



www.carmma.org



Campaign on Accelerated Reduction of Maternal Mortality in Africa

No woman should die giving life. It's within our reach. It's in our hands.

**STIRRING
CONTINENTAL
CONSCIENCE
INTO ACTION**

**SUCCESS IN
MATERNAL
DEATH
REDUCTION**

Africa is winning



African Union Commission



United Nations Population Fund



FULL NAME

Campaign on Accelerated Reduction of Maternal Mortality in Africa

DATE OF BIRTH

2009

INITIATORS

African Union in collaboration with UNFPA and others

COUNTRIES of Launches

2012

South Africa

2011

Botswana, Liberia, Democratic Republic of Congo, Gabon, Tanzania, Equatorial Guinea, Burundi, Burkina Faso, Tunisia and Niger.

2010

Ethiopia, Sierra Leone, Central African Republic, Uganda, Cameroon, Mauritania, Lesotho, Zambia, Zimbabwe, Guinea Bissau, Senegal, Gambia, Eritrea, Angola, Togo, Benin, Congo Brazzaville and Kenya.

2009

Mozambique, Malawi, Rwanda, Nigeria, Swaziland, Ghana, Namibia and Chad.

Vision/Mission

Our vision

No Woman should die giving life

Our mission is to accelerate action across Africa to reduce maternal, newborn and child mortality.

Our strategic actions

1. Build on existing efforts to improve maternal, newborn and child health across Africa – particularly by sharing best practice.

2. Generate and share data on maternal, newborn and child health.

3. Advocate for increased political commitment, and mobilize domestic resources in support of maternal, newborn and child health.

4. Communicate with the wider African public and inspire action.

Connections/Linkages

- > *UN Secretary General's Global Strategy on Women's and Children's Health*
- > *Commission on Information and Accountability for Women's and Children's Health*
- > *The UN Commission on Life-Saving Commodities for Women and Children*
- > *Family Planning Summit on repositioning family planning*
- > *The Global and Regional Partnerships on Reproductive, Maternal, Newborn and Child Health*
- > *The Thematic Think Piece for Health in the post 2015 UN Development Agenda*
- > *The Save the Mother and Save the Child Initiative of the Prevention and Elimination of Mother-to-Child Transmission of HIV*
- > *Safe Motherhood Initiative*
- > *White Ribbon Alliance Initiative*
- > *The Continental Policy Framework for Sexual and Reproductive Health and Rights*
- > *The Maputo Plan of Action*
- > *The African Health Strategy*
- > *The Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases*

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Her Excellency, Dr. Nkosazana Dlamini-Zuma, AUC Chairperson



Women constitute more than 50 per cent of the continent's population and their engagement in all spheres of human endeavour is imperative. Africa has unacceptably high maternal and infant mortality rates. What women in other countries – especially in the developed world – take for granted as a normal physiological function of giving birth and ensuring the continuation of the human race, on our continent means putting your life at risk. The death of a mother is not just the death of an individual. It means the survival of the young children that she may be leaving behind is not guaranteed, and if they survive, they may not reach their full potential in life. And of course, the loss of a mother is a loss to the family and the community.

