries identify and prioritize areas within the health system that need support to improve maternal survival. Improving the national health system to deliver quality care to all will allow women more regular access to medical services. More regular interactions with the health system—including pre- and postnatal visits—will also allow women consistent support for family planning, preventing unwanted pregnancies and diminishing the unmet need for contraception.

Investments in maternal health will also contribute to the building of health systems better able to respond to all medical needs and emergencies, not just those faced in pregnancy and childbirth. The strengthening of health systems at the national, district and community levels to expand coverage will contribute to sustainable improvements in health at the population level. For example, the sound functioning of a primary health centre will contribute to the reduction of child mortality from severe disease (pneumonia, diarrhoea, malaria). The availability of surgery, anesthesia and a blood bank made available for maternal health in the district hospital will contribute to much improved survival rates from severe injuries or other urgent surgical conditions.

Costs and financial resources required

In developing countries, it costs approximately $50 to ensure a safe pregnancy and delivery, protecting the life of the mother and newborn child. This corresponds to about $3 to $4 per capita annually.[29] A recent review of estimates has calculated that in 51 aid-dependent countries, these services will cost around $2.4 billion in 2009, increasing to $7 billion by 2015 plus an estimated $1 to $1.5 billion annually for family planning services.[30]

With an increase in the share of government expenditures for health by developing countries towards the 15 per cent target and increased development assistance by OECD countries towards 0.7 per cent of GNI by 2015, this financial target can be reached.

4. Building on the Momentum

A positive momentum is building around MDG5 as international organizations are joining forces. The Partnership for Maternal Newborn and Child Health (PMNCH) has helped to ensure that maternal health receives a far greater priority in the global health agenda.

Several major international conferences have taken place in the last year, bringing together government leaders, ministry of health officials, NGOs and civil society. The landmark Women Deliver Conference in London in October 2007 convened over 1,800 participants from 109 countries to mark the 20th anniversary of the Safe Motherhood Initiative. The Statement from the Ministers' Forum and the

[28] *Everybody's Business: Strengthening health systems to improve health outcomes: WHO's framework for action. World Health Organization. 2007.*

[29] *Graham WJ, Cairns J, Bhattacharya S, Bullough CHW, Quayyum ZQ, Rogo K. Maternal and Perinatal Conditions. Chapter 26 in Disease Control Priorities in Developing Countries. Second Edition. Oxford University Press and The World Bank 2007.*

[30] *The Global Campaign for the Health Millennium Development Goals. First year report 2008. Published by the Office of the Prime Minister of Norway, Oslo, September 2008.*

call from the participants put forth a renewed commitment to improving maternal health.[31] Six months later the Countdown to 2015 Conference brought together important members of the global health community to track progress on the maternal and child health MDGs and to commit to a call for future action.[32]

Following these conferences, United Nations Secretary General Ban Ki-moon declared in May 2008 that the world's maternal death rates are "unacceptable" and that strengthening national health systems is key to improving them. The G8, at their 2008 summit in Japan, committed to greater efforts in support of reproductive, maternal and child health.

The Global Campaign for the Health MDGs, which started in 2007, has already received significant commitments, including Norway's pledge of $1 billion for maternal, newborn and child health over the next 10 years and Canada's contribution to the UNICEF Catalytic Initiative to save a million lives. The United Kingdom is also playing a prominent role. In September 2007, Prime Minister Gordon Brown convened leaders in London to create an International Health Partnership to support developing countries in strengthening their national health systems to achieve the health MDGs. The Prime Minister's wife, Sarah Brown, is working closely with the White Ribbon Alliance on a maternal mortality campaign calling for $10 billion annually for maternal newborn and child health, as well as increases in the number of trained health workers. Recently the Bill & Melinda Gates Foundation convened a maternal health task force, with support from EngenderHealth.

The heads of the eight global agencies working in health meet regularly to discuss how to further strengthen their contribution to progress in global health and how to better support countries. This group, known as the H8, comprises WHO, UNICEF, UNFPA, the World Bank, UNAIDS, The Global Fund, the GAVI Alliance and the Bill & Melinda Gates Foundation. As part of this effort towards alignment and harmonization, WHO, UNICEF, UNFPA and the World Bank are increasingly providing joint support to countries as they work towards improving maternal and newborn health (Annex 2).

Based on the principles of the Paris Declaration and of national ownership, this work must lead to coordinated country support to the one MDG-driven, results-based national health plan, with predictable, progressively increasing and sustained financing.

[31] *http://2007.womendeliver.org/closing/pdf/WD_Ministers_Statement_English_FINAL.pdf*
[32] *http://www.countdown2015mnch.org/*

The Business Plan

1. Overall Goal

The MHTF aims to boost support to high maternal mortality countries to reduce maternal mortality and morbidity.

2. Guiding Principles

#1. Maternal and reproductive health as a human right and as key to addressing gender equality

The World Health Organization states in its constitution, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." and that every country in the world recognizes at least one treaty that includes human rights related to health.[33]

The rights-based approach to public health and development work is increasingly promoted by international health organizations, translating these fundamental rights into quantitative measures of access, coverage and ultimately impact: survival and reduction of morbidity. The right to reproductive and maternal health underlies the ICPD Programme of Action and Millennium Development Goal 5, as expressed in the target *universal access to reproductive health*.

Working to ensure that every pregnancy is wanted and that every birth is safe promotes gender equality, as maternal mortality is the greatest health inequity in the world.

The work of UNFPA's MHTF is driven by the fundamental right to safe pregnancy and childbirth for every woman, regardless of socio-economic status, geographic location, cultural or religious beliefs. Support to countries will assist in expanding the coverage of family planning and maternal health services to increase access for vulnerable and marginalized populations such as adolescent girls, women living in rural areas, persons with disabilities and members of ethnic minorities. By focusing on the countries with the highest maternal mortality and by combining national capacity building, the provision of reproductive health and maternal health commodities as well as catalytic funding, the MHTF is able to contribute to maternal survival where it is needed most.

The strategies and outputs of the MHTF are drawn from–and align with–UNFPA's Strategic Plan 2008-2011 and UNFPA's Sexual and Reproductive Health Framework as part of the support for the provision of a basic package of SRH services, including family planning, pregnancy-related services, skilled attendance at delivery and emergency obstetric care.[34]

The MHTF will address high adolescent fertility, and therefore will contribute to UNFPA's focus on young people. Meeting the unmet need for family planning will also address high and unwanted fertility which is the root of inter-generational transmission of poverty. Meeting this need will improve quality of life and contribute to sustainable human development.

The work of the MHTF is also guided by the recognition that improvements in maternal health are heavily dependent on the information, knowledge and opportunities individuals and couples have to exercise their rights. When empowered, communities are not just recipients; they can play an active role in reducing maternal mortality and morbidity by advocating for their right to quality health care and supporting women's access to services. The MHTF will support efforts to raise awareness and community mobilization around the importance of maternal health and family planning as part of the national agenda and the need for strong national governance and leadership to make women's health a priority in every country.

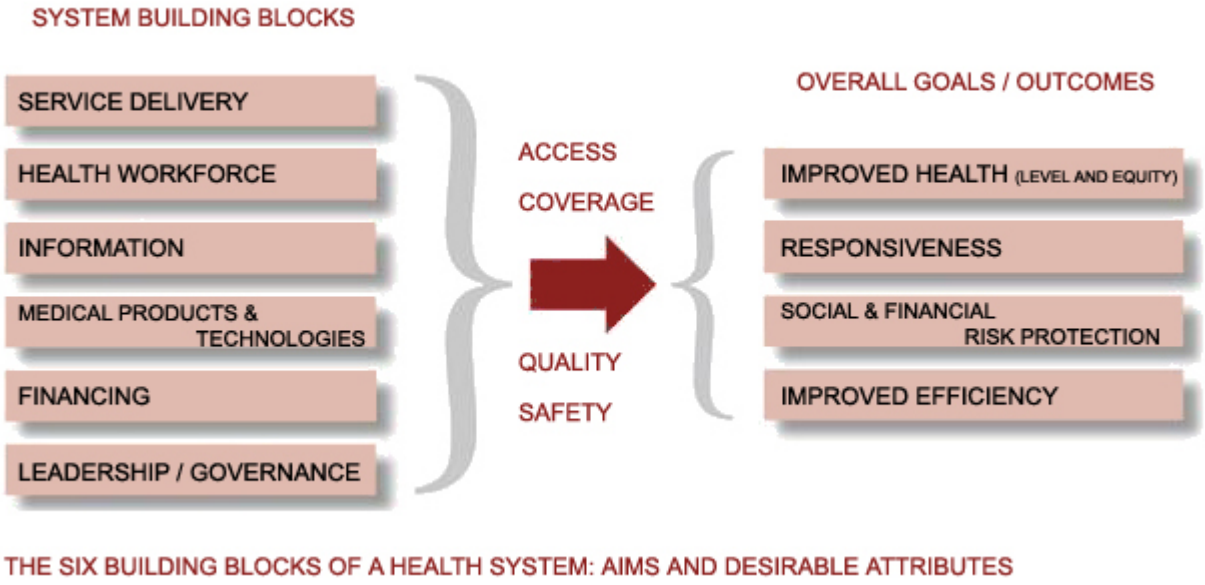
#2. Country-owned and country-driven development

The work of the MHTF will promote national ownership and capacity building in line with the principles of the Paris Declaration on Aid Effectiveness. The improvement of maternal health is viewed within the broader spectrum of sexual and reproductive health and as part of the one national health plan

[33] *http://www.who.int/hhr/en/*

[34] *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All. Reproductive Rights and Sexual and Reproductive Health Framework. United Nations Population Fund. May 2008.*

FIGURE 8. THE WHO HEALTH SYSTEM FRAMEWORK



Source: WHO Health System Strengthening Strategy 2007

and health systems strengthening. The MHTF will work with governments and key partners to strengthen MDG-driven national health systems to ensure universal access to the three recognized pillars for improving maternal health:

- Family planning
- Skilled care in pregnancy and childbirth, including quality facility deliveries
- Emergency Obstetric and Newborn Care

The MHTF will provide strategic capacity building and resources to address priorities identified at the country level by ministries of health in collaboration with key partners. This work will be guided by the WHO Health System Framework and its six building blocks (Figure 8).[35]

In response to requests from countries for more streamlined funding processes and reporting, UNFPA is working to closely coordinate the activities of the three health thematic funds - Maternal Health, Fistula, and Reproductive Health Commodity Security. The results framework for the MHTF is closely linked to the other Thematic Funds, as well as to the UNFPA's Midwives Programme. While maintaining the focus on specific results, it is envisaged that the thematic funds will move towards a joint country application and reporting process in 2009.

Similarly, enhanced maternal and newborn health support from agencies within the United Nations will be better streamlined to avoid duplicate efforts and further burden countries. As noted in the Joint Statement (Annex 2), UNFPA, UNICEF, WHO and the World Bank are committed to working together at the global, regional and country levels.

#3 A focus on results and strong support to national monitoring and evaluation: MDG-driven and performance-based national health system strengthening

Much attention will be given to measuring results and strengthening national capacity to do so.

As will be seen in the Results Framework and in the Monitoring and Evaluation Sections of this document, we now have a solid set of internationally-agreed upon impact, outcome and coverage indicators. The challenge is to strengthen, with partners, the capacity of the one national health management information system (HMIS) and to secure periodic facility and district reporting on a minimum number of robust indicators of progress in all countries supported by the MHTF. This, together with periodic population-based surveys,

[35] *Everybody`s Business: Strengthening health systems to improve health outcomes: WHO`s framework for action. World Health Organization. 2007.*

should enable UNFPA to better report to financial contributors and its Executive Board.

Lessons learned on effective performance-based financing for health, including those from the current efforts supported by the World Bank, will be shared with countries so as to ensure inclusion as deemed appropriate.

3. The Maternal Health Thematic Fund embedded in UNFPA's Strategic Plan and Joint UN work on Maternal and Newborn Health

The work of the MHTF stems from UNFPA's Strategic Plan 2008-2011 Outcome *2.2- Access and utilization of quality maternal health services increased in order to reduce maternal mortality and morbidity.* The work of the MHTF will also contribute 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.*

As part of the WHO-UNICEF-UNFPA-World Bank joint support to countries to accelerate progress towards MDG5, the MHTF will support an increasing number of countries through a series of waves, reaching around 25 countries before the end of 2009 and reaching all 60 high maternal mortality countries no later than 2012, subject to funding. In each country, the level of effort should increase progressively. Thus, it will be critical to rapidly expand the resource base for the MHTF. Through solid reporting on results, it is hoped the MHTF will foster a virtuous cycle similar to that at the Global Fund under the theme: "raise it, spend it, prove it", to use the words of Richard Feachem, the Global Fund's former head.

4. Supporting National Capacity Building

Strengthening UNFPA's Country Offices to better contribute to national capacity building

In order to optimally support national capacity building and health system strengthening, and to manage the additional resources provided through the MHTF, UNFPA is strengthening its country office capacity, in numbers and skills mix, through the provision of tools and job aids, and timely access to international experts. This effort aligns with UNFPA's re-organization towards a greater field focus.

Network of regional institutions and roster of experts

UNFPA and partners are in the process of establishing a network of regional institutions and a roster of international experts. Long-term arrangements are being explored and will include institutions from Africa and Asia to foster South-South collaboration. The roster will include national experts who will be available for short periods to support countries in their region, sharing lessons learned and best practices. This roster will be developed in close collaboration with WHO, UNICEF, the World Bank and key academic partners, in particular the Columbia University Averting Maternal Death and Disability Program. This is described at length in the MOU signed between UNFPA, UNICEF and Columbia University on strengthening national capacity for EmONC.[36]

5. Maternal Health Thematic Fund Results Framework

The Maternal Health Thematic Fund Results Framework is anchored to MDG5 and to the UNFPA Strategic Plan 2008-2011.

The MHTF Results Framework is linked to three other key UNFPA programmes and their respective results frameworks:

- The Global Programme on Reproductive Health Commodity Security
- The Campaign to End Fistula, Global Programme Proposal; Making Motherhood Safer by Addressing Obstetric Fistula 2006-2010
- The UNFPA- ICM Midwives Programme

[36] *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. UNFPA, UNICEF, Columbia University, 17 July 2008.*

Outputs

One of the fundamental principles underpinning the work supported by the MHTF will be country-owned and country-driven development and support to the one national health plan. Therefore the specific outputs and activities supported by the MHTF in each country will be determined by the country through a consultative process with key stakeholders.

There will be, however, a set of seven essential outputs which the MHTF will support in every country (unless otherwise fully supported). In collaboration with government and key partners the MHTF will support:

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 EmONC
3. National health plans focus on SRH, especially family planning and EmONC with strong RH/HIV linkages to achieve the health MDGs
4. National responses to the human resource crisis in MNH, 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 MDG5 from government and donors

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

As stated in UNFPA's Sexual and Reproductive Health Framework, [37] a main strategy for improving maternal health will be advocacy and policy dialogue. The MHTF will contribute to an evidence base for advocacy and resource mobilization at the country, regional and global levels. This will contribute to universal access to a basic package of SRH services as described in the framework.

The MHTF will act as a leveraging mechanism, generating awareness and support for maternal health. Increased visibility and understanding among governments, civil society, the general public and private sector on the issues related to maternal health will build greater awareness and support for action. This is true at the national, regional and global levels. It will thus be important to increase recognition of the issues surrounding maternal health and reproductive health among the media, donors, policy makers, communities and the general public through advocacy, media, communication for social change and community mobilization.