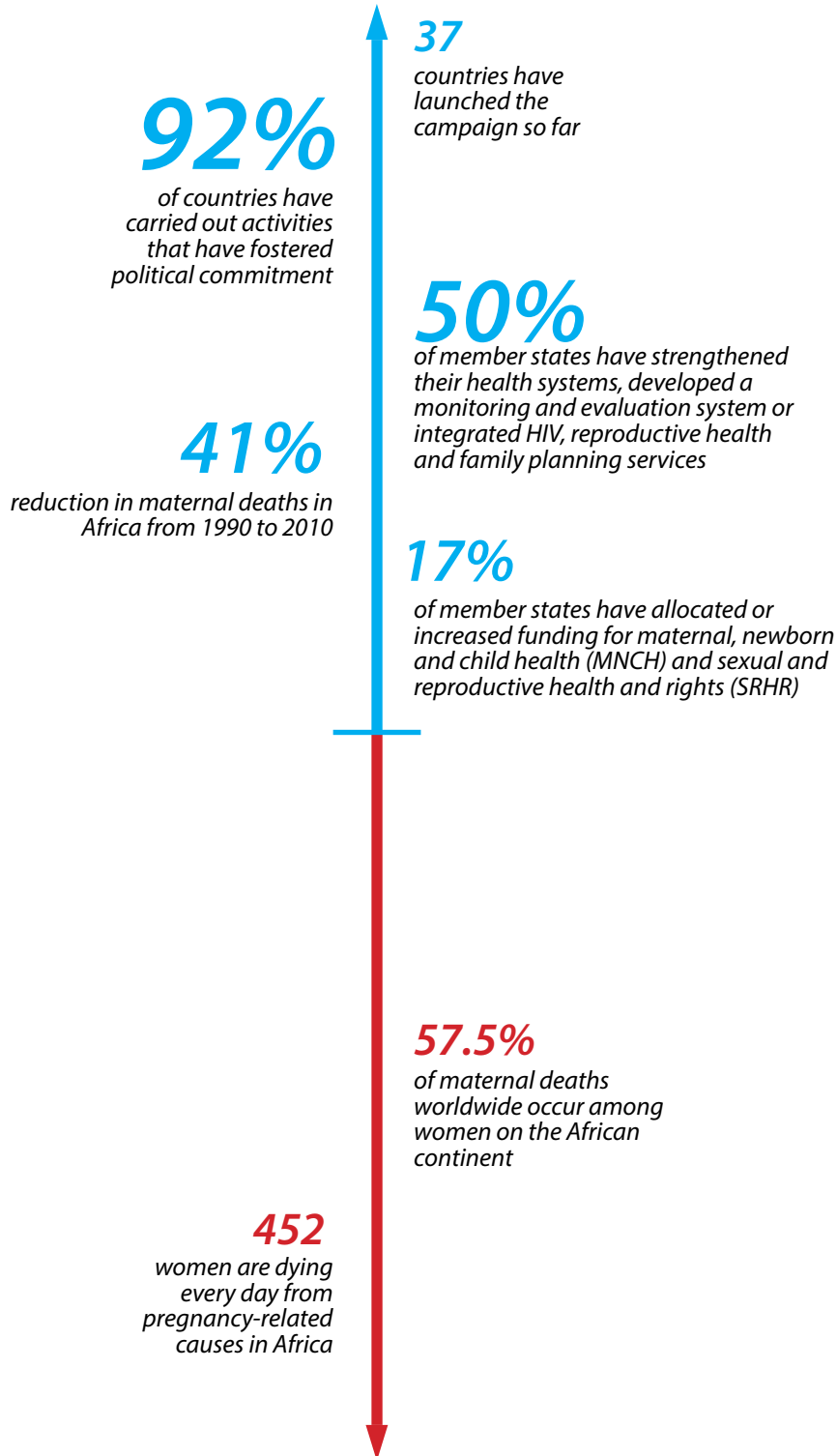


Dr. Babatunde Osotimehin, Executive Director, United Nations Population Fund (UNFPA)

Africa has many accomplishments in which to take pride and confidence, including a 41 per cent reduction in maternal mortality. Progress on many fronts is dramatic with a new sense of optimism found right across the continent. But if the continent is to make the most of its rich potential, there are many challenges still to overcome. And none is bigger than further improving Africa's still unacceptably high record on maternal health. While Africa has only 14 per cent of the world's population, it accounts for well over half of all maternal deaths worldwide – deaths that are overwhelmingly avoidable. For it is not untreatable diseases but the lack of access to family planning, basic care around childbirth, skilled attendance, health checks and advice in pregnancy that are the main reasons for this loss of human life.

It is a mark of the new determination across Africa, to remove obstacles to progress, that we are seeing a major drive to end this unnecessary death toll. The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) was launched three years ago by the African Union, with the support of UNFPA, the United Nations Population Fund, which I am privileged to head. CARMMA has enjoyed tremendous support at the highest levels. We see success stories right across the continent, with strengthened health systems, increased funding and new partnerships between the public, private and voluntary sectors. However, despite some remarkable results, over 450 women and girls continue to die in Africa every day from complications in pregnancy or childbirth. If the continent is to continue the remarkable economic and social progress achieved over the last decade, then reducing child and maternal deaths must be a top priority. It is within our reach that no woman should die giving life. The realization of this commitment is also in our hands.