MHTF resources will be used to support the ministries of health, convene partners and bring together district health management teams for planning, problem-solving during scale-up, emulation between districts and monitoring of progress.

The MHTF will also focus on partnership-building in order to provide more harmonized support to countries, as well as to raise awareness about maternal and reproductive health. The MHTF will build on UNFPA's existing partnerships with key stakeholders at national, regional and global level. The positioning of the MHTF within the joint UN-MNH accelerated support to countries represents a harmonized effort by United Nations agencies in accelerating progress towards MDG5.

As part of this effort, UNFPA and UNICEF have signed a memorandum of understanding with Columbia University (Averting Maternal Death and Disability Program) to provide joint technical support to countries, focusing on the area of EmONC.

UNFPA is a member of the Partnership for Maternal, Newborn and Child Health (PMNCH) and sits on the advisory board of the Women Deliver Initiative—a global advocacy and outreach effort focused on promoting and advancing maternal and women's health. As a member of these and other communication and advocacy initiatives, UNFPA is well positioned in the global framework of maternal health initiatives and will carry out a supportive role based on its comparative advantage in advocacy, media, communication, technical assistance and programming to raise awareness and resources for MDG5.

[37] *Making Reproductive Rights and Sexual and Reproductive Health a Reality for All. Reproductive Rights and Sexual and Reproductive Health Framework. United Nations Population Fund. May 2008.*

2. Up-to-date needs assessments for the SRH package with a particular focus on family planning, human resources for MNH, and EmONC

The MHTF will prioritize supporting national assessments in the areas of family planning/RHCS (with the Global Programme on RH Commodity Security), human resources for MNH and EmONC. These assessments will provide valuable quantitative and descriptive information for advocacy and policy dialogue. For countries lacking up-to-date assessments, this process will 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 approach in each country.

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

The MHTF will support ongoing national planning processes including the enhancement of existing **national and district health plans, including service delivery plans,** to ensure that they include community mobilization, family planning education and services, quality facility deliveries, and RH/HIV integration.

a) Community mobilization
National efforts in community mobilization around SRH, including demand creation for family planning and birth planning, should be supported as part of UNFPA's general support and in close collaboration with the Global Programme on RH Commodity Security.

b) Family planning education and services
Family planning education and services should be offered in every community and in every primary health facility (public and private). Meeting the unmet need for family planning will require that every health facility provides quality family planning services as an integral part of SRH and primary health care. Reproductive health commodity security (RHCS) will need to be ensured at every level (national, district and facility).

c) Quality facility deliveries
In order to reduce maternal mortality, countries will need to ensure that all women, especially those from marginalized areas and populations, have access to a quality facility delivery in a primary health centre (public and private) with a skilled health professional capable of providing basic EmONC. Referral to a district hospital for comprehensive EmONC, including caesarean section and/or blood transfusion, should also be readily available.[38] In order to achieve this level of access, service delivery plans must include:

- For every 500,000 population and every sub-national area / district, a minimum of five basic EmONC primary health facilities
- For every 500,000 population and every sub-national area / district, at least one of these facilities provides comprehensive EmONC.[39]

d) RH/HIV Integration and prevention of mother-to-child transmission
Reducing maternal mortality in countries with high HIV prevalence will involve support to HIV prevention initiatives and their integration within reproductive health. In line with United Nations Resolution 60/262 Political Declaration on HIV/AIDS, the MHTF will support the United Nations commitment to:

...ensuring that pregnant women have access to antenatal care, information, counseling and other HIV services and to increasing the availability of and access to effective treatment to women living with HIV and infants in order to reduce mother-to-child transmission of HIV, as well as to ensuring effective interventions for women living with HIV, including voluntary and confidential counsel-

[38] *The Global Campaign for the Health Millennium Development Goals. First year report 2008. Published by the Office of the Prime Minister of Norway, Oslo, September 2008.*

[39] *The Indicators for Monitoring the Availability and Use of Obstetric Services: A Handbook. WHO, UNFPA, UNICEF, Columbia University, Draft 9 September 2008. Publication expected first quarter 2009.*

ing and testing, with informed consent, access to treatment, especially life-long antiretroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care.[40]

Support from the MHTF will align with the four elements of comprehensive prevention of mother-to-child transmission (PMTCT):

- Prevent primary HIV infection among girls and women
- Prevent unintended pregnancies among women living with HIV
- Reduce mother-to-child transmission through anti-retroviral drug treatment or prophylaxis, safer deliveries and infant feeding counseling
- Provide care, treatment and support to women living with HIV and their families[41]

4. National response to the human resource crisis in MNH, with a focus on planning and scaling-up of midwifery and other mid-level providers

A national MNH service delivery plan will require a well deployed, competent and motivated health workforce, a key building block of the health system. A major thrust of the MHTF will be to support countries to increase skilled attendance at delivery with a focus on midwives. This will involve support to national assessments and planning of human resources for maternal health as part of broader national health human resource planning.

The ***joint UNFPA-International Confederation of Midwives (ICM) Midwives Programme,*** described in detail elsewhere, is a priority component of the MHTF.[42]

The following issues will be addressed:

- Numbers and deployment of midwives and others with midwifery skills (MOMS)
- Regulatory environment to enable midwives to perform the seven signal functions of basic EmONC
- Scale-up of production to achieve the required numbers for the service delivery plan (midwifery schools, skills-based curricula, clinical training sites, etc.)
- Team work within primary health centres and district hospitals including task shifting with standardized protocols and adequate supervision to increase the number of deliveries than can be safely overseen by midwives
- Strengthening of national midwifery associations and councils

Countries participating in the MHTF will receive midwifery support, particularly in the form of national and/or international midwifery advisers.

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

A dual approach: addressing systemic issues and resolving bottlenecks to scale-up

Teaming up with key development partners, the in-country approach to health system strengthening will use a combination of addressing systemic issues (such as building up the midwifery cadre), while supporting the resolution of bottlenecks. Coverage rates often progress slowly because of bottlenecks which may be relatively straightforward to solve.

For example, in a meeting with a minister of health from West Africa and his team in early 2008, it was revealed that family planning was being offered in only one out of five primary health care facilities. A cursory assessment indicated that this should be relatively simple and low cost to address through MoH decisions and management, some training, logistics capacity strengthening, contraceptive supplies and modest additional financing. Similarly, ensuring that midwives are authorized to carry out the seven signal functions of basic EmONC

[40] *Resolution Adopted by the General Assembly. 20/262 Political Declaration on HIV/AIDS. United Nations General Assembly 60th Session. 15 June 2006.*

[41] *A Framework for Priority Linkages. WHO, UNFPA, IPPF, UNAIDS, 2005.*

[42] *UNFPA investing in Midwives and others with midwifery skills to accelerate progress towards MDG5. A proposal for 3 years. 14 March 2008.*

through national regulation and ensuring the required in-service training, could increase the provision of basic EmONC at a relatively low marginal cost and effort. This could have a rapid and significant impact on reducing maternal mortality from causes such as haemorrhage or eclampsia.

This approach to resolving bottlenecks is one of the components behind some highly successful child survival programmes. Figure 9 represents the approach, which aims to achieve the highest increase in coverage of an effective intervention in the least amount of time and with the least amount of resources. Such an approach addresses the more long-term systemic issues, such as scaling up the production of midwives.

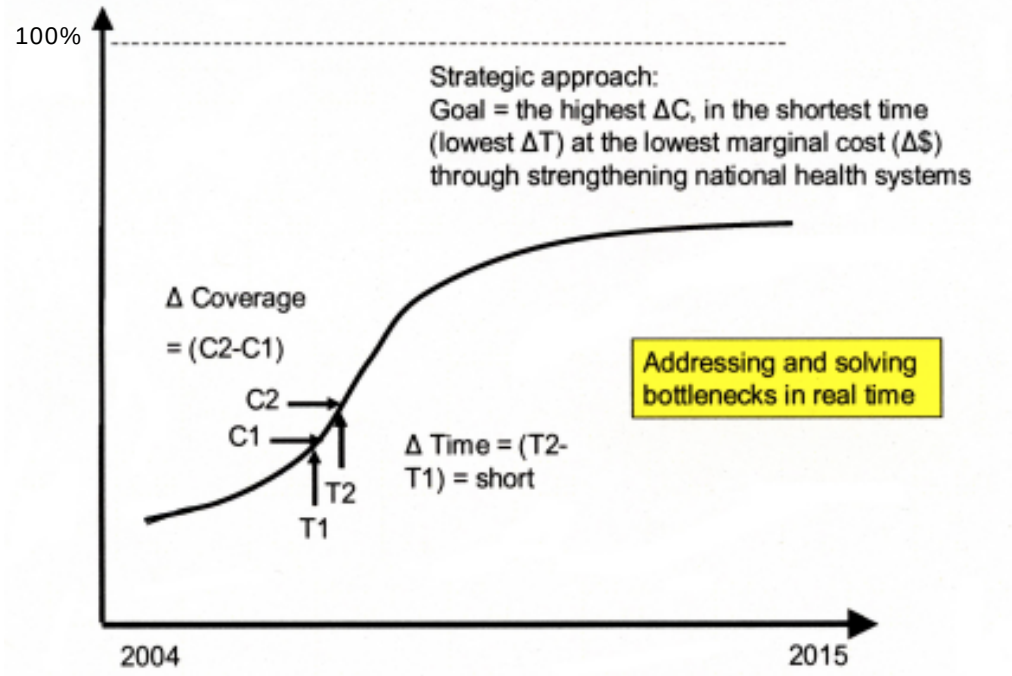
Family planning

MHTF support to family planning is closely coordinated with the Global Programme on RH Commodity Security, which will provide key resources. There are many factors that affect access to and use of family planning services. A variety of approaches will be considered and areas of support within family planning carefully selected by each country. For some countries advocacy and communication campaigns are needed to address lack of information or misinformation—and to enhance political support. In other countries, quality of family planning services needs to be improved through skills building amongst health care providers, more user-friendly health services, or community-based distribution of contraceptives and other RH services, including for HIV prevention. Outreach activities should be implemented to galvanize community participation and target those at risk for social exclusion from such services. Family planning services may need to be strengthened in some regions / districts through improvement in HMIS, linkages of family planning services with post-partum and post-abortion services, or supply management and distribution.

The most conservative estimates indicate that unsafe abortions are responsible for about 13 per cent of maternal deaths. Therefore, it is important to prevent unsafe abortions by increasing access to family planning, emergency contraception and access to post-abortion care. Post-abortion care also provides a very important entry point for provision of family planning services to women who need it most at a time when they are most open to receive it.

Most women want to use family planning after childbirth and are thus open to information and method provision immediately after their delivery, while still in contact with the health system. Provi-

FIGURE 9. SCALING-UP COVERAGE FOR IMPACT: THE BEST USE OF RESOURCES TO SCALE-UP RAPIDLY... MAKING THE MONEY WORK TO ACHIEVE RESULTS RAPIDLY



sion of voluntary family planning to post-partum women will prevent short intervals between deliveries, and will positively affect both maternal and child health.[43],[44]

EmONC services including upgrading of priority EmONC facilities

Much has been learned about supporting maternal health in resource-poor settings. One of the programs that has achieved high impact is the Columbia University-UNFPA-UNICEF Averting Maternal Death and Disability (AMDD) Program funded by the Bill & Melinda Gates Foundation (1999-2005). Peer-reviewed publications, its external evaluation and extensive documentation have clearly demonstrated the impact of this programme and have provided many practical lessons for programming in resource-poor settings.[45], [46] Over a period of five years, this programme has succeeded in doubling the number of women served and reducing by half the obstetric case fatality rate (the proportion of women dying from obstetric complications). The reader is referred to one of the more useful publications for revitalizing and scaling-up EmONC services, Practical Lessons from Global Safe Motherhood Initiatives: Time for a New Focus on Implementation.[47]

UNFPA will work with governments in collaboration with Columbia University, UNICEF and WHO to carry forward this successful approach. Based on the needs assessments in each country, a systematic approach to strengthening national health plans will be undertaken in the area of EmONC service delivery, including the costing of these plans.

More and more is known about the potential impact of reviewing maternal deaths and near-misses at facility level in terms of reducing the third delay and improving the quality of care and reporting. Based on national strategies, the MHTF will support efforts to institutionalize such practices. [48]

The MHTF will also provide resources for the revitalization of priority maternal health services, to bring them up to basic or comprehensive EmONC standards as required. This will be done through in-service training, MNH commodities (see below), upgrading of facilities and strengthening of HMIS. Basic and comprehensive EmONC facilities that have important clinical training responsibilities will receive particular attention in order to contribute to the scale-up in production of quality skilled health professionals and midwives in particular.

Essential maternal and newborn health commodity security improved

UNFPA, UNICEF and WHO are in the process of updating their lists of MNH equipment and supplies, and are planning to further strengthen procurement services to address quality, price, and maintenance, including strategic spare parts, and other important issues. This work, to be completed in 2009, will facilitate the capacity building work in countries as they move towards self-sufficiency in national procurement, supply chain management and maintenance of equipment. The MHTF and the Global Programme on Reproductive Health Commodity Security (GPRHCS) will support the strengthening of this key health system building block. Access to quality essential equipment, supplies and drugs will thus be strengthened with national, MHTF, GPRHCS and other resources.

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

Support will be provided to countries to strengthen their capacity to monitor progress. Ensuring that every country supported by the MHTF has up-to-date assessments in family planning/RHCS, human resources for MNH and for EmONC will enable countries to determine baselines for measuring progress towards MDG5. Support will also be provided to national HMIS to ensure the adoption and

[43] *Jones G, Steketee RW, Black RE, Bhutta ZA, Morris SS, and the Bellagio Child Survival Study Group. How many child deaths can we prevent this year? Lancet 2003; 362: 65–71.*

[44] *Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland, 13-15 June, 2005. www.who.int.*

[45] *Caro DA, Murray SF, Putney P. Evaluation of the Averting Maternal Death and Disability Program. A Grant from the Bill and Melinda Gates Foundation to the Columbia University Mailman School of Public Health. 26 July 2004.*

[46] *www.amddprogram.org.*

[47] *Freedman LP, Graham WJ, Brazier E, et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. Lancet 2007; 370:13831390.*

[48] *Beyond the numbers. Reviewing maternal deaths and complications to make pregnancy safer. WHO, Department of Reproductive Health and Research, 2004.*

regular use of the internationally-agreed MNH indicators within the HMIS in each country. Technical assistance will be provided to improve HMIS at facility, district and national levels, use for programme management at each level and regular bi-directional information flows between levels. This should foster friendly emulation between districts, a highly successful strategy for scale-up. The organization and delivery of monitoring and evaluation (M&E) courses for maternal and newborn health programmes by universities in developing countries is part of the MHTF-funded partnership with IMMPACT – University of Aberdeen.

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

The work supported by the MHTF will contribute to investing current resources more effectively and efficiently, and with a greater focus on SRH and MNH. It will also support government and partners in leveraging additional resources for maternal and newborn health. This will be done through policy dialogue; the availability of detailed quantitative information on the national situation provided by the needs assessments; the quality and results focus of the national health plans to reduce maternal mortality; the costing of these plans; the improved reporting on results through strengthened monitoring; and the momentum created through the national partnership building.

Other outputs as determined by each country

While the above seven outputs are essential, unless they have already been fully supported through other means, countries are encouraged to prioritize their requests for support for other important areas of maternal health such as improving financial, sociocultural and geographic access to sexual and reproductive health services.

Many women in high maternal mortality countries experience significant barriers to accessing the full range of sexual and reproductive health services. Countries may request support from the MHTF for a number of activities related to reducing gaps in health equity such as mapping exercises to determine coverage rates among marginalized groups, community-based initiatives to extend coverage to isolated communities, and partnership with and contribution to national performance-based funding.