CARMMA IN NUMBERS



CARMMA STIRS CONTINENTAL CONSCIENCE INTO ACTION



The aim of CARMMA is to use the vehicles of policy dialogue, advocacy and community social mobilization to enlist political commitment throughout the continent, increase resources and boost Maternal Health

At the continental launch, in 2009, countries were urged to launch the campaign and to develop mechanisms for implementation and monitoring progress.

Since the first national launch, by Mozambique on 3 August 2009, 37 countries have now launched the campaign: eight in 2009; 18 in 2010; 10 in 2011, and one in 2012. With launching comes the implementation of commitments, policies and activities that include community mobilization; the development of National Road

Maps; provision of sustainable funding; the strengthening of health systems; development of monitoring and evaluation mechanisms; promotion of integrated HIV and AIDS, and strengthening of reproductive and family planning services.

Continently, the campaign has made tremendous progress since those early days, with several countries adopting National Road Maps and developing Strategic Health Development Plans. CARMMA has also become the platform for mobilizing commitments and support for the UN Secretary General's Global Strategy on Women's and Children's Health and the implementation of the recommendations for the Commission on Information and Accountability (COIA) of the Global Strategy. CARMMA has

become an integral part of the health sector landscape and the maternal and neonatal health road map in Africa.

Such integration of CARMMA into existing Maternal and Newborn Health (MNH) strategies is critical because of the need to ensure government ownership of the campaign, so as to boost its sustainability and visibility.

Countries such as Zimbabwe, Namibia and Sierra Leone now have extensive MNH programmes. In Namibia, inter-sectoral collaboration at the national level is marked by the involvement of various ministries and civil society in the national coordination mechanism.

In Sierra Leone, access to care at health facilities increased with free health care services for pregnant and lactating women and under-five children. The involvement

of civil society organizations in monitoring RH commodities has also improved accountability and transparency.

In most countries that have launched the campaign, there is broad engagement of all stakeholders, and growing collaboration among maternal, newborn and child health partners.

The strengthening of health systems, including the training of health workers, is being emphasized in many countries, including Uganda, Botswana, Gambia and Eritrea. With the support of partners, including UNFPA, Uganda operates a bursary scheme for the training of midwives, while Botswana has broad training programmes for doctors, midwives, and nurses. UNFPA, WHO and the Global Fund are supporting similar processes in Gambia. Eritrea is providing in-service training to midwives and other health care providers, as well as to young doctors, in

the provision of Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services, with Intrauterine Device (IUD) and Norplant insertions introduced following the launch of CARMMA in the country.

Many countries, including Swaziland, Ghana and Malawi, are going ahead with the provision of facilities and equipment aimed at providing the best care for pregnant women and newborns. Swaziland has equipped a regional hospital with basic MNH equipment such as a digital Doppler, scanner, and delivery

kits, and resuscitation equipment for the adult and child.

Cameroon has also begun a pilot project in which obstetric kits are being made available to pregnant women at a fixed price. It is notable that as a result of this, the number of monthly deliveries increased by about 70 per cent in participating health facilities within six months.

Through CARMMA, Malawi is also aiming to bring MNH services closer to the community and promote access to Sexual and Reproductive Health (SRH) services, including the provision of Depo-Provera to clients by

With launching comes the implementation of commitments, policies and activities that include mobilization; the development of National Road Maps; provision of sustainable funding; the strengthening of health systems; development of monitoring and evaluation mechanisms; promotion of integrated HIV and AIDS, and strengthening of reproductive and family planning services.

health surveillance assistants; while Nigeria is using anti-shock garments, Misoprostol and magnesium sulphate in the management of post-partum haemorrhage and eclampsia.

One of the most important dimensions of the work that is going on throughout Africa on maternal mortality is the remarkable use of partnership and collaboration. Rwanda decided to merge CARMMA with the White Ribbon Alliance (WRA) Initiative in national efforts to reduce maternal mortality and morbidity. Maternal mortality review is

also becoming institutionalized in many countries. In Namibia, maternal death review tools have been launched, and reviews are being put in operation in all district hospitals. Swaziland holds quarterly review meetings as well as an annual one; while in Gambia, since 2010, hospitals have been carrying out maternal death audits with the assistance of UNFPA. In Uganda, the government has made maternal death a notifiable condition, and Maternal and Perinatal Death Review (MPDR) has been institutionalized, with notification to the Ministry of Health required within 24 hours.