In line with UNFPA's Sexual and Reproductive Health Framework, the MHTF will encourage and support countries in their efforts to empower communities to demand access to quality maternal health services, including family planning. Demand-creation and community mobilization activities, supported by the MHTF, could include communication or social marketing campaigns around family planning and MNH, male involvement initiatives, training of community representatives on health issues and verbal autopsies. Efforts may also be supported to increase community participation in order to create culture- and gender-sensitive maternal and reproductive health initiatives.

UNFPA recognizes that special efforts must be made to reach out to adolescents, both married and unmarried, with reproductive health information, including HIV prevention. Depending on the expressed needs of each country, the MHTF will support advocacy for the rights of young people to education and to access reproductive health services and the campaign for changes in policies and laws, particularly around access to care and child marriage.[49]

[49] *PATH and United Nations Population Fund. Meeting the Need: Strenthening Family Planning Programs. Seattle: PATH/ UNFPA; 2006.*

Maternal Health Thematic Fund Results Framework

Millennium Development Goal 5: To Improve Maternal Health

Target: Reduce the maternal mortality ratio by three quarters, between 1990 and 2015

Indicators:

- Maternal mortality ratio
- Proportion of births attended by skilled health personnel

Target: Achieve, by 2015, universal access to reproductive health

Indicators:

- Adolescent birth rate
- Antenatal care coverage (at least one visit and at least four visits)
- Unmet need for family planning
- Contraceptive prevalence rate

UNFPA Strategic Plan

Outcome 2.2 Access to and utilization of quality maternal health services increased in order to reduce maternal mortality and morbidity
And contributing to Outcomes 2.1 Universal Access to SRH, 2.3 Access to and utilization of family planning and 2.4 Demand, access to and utilization of quality HIV and STI prevention services.

Indicators as above plus:

- Proportion of countries with national development plans that allocate domestic resources for an essential sexual and reproductive health package
- Proportion of countries where Caesarean section as a proportion of all births falls in the range of 5-15 per cent (national, rural and urban)
- Proportion of service delivery points offering at least three modern methods of contraception

Country Level – as part of UNFPA's Country Programme (Support to the one national health plan in close coordination with WHO, UNICEF, the World Bank. regional development banks and other key partners)

Outputs	Indicators (Note: Baselines and Targets for indicators to be identified by each country)[50]	Potential Areas of MHTF Support / Activities based on National Priority Setting	Assumptions / Risks
1. Enhanced political and social environment for MNH and SRH: national advocacy, engagement of civil society, national coordination and partnership building	• National communication and advocacy strategy developed • Coordination Team in place, led by MoH, with UNFPA, WHO, UNICEF, the World Bank, Regional Development Bank, key bilaterals, civil society and other partners	• Support national stewardship, advocacy, communication and convening of key partners including civil society for MNH • Support activities to promote national approaches for the integration of maternal health into the district primary health care package and into sectoral frameworks and national development instruments	• MoH leadership • Commitment by national leadership including in MoF • Commitment by donor agencies to provide predictable, sustained and increasing funding in each MHTF-supported country

[50] *See Annex 1. MHTF Results Framework Indicator Table for Means of verification, Frequency of reporting and other information.*

	• District Health Management Teams (DHMT) convened regularly by MoH to plan and monitor quality MNH scale-up	• Support activities to include the issue of child marriage and unwanted pregnancy among adolescents in national assessments, planning and advocacy strategies • Support the regular convening of district health management teams to support planning, scale-up and M&E	
2. Support to up-to-date needs assessments for the SRH package with a particular focus on family planning, human resources for MNH, and EmONC	• Up-to-date needs assessments for MNH as part of national health plan including: FP/RHCS; Human Resources for MNH in the context of human resources for health; and EmONC	• Facilitate technical assistance and provide financial resources to support up-to-date national and district assessments and plans as related to EmONC, FP/RHCS, and HR for MNH	• MoH fully owns national assessments and MDG-driven planning processes • Availability of timely technical assistance / capacity building from national experts and regional institutions
3. National health plans focus on SRH, especially family planning and EmONC with strong RH/HIV linkages to achieve the health MDGs	• Up-to-date costed national plans for FP/RHCS and EmONC • Proportion of service delivery points where women attending antenatal care receive VCT and PMTCT	• Support national and district health plans including their service delivery plans to ensure that they include community mobilization, family planning education and services, quality facility deliveries, and RH/HIV integration: ▸ national efforts in community mobilization around SRH, including demand creation for family planning and birth planning ▸ family planning education and services to be offered in every community and in every primary health facility (public and private) ▸ reproductive health commodity security (RHCS) be ensured at every level (national, district and facility) ▸ all women have access to a quality facility delivery in a primary health centre (public and private) with a skilled health professional capable of providing basic EmONC. ▸ referral to a district hospital for comprehensive EmONC • Support RH-HIV integration, joint FP/HIV prevention, antenatal VCT and PMTCT • Support national planning processes for costing and financing of MNH components within the national health plans including work on sector	• MoH fully owns national assessments and MDG-driven planning processes • Availability of timely technical assistance / capacity building from national experts and regional institutions • National HIV /AIDS constituency fully committed to RH / HIV integration

		MTEFs, predictability and sustainability of funding, and fiscal space; support the availability of costing packages; • Support planning to improve financial access (e.g. work with World Bank on performance-base financing)	
4. Support the national response to the human resource crisis in MNH, with a focus on planning and scaling up of midwifery and other mid-level providers (as per Midwives Programme Document) **4.1 National health human resource plans for MNH include internationally-agreed upon requirements for family planning, normal delivery and basic and comprehensive EmONC district-based service delivery** **4.2 Upgraded midwifery education and training programs with curricula based on the ICM essential competencies for basic midwifery practice** **4.3 Increased number of midwifery associations with capacity to advocate for and implement the scaling up of midwifery services in the country** **4.4 National regulatory professional standards and monitoring systems in place to ensure sustainability of high quality midwifery services and care**	• National MNH human resource needs assessments up-to-date • National MNH human resource plan developed • Number and Proportion of midwifery training institutions, in all participating countries, with revised and culturally appropriate curricula - based on ICM essential competencies adopted and implemented • Annual number of midwifery graduates from national midwifery training institutions in all participating countries being deployed at basic and comprehensive EmONC facilities • Number and proportion of midwives, in all the participating countries, who are authorized and empowered to administer the core set of life-saving interventions (the 7 Basic EmONC functions) • Proportion of midwives, in the participating countries, who benefit from systems for compulsory supportive supervision and continued education for midwives • Proportion of participating countries with a national midwifery council/board, with international standards	**See joint UNFPA-International Confederation of Midwives (ICM) Midwives Programme document for detailed description of UNFPA support for this output.** This output can include: • Support to national policies, planning and programmes for HR for MNH with a focus on midwifery: production, deployment, retention including task shifting and team work (national regulations based on international standards, professional associations, standardized protocols and supervision, job aids, etc.) and national scale-up of training institutions • Support to the expansion/updating of existing midwifery schools–and the development of new schools–based on international standards • Support the development of national bursary programmes for midwifery students from rural areas–refundable through provision of service in underserved areas for equivalent number of years • Capacity building with the national midwifery association • Support the development of roster of midwifery schools (international and regional) capable of supporting development of new schools in MHTF countries	• Agreement and strong support by MoH • Existing buy-in and willingness of the institutions to enhance scaling-up and training (Risks: midwifery training institutions and programmes do not have sufficient resources and sustained support) • Sufficient national financial resources • ICM training programmes in advocacy and capacity building for midwifery associations are culturally appropriate and effective • Strong support from MoH and legislators for continued professional midwifery training, supervision and midwives' protection

5. National equity-driven scale-up of family planning and EmONC services, maternal and newborn health commodity security (in close coordination with UNFPA's Global Programme on RHCS and with joint financial support) **5.1 Access to family planning improved** **5.2 Access to quality EmONC improved** **5.3 Essential maternal and newborn health commodity security improved (in close coordination with UNFPA's Global Programme on RHCS and with joint financial support)**	• Proportion of service delivery points offering at least three modern methods of contraception **United Nations EmONC Indicators** • Case fatality rate for direct obstetric causes in facilities • Availability of emergency obstetric and newborn care: basic and comprehensive EmONC facilities • Proportion of all births in EmONC facilities • Met need for EmONC • Proportion of country commodity requests satisfied	• Support the scaling-up of family planning services to every health facility and resolving of bottlenecks in real time • Support training of staff for family planning • Support post-partum family planning • Advocacy and support for family planning services to be integrated into post-partum care • Support the scaling-up of maternal health services– and resolving of bottlenecks -, including supporting strengthening service delivery in– and upgrading–priority basic and comprehensive EmONC facilities • Support approaches with other sectors to reduce the three delays (communication, transport, e.g. taxi association voucher systems etc.) • Capacity building for quality of care (e.g., accreditation of facilities, work with professional associations, national regulations, maternal death audits, etc.) • Support the provision of contraceptives • Support the provision of essential MNH drugs, supplies and equipment • Strengthening of national capacity development in health supplies logistics systems	• Sustained and sufficient national and donor financial commitments • Committed district health management teams • Motivated health workers
6. Monitoring and results-based management of national MNH efforts supported	• Internationally-agreed MNH indicators integrated in national HMIS • Mandatory notification of maternal deaths • Annual number of maternal death audits • Proportion of districts reporting yearly on nationally-agreed MNH indicators	• Support to national HMIS: review and adoption of international MNH indicators within national HMIS • National capacity building for HMIS, including technical assistance and participation in training courses (e.g., IMMPACT – IPACT) • Support to HMIS strengthening including in-service training with district teams and health facilities teams • Support to periodic national census and surveys (DHS, MICS, others) to measure maternal mortality and related population-based MNH/FP indicators	• Integration of internationally-agreed indicators for RH/MNH in health system strengthening efforts such as IHP+, etc. • MoH committed to sustained results-based approach and to regular facility and district reporting through strong HMIS

		• Support periodic MNH/RH reviews/evaluations as part of health sector reviews	
7. Support to countries in leveraging additional resources for MDG5 from government and donors	• Share of government expenditure for health (as per annual government figures) • National budget for MNH overall and per capita (including all flows: domestic and external), as measured through national health accounts where they exist	• Support government to mobilize and leverage resources for maternal and reproductive health from domestic and external sources	• Sustained national and donor financial commitments
Other outputs as determined by each country	***Please refer to country-specific proposals to the MHTF for each MHTF supported country***		
REGIONAL LEVEL - AS PART OF UNFPA'S REGIONAL PROGRAMMES: TO STRENGTHEN REGIONAL STEWARDSHIP AROUND MNH - POLICY DIALOGUE AND COORDINATION			
1. Increased regional recognition of MNH by policy makers **2. Enhanced regional coordination around MNH** **3. Increased South-South support to national capacity building** **4. Increased support at regional level for midwifery as a key health workforce for the achievement of MDG5** **5. Increased sharing of lessons learned and production of evidence**	• Number of regional meetings on MNH • Annual number of South-South MNH capacity building missions / exchanges with MHTF-supported countries • Presence of regional efforts to standardize midwifery curricula within regions based on international standards • Number of MHTF-supported countries in each region with a functioning national Midwifery Council / Board	• Supporting UNFPA Regional Programmes with additional technical capacity • Support regional advocacy and commitment for MNH (e.g., Maputo Plan of Action, parliamentary associations, high-level meetings, etc.) • Work with WHO to ensure MNH high on agenda of regional health meetings and with the World Bank for regional finance meetings • Support regional capacity building through the technical assistance network of regional institutions and individuals, working with UNICEF and Columbia University (see UNFPA-UNICEF-Columbia University AMDD MOU) • Support regional inter-agency coordination on MNH (WHO, UNICEF, UNFPA, World Bank, Regional Development Banks (e.g., Harmonization for Health in Africa, regional directors meetings, etc.) • Support standardization of curricula and exchange of experiences as related to human resources for MNH	• Regional commitment to SRH (such as Maputo Plan of Action in Africa) • Effective United Nations regional coordination (e.g. Harmonization for Health in Africa, regular meetings of regional directors) • Effective and culturally appropriate advocacy for midwifery is feasible

GLOBAL LEVEL - AS PART OF UNFPA'S GLOBAL PROGRAMME: TO STRENGTHEN GLOBAL STEWARDSHIP AND COORDINATION AROUND MNH			
1. Global stewardship and leadership for MNH enhanced **2. Joint UN-MNH support to countries** **3. Technical assistance network established and functioning** **4. Increased support at global level for midwifery as a key health workforce for the achievement of MDG5** **5. Advocacy for maternal health**	• Level of financing for MNH for high maternal mortality countries • Number of countries receiving joint UN-MNH support • Number of institutions actively participating in the technical assistance network	• Support global advocacy and resource mobilization / leveraging for MNH • Support joint UN-MNH work and coordinated action to provide enhanced support to 25 priority countries by end of 2009 and to the 60 priority countries by end of 2012 • Contribute to the development of a global programme of work with key stakeholders to accelerate progress towards MDG5 (participate in follow-up to the campaign for the health MDGs and efforts of Norway, UK, Sweden and the Bill & Melinda Gates Foundation) • Support the Partnership for Maternal, Newborn and Child Health • Support global communication and advocacy initiatives focusing on MNH • Developing print and audio-visual advocacy and media materials in several languages • Pitching stories to the media, issuing press releases and holding press events to increase media coverage of the issue • Working with high net worth individual donors and philanthropic groups that raise funds and awareness about maternal health	• Global commitment to MNH sustained • Effective follow-up of the WHO-UNFPA-UNICEF-World Bank Joint Statement on Maternal and Newborn Health • Donor governments and foundations provide sufficient multilateral funding for MNH, including to the MHTF **Risks:** • **Donor fatigue / insufficient donor support** • **Global financial crisis** • **Competition for other development priorities**

6. Budget

The proposed MHTF budget is based on a progressively increasing income scenario for 2008-2011, totaling around $500 million. Under such income projections, significant progress can be made in 25 countries mostly of middle size, but with some larger ones (such as Bangladesh and Ethiopia); and work could begin towards the end of the 2008-11 cycle in approximately 48 countries. We would thus be on the way to providing support to the 60 high maternal mortality countries by no later than 2012.

It is worth remembering that the MHTF funding is meant to be catalytic; $500 million over four years represents less than two per cent of the $6 billion to $7 billion annually estimated by WHO, plus the $1.5 billion annually for family planning. It is assumed that priority countries will receive the bulk of their health ODA through other mechanisms, ideally through pooled sector funding of an MDG-driven national health plan through a Sector Wide Approach (SWAp).

Financial requirements for the MHTF increase rapidly over the next four years, based on both the increasing number of countries (12 countries per year) and the rapidly increasing level of yearly effort in each country supported as scale-up progresses.

Ideally, pledges from donors should be multi-year (for the period 2008-2011) and progressively increasing, commensurate with the growing financial requirements of the MHTF.

These resources should provide an important contribution to the WHO-UNICEF-UNFPA-World Bank joint support to countries to accelerate progress towards MDG5.