“One of our priorities is Millennium Development Goal 5 – improving maternal health,” said Mr. Bunmi Makinwa, Director of UNFPA’s East and Southern Africa Regional Office. The “2012 Status Report on Maternal, Newborn and Child Health” points to unacceptably high maternal and child mortality and morbidity, despite some progress in improving the health of women and children: “Despite the progress recorded, Africa is still

confronted with formidable challenges as it strives towards the attainment of the MDGs, especially MDGs 4 and 5 by 2015,” says the report.

Continently, Africa has woken up to the wise words of Former Zambian president Rupiah Bwezani Banda: “Maternal mortality is not only an injustice, it is also a tragedy.”

On account of the commitment of African leaders and their development partners, “No Woman Should Die Giving Life”.

CARMMA Timeline

2006

Africa, through the Maputo Plan of Action, declared the equivalent of a state of emergency on maternal and child health.

2010

The African Union Summit in Uganda was convened under the theme: "Maternal, Infant and Child Health and Development in Africa."

2011

At the 5th session of the Pan African Parliament in Johannesburg, it was stressed that maternal, newborn and infant health is critical to overall human and social development in Africa, and governments were urged to devote greater financing towards the health of women and children.

2012

Launch of the CARMMA website (www.carmma.org) by the Department of Social Affairs of the African Union Commission.

2013

CARMMA special event on "Reinforcing the Campaign on Accelerated Reduction in Maternal Mortality in Africa" at the twentieth Ordinary Session of the Assembly of the African Union, organized by the Department of Social Affairs of the African Union Commission, in collaboration with UNFPA and the African Development Bank.

2009

Launch of CARMMA

2011

The African Union Conference of Ministers of Health expanded CARMMA to include newborn and child health, as mandated by the 15th Ordinary Session of the AU Assembly.

2012

UNFPA, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) held a regional workshop on maternal death review with representatives from 26 sub-Saharan African countries, in Burkina Faso and Tanzania.

2013

Expected outcomes:

- Reinforcing commitment to Maternal Health
- Increase in financial resources for Maternal Health
- Intensified actions on Maternal and Neonatal Health.



Countries that are preparing to launch CARMMA

SUCCESS IN MATERNAL DEATH REDUCTION

Report Shows Africa is on a Winning Track



Among the more prominent success stories for Africa, the report shows that Equatorial Guinea has achieved MDG5, one of 10 countries worldwide that did so during the period. Its maternal death rate dropped by 81 per cent, from 1200 to 240 per 100,000 live births, between 1990 and 2010.

With the majority of African countries having implemented CARMMA, 2012 bore good news in the form of an impressive 41 per cent decline in maternal mortality in Africa from 1990 to 2010, according to the report *Trends in Maternal Mortality: 1990 to 2010* by the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).

While there were 850 deaths per 100,000 live births in 1990, that rate had declined to a regional average of 500 deaths per 100,000 live births by 2010, with no fewer than 24 of the 46 sub-Saharan countries achieving a reduction of more than 40 per cent.

The report shows that in 2010, while the global maternal mortality ratio was 210 maternal deaths per 100,000 live births, sub-Saharan

Africa had the highest maternal mortality ratio at 500 maternal deaths per 100,000 live births. In Africa, a woman still faces a one-in-39 lifetime risk of dying due to pregnancy or childbirth-related complications; that risk is one in 3,800 in developed countries.

Among the more prominent success stories for Africa, the report shows that Equatorial Guinea has achieved MDG 5, one of 10 countries worldwide that did so by 2010. Its maternal death rate dropped by 81 per cent, from 1200 to 240 per 100,000 live births. Eritrea is considered on track to achieve MDG 5, its maternal death rate having dropped from 880 to 240 per 100,000 live births.

The publication also demonstrates how, beginning in 1990, the decline in maternal mortality numbers became more rapid in five year

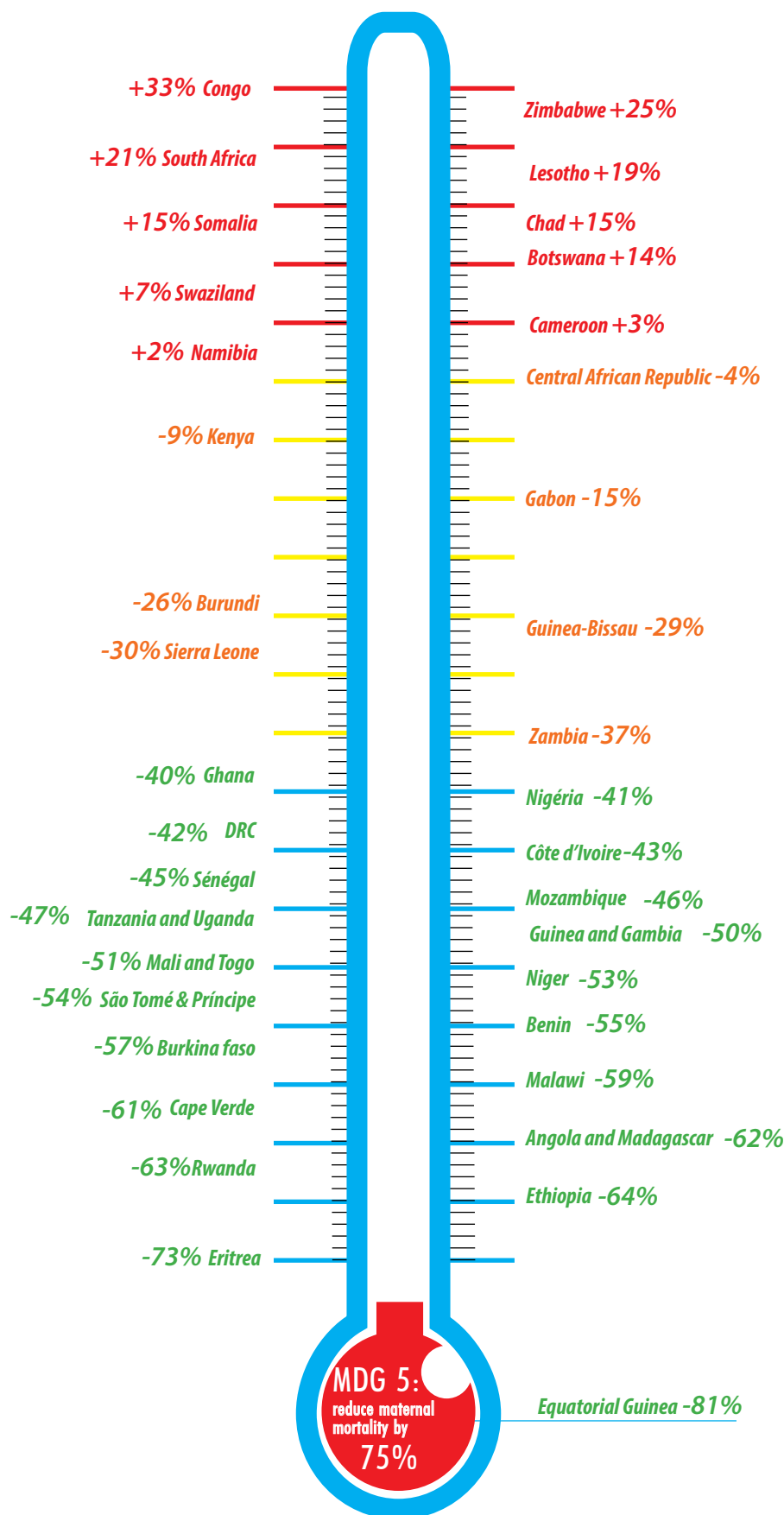
increments, with the biggest drop recorded between 2005 and 2010 - from 630 to 500 deaths per 100,000 live births (see *Trends in Maternal Mortality: 1990 to 2010*, Page 56).

Five countries in sub-Saharan Africa - Botswana, Lesotho, Namibia, South Africa and Swaziland - showed an increase in maternal deaths from 2000 to 2005 on account of HIV, but their maternal mortality rates are currently dropping as antiretroviral treatment has become more available.

While substantial progress has been achieved in almost all regions, many African countries will be particularly encouraged by this report in their efforts to reach the MDG target of reducing maternal deaths by 75 per cent by 2015.