Impact of different levels of funding on the MHTF-supported programme of work

Scenario One: $70 million to $75million a year: initial work in 25 countries

A total of around $72 million will be required for

Maternal Health Thematic Fund Budget–$500 million over four years

	2008	2009	2010	2011	2008-2011	% of Total
Number of countries added each year	12	12	12	12		
Total number of MHTF-supported countries	12	24	36	48	48	
	$M	$M	$M	$M	$M	
Country Level Outputs						
1. Enhanced political and social environment for MNH	1.02	3.06	6.12	12.24	22.44	
2. Needs assessments	2.04	6.12	12.24	24.48	44.88	
3. National Health Plans strengthened for FP and EmONC	2.04	6.12	12.24	24.48	44.88	
4. National response to human resource crisis-midwifery	6.12	18.36	36.72	73.44	134.64	
5. Support to national scale-up of FP an EmONC*	6.12	18.36	36.72	73.44	134.64	
6. Monitoring and results-based management	2.04	6.12	12.24	24.48	44.88	
7. Leveraging of additonal resources for MDG5	1.02	3.06	6.12	12.24	22.44	
Country Level Total	20.40	61.20	122.40	244.80	448.80	**95.3**
Regional Level	0.70	1.40	1.40	1.40	4.90	**1.0**
Global Level	2.18	4.35	5.35	5.35	17.23	**3.7**
Total less indirect costs**	23.28	66.95	129.15	251.55	470.93	**100**
Total	**24.90**	**71.64**	**138.19**	**269.16**	**503.89**	

Notes: * In close collaboration with Global Programme on Reporductive Health Commodity Security
** Indirect costs = 7%

operations in 2009. Since the four United Nations agencies have committed to accelerated support in 25 countries by the end of 2009, the minimum scenario to begin work in the 25 countries would be funding of the order of $25 million in 2008 and $70 million to $75 million per year thereafter. However, such a funding level would not allow much support to scale up in those 25 countries, and would preclude expanding to the other 35 or so high maternal mortality countries.

Scenario Two: Continued expansion to $140 million in 2010 and $270 million in 2011: important contribution in 48 of the 60 high maternal mortality countries

Adding 12 countries in each of 2010 and 2011 and scaling up coverage within each country would require around $140 million in 2010 and $270 million in 2011. This, coupled with the resources of UNICEF, the World Bank and the continued technical support of WHO, could go a long way in ensuring that the national health system can improve maternal and newborn survival, achieving better results—and value for money—with its overall sector resources.

7. Management and Governance

The management and governance of the MHTF will respect the usual UNFPA accountability lines, as well as the approved thematic fund guidelines. Specifically, accountability for country activities rests with the representative who is supervised by her/his regional director. Regional activities are the responsibility of the respective regions supervised by their regional director. All global activities will be supervised under the Director of the Technical Division (TD) or the Information and External Relations Division (IERD), as relevant. The overall program stewardship rests with the Deputy Executive Director of Programs and with the Executive Director.

A small team at UNFPA headquarters, within the Sexual and Reproductive Health Branch of the Technical Division, will manage and coordinate the MHTF. The team will include a coordinator, an M&E specialist and a finance associate, as well as administrative and consultative support where needed. Most importantly, the coordination team will work to ensure that the MHTF effort represents a UNFPA-wide approach by including input from all divisions as we work towards a common goal. In order to operationalize this integrated strategy, one consolidated annual workplan including all relevant divisions is being developed.

The Maternal Health Inter-Divisional Working Group (MH-IDWG) has been created as a mechanism for communication and coordination. The MH-IDWG operates on both a policy and working level to assure coherence in planning, funding allocations, reporting and other functions for country, regional and global programs. At the working-group level, focal points have been identified within each division to participate in the MH-IDWG and liaise between divisions and the MHTF team to ensure that every relevant unit is effectively involved. The MH-IDWG meets monthly at the working level and annually at the policy level.

All countries considered for support from the MHTF have high maternal mortality, defined as an MMR greater than 300 maternal deaths for every 100,000 live births. The country selection process is highly interactive, involving consultations with countries, regions and other United Nations agencies. Beyond high MMR, countries selected for support must be identified as having the potential for rapid success based on the criteria listed below or be facing significant maternal health needs due to humanitarian crisis.

Criteria for the selection of countries for MHTF support:

1. Participation in recent global initiatives, and in particular the International Health Partnership (IHP+)
2. Strong national commitment
3. Strong country office commitment and leadership

Countries will be selected to join in successive waves as funding becomes available, until eventually all 60 high maternal mortality countries are supported.

Application Process

Countries are asked to submit a simple proposal outlining the maternal and reproductive health outcomes they would like to achieve and the associated activities for which they need support. Countries will be allocated funding on an annual basis through an annual workplan based on the amount requested in the proposal and the availability of MHTF resources. This funding will support the

country programme as part of "other resources" in the country programme document approved by the Executive Board. The MHTF is not intended to be a parallel funding entity, but an integrated component of each country's programme to ensure optimal in-country results.

Contributions received by the MHTF from donors will be pooled. Donors will receive one consolidated annual report that will include both generic and country-specific results. The funding mechanism is intended to be simple and flexible to allow countries to adapt to changing situations and needs. Pooling resources under one thematic area, rather than many separate projects, will also reduce transactional costs at every level and allow for a more harmonized development effort in countries. To further streamline support to countries, and increase continuity, UNFPA is considering the integration of the Fistula Programme into the MHTF. As mentioned earlier, the Midwives Programme, which is still in part funded as a separate project, has been recently integrated within the MHTF. There will be close coordination of country support with the global programme for RHCS so as to decrease transaction costs with ministries of health and streamline workflows and business processes with country offices, regions and headquarters.

The work of the MHTF will be guided by this business plan as well as a set of tools and publications. Most of these tools for MNH needs assessment, planning, implementation, scale-up and monitoring already exist. Work is on-going to make them easily available to countries. Some will require development / adaptation, particularly those related to human resources planning for MNH.

8. Monitoring and Evaluation and Reporting

Strengthening national capacity for monitoring MNH is a prominent feature of MNH support. Support from the MHTF will aim to strengthen the national HMIS to ensure that a minimal set of internationally agreed MNH indicators are included and reported on annually. In this regard, work led by WHO is on-going, including in particular support through the International Health Partnership M&E framework.[51]

It will be critical to capture these indicators at facility, district and national levels. Strengthening M&E capacity at district-level will thus be important. This will be supplemented with periodic population-based surveys, to measure such indicators as unmet need for family planning and contraceptive prevalence.

Preliminary discussions have begun with academic institutions to explore the feasibility and costs of measuring maternal mortality every three years in all priority countries (60 of them) so as to provide a few time points between now and 2015 (for example 2009, 2012, 2015).

The coverage, outcome and impact indicators are imbedded in the MHTF Results Framework. Please see Annex 1 (the MHTF Results Framework Indicator Table), for means of verification, frequency of reporting and other relevant information on each indicator.

The country-specific UNFPA outputs and activity indicators will be prepared by UNFPA country offices in close consultation with MoH and partners.

Annual report

A consolidated annual report will be prepared with both overall and country-specific results. This will also include reporting financially on income and on the use of resources.

9. Conclusion

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 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, in a not too distant future, a world where maternal mortality has been eliminated.

[51] *A common framework for monitoring performance and evaluation of the scale up for better health. Monitoring & Evaluation Working Group, International Health Partnership+. February 2008.*

Annex 1. MHTF Results Framework Indicator Table

Indicators	Means of Verification	Frequency	National Baselines (to be completed by each country	National Targets (to be completed by each country
MDG5				
• Maternal mortality ratio	• Census, DHS, MICS, other MM population-based studies	Every 3 - 10 years		
• Proportion of births attended by skilled health personnel	• HMIS, DHS, MICS	Every 1 - 5 years increasing to yearly		
• Contraceptive prevalence rate	• DHS, MICS	Every 3 - 5 years		
• Adolescent birth rate	• DHS, Census	Every 5 years		
• Antenatal care coverage (at least one visit and at least four visits)	• HMIS	Every year		
• Unmet need for family planning	• DHS, MICS	Every 3 - 5 years		
UNFPA Strategic Plan (with all of the above)				
• Proportion of countries with national development plans that allocate domestic resources for an essential sexual and reproductive health package	• MOH budgets and financial reports	Yearly		
• Proportion of countries where Caesarean section as a proportion of all births falls in the range of 5-15% (national, rural and urban)	• HMIS, DHS, MICS	Every 1 - 5 years increasing to yearly		
• Proportion of service delivery points offering at least three modern methods of contraception	• HMIS	Yearly		
National output indicators				
• National communication and advocacy strategy developed	• Existence of document	Once before 2011		
• Coordination team in place, led by MoH, with UNFPA, WHO, UNICEF, the World Bank, Regional Development Bank, key bilaterals, civil society and other partners	• Minutes of meetings of coordination team	Yearly		

• District health management teams (DHMT) convened regularly by MoH to plan and monitor quality MNH scale-up	• Meeting reports	Yearly		
• Up-to-date needs assessments for MNH as part of national health plan including FP/RHCS, human resources for MNH and EmONC	• Existence of document	Less than 5 years old		
• Up-to-date costed national plans for FP/RHCS and EmONC • Proportion of service delivery points where women attending antenatal care receive VCT and PMTCT	• Existence of documents • HMIS	Less than 5 years old Yearly		
• National MNH human resource needs assessments up-to-date • National MNH human resource plan developed • Number and proportion of midwifery training institutions, in all participating countries, with revised and culturally appropriate curricula– based on ICM essential competencies adopted and implemented • Annual number of midwifery graduates from national midwifery training institutions in all participating countries being deployed at basic EmONC and comprehensive EmONC facilities • Number and proportion of midwives, in all the participating countries, who are authorized and empowered to administer the core set of life-saving interventions (the seven basic EmONC functions) • Proportion of midwives, in the participating countries, who benefit from systems for compulsory supportive supervision and continued education for midwives • Proportion of participating countries with a national midwifery council/board, with international standards	• Existence of documents • Existence of documents • From UNFPA CO, by verification of documents from each school • From UNFPA CO, by verification of documents from each school • From MoH documents • From midwifery association's documents • Direct verification by ICM and UNFPA regional offices	Less than 5 years old Less than 5 years old Yearly Yearly Every 1 - 5 years Every 1 - 5 years Every 1 - 5 years		

• Proportion of service delivery points offering at least three modern methods of contraception **United Nations EmONC Indicators**	• From HMIS (note UNFPA strategic plan indicator and also part of GPRHCS M&E framework) **See: The Indicators for Monitoring The Availability and Use of Obstetric Services. WHO, UNFPA, UNICEF. Columbia University. Submitted for publication 2009. (Note: updated edition from 1997 document)**	Yearly		
• Case fatality rate for direct obstetric causes in facilities	• From EmONC needs assessments and HMIS	Every 1 - 5 years increasing to yearly		
• Availability of emergency obstetric and newborn care: basic and comprehensive EmONC facilities	• From HMIS	Every 1 - 5 years increasing to yearly		
• Proportion of all births in EmONC facilities	• From HMIS	Every 1 - 5 years increasing to yearly		
• Met need for EmONC	• From HMIS	Every 1 - 5 years increasing to yearly		
• Proportion of country commodity requests satisfied	• From national requests received	Every 1 - 5 years increasing to yearly		
• Internationally-agreed MNH indicators integrated in national HMIS	• From HMIS (includes MDG5, FP in SDPs, United Nations EmONC indicators)	Every 1 - 5 years		
• Specific notification of maternal deaths	• From HMIS	Yearly		
• Annual number of maternal death audits increased	• From HMIS	Yearly		
• Proportion of districts reporting yearly on nationally-agreed MNH indicators	• From HMIS	Yearly		

• Share of government expenditure for health (as per annual government figures) • National budget for MNH overall and per capita (including all flows: domestic and external), as measured through national health accounts where they exist	• From government annual financial reports • From MoH reports	Yearly Yearly		
Other country-specific outputs (Please refer to country-specific proposals to the MHTF and country AWPs for each MHTF supported country) • Other indicator … • Other indicator …				
Regional output indicators				
• Number of regional meetings on MNH	• From UNFPA RO	Yearly		
• Annual number of South-South MNH capacity building missions / exchanges involving MHTF-supported countries	• From UNFPA RO	Yearly		
• Presence of regional efforts to standardize midwifery curricula within regions based on international standards	• From ICM and UNFPA RO	Yearly		
• Number of MHTF-supported countries in each region with a national midwifery council/board established and functioning	• From UNFPA COs	Yearly		
Global output indicators				
• Level of financing for MNH for high maternal mortality countries	• From global studies (e.g. WHO, UNFPA, UNICEF, World Bank costing)	Every 3 - 5 years		
• Number of countries receiving joint UN-MNH support	• From UN-MNH working group	Yearly		
• Number of institutions actively participating in the technical assistance network	• From UNFPA MHTF coordination team	Yearly		

Annex 2.

A. Joint Statement on Maternal and Newborn Health
B. WHO-UNFPA-UNICEF-World Bank Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care
C. Proposed List of Priority Countries for UN MNH Joint Work

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

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.[1,2] 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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[1] 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/MDGafrica07.pdf

[2] The Millennium Development Goals Report. United Nations. 2007.
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
Family Planning	UNFPA, WHO	UNICEF, WB
Antenatal Care	UNICEF, WHO	UNFPA, WB
Skilled Attendance at Birth	WHO, UNFPA	UNICEF, WB
B-EmONC[3]	UNFPA, UNICEF	WHO, WB
C-EmONC[4]	WHO, UNFPA	UNICEF, WB
Post-partum	WHO, UNFPA	UNICEF, WB
Newborn care	WHO, UNICEF	UNFPA, WB
Maternal and Neonatal Nutrition	UNICEF, WHO,WB (for maternal nutrition)	UNFPA

[3] B-EmONC Basic Emergency Obstetric and Newborn Care

[4] 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 *UNAIDS Technical Support Division of Labour*	
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

Proposed list of Priority Countries for UN MNH Joint Work

Country	MMR	Lifetime risk of maternal death. 1 in	IHP	Catalytic	EU	Gates	Norway	CIDA-PMTCT	UNFPA-MHTF	WB-Norway	SPP*	GF-MNH	Joint UN-MNH
Afghanistan	1800	8		1						1	1		1
Angola	1400	12			1						1		
Bangladesh	570	51											1
Benin	840	20		1					1	1	1		1
Burkina Faso	700	22	1	1	1	1			1		1		1
Burundi	1100	16	1						1			1	
Cambodia	540	48	1	1					1				1
Cote d'Ivoire	810	27										1	
Djibouti	650	35							1				
DRC	1100	13								1			1
Eritrea	450	44								1			
Ethiopia	720	27	1	1					1	1	1		1
Ghana	560	45		1						1	1		1
Guyana	470	90			1				1				
Haiti	670	44			1				1				1
India (very high MMR states)	450	70		1			1						1
Kenya	560	39	1		1								1
Lesotho	960	45						1					
Liberia	1200	12		1									1
Madagascar	510	38	1						1	1			
Malawi	1100	18		1	1	1			1		1		1
Mali	970	15	1	1									1
Mozambique	520	45	1	1		1					1		1
Nepal	830	31	1										1
Niger	1800	7		1	1							1	1
Nigeria	1100	18					1				1		1
Pakistan	320	74		1			1				1		1
Rwanda	1300	16								1			1
Senegal	980	21											
Sierra Leone	2100	8											1
Sudan	450	53							1				
Swaziland	390	120						1			1		
Tanzania	950	24		1	1		1				1	1	1
Uganda	550	25											1
Vietnam	150	280	1								1		
Zambia	830	27	1					1		1			1
Zimbabwe								1			1		1
Total			**11**	**14**	**8**	**3**	**4**	**4**	**11**	**9**	**14**	**4**	**25**

Selection criteria

Sub-set of 68 Countdown countries

Very high MMR > 550

Committed Country Teams (governement and partners)

Potential for scale-up including availability of financial resources