TRENDS IN MATERNAL MORTALITY

The target of Millennium Development Goal 5A (MDG 5A) is to reduce maternal mortality by three quarters (75 per cent) by 2015. This graphic shows each country's percentage of progress made. (Source: *Trends in Maternal Mortality, 1990-2010*, Who, UNICEF, UNFPA and the World Bank, 2012.)



STEPS TOWARDS ACHIEVING RESULTS

CARMMA is a conducive platform to implement different strategies and actions. The graphic below shows the most popular ones among African countries.



Benin, Burundi, Chad, Central African Republic, Democratic Republic of Congo, Djibouti, Gambia, Ghana, Guinea, Guinea-Bissau, Lesotho, Liberia, Madagascar, Mauritania, Niger, Nigeria, Rwanda, Sao Tome et Principe, Senegal, South Sudan, Sudan, Tanzania, Zambia, Zimbabwe



Benin, Burundi, Cameroon, Chad, Central African republic, Congo, Democratic Republic of Congo, Djibouti, Gambia, Ghana, Guinea-bissau, Lesotho, Madagascar, Mauritania, Mozambique, Niger, Sao Tome et Principe, Senegal, South Sudan, Tanzania, Uganda, Zambia



Cameroon, Chad, Central African Republic, Congo, Democratic Republic of Congo, Djibouti, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Niger, Rwanda, Senegal, South Sudan, Sudan, Tanzania, Uganda



Burkina Faso, Burundi, Cameroon, Chad, Congo, Djibouti, Ethiopia, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mauritania, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Tanzania



Benin, Burkina Faso, Cameroon, Chad, Comoros, Congo, Ghana, Guinea, Lesotho, Liberia, Malawi, Mali, Niger, Nigeria, Sierra Leone, South Sudan, Sudan, Tanzania, Zimbabwe



Burundi, Chad, Central African Republic, Congo, Democratic Republic of Congo, Djibouti, Ethiopia, Gambia, Guinea-Bissau, Madagascar, Mauritania, Mozambique, Niger, São Tomé and Príncipe, Senegal, South Sudan, Sudan



Cameroon, Central African Republic, Democratic Republic of Congo, Djibouti, Ethiopia, Gambia, Ghana, Lesotho, Liberia, Madagascar, Mauritania, Mozambique, South Sudan, Sudan, Tanzania, Togo, Uganda



Benin, Burundi, Cameroon, Chad, Central African Republic, Congo, Djibouti, Gambia, Ghana, Guinea, Guinea-Bissau, Mauritania, Nigeria, São Tomé et Príncipe, Tanzania, Uganda



Benin, Botswana, Cameroon, Chad, Central African Republic, Democratic Republic of Congo, Djibouti, Ethiopia, Mozambique, South Africa, Uganda



Burkina Faso, Burundi, Cameroon, Chad, Mauritania, Niger, South Sudan, Tanzania



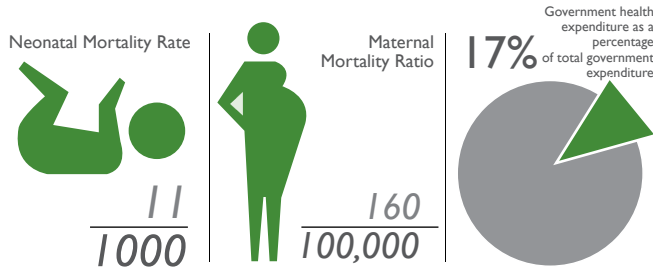
Benin, Chad, Central African Republic, Democratic Republic of Congo, Lesotho, Niger, South Sudan



Benin, Burkina Faso, Comoros, Niger

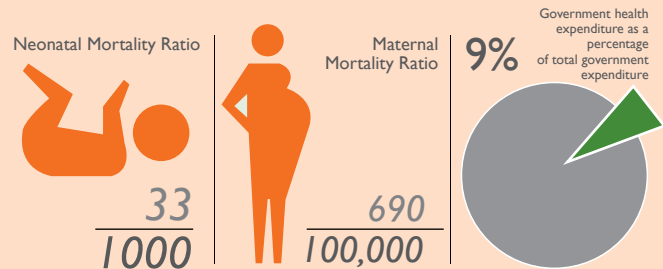
COUNTRY HIGHLIGHTS

Botswana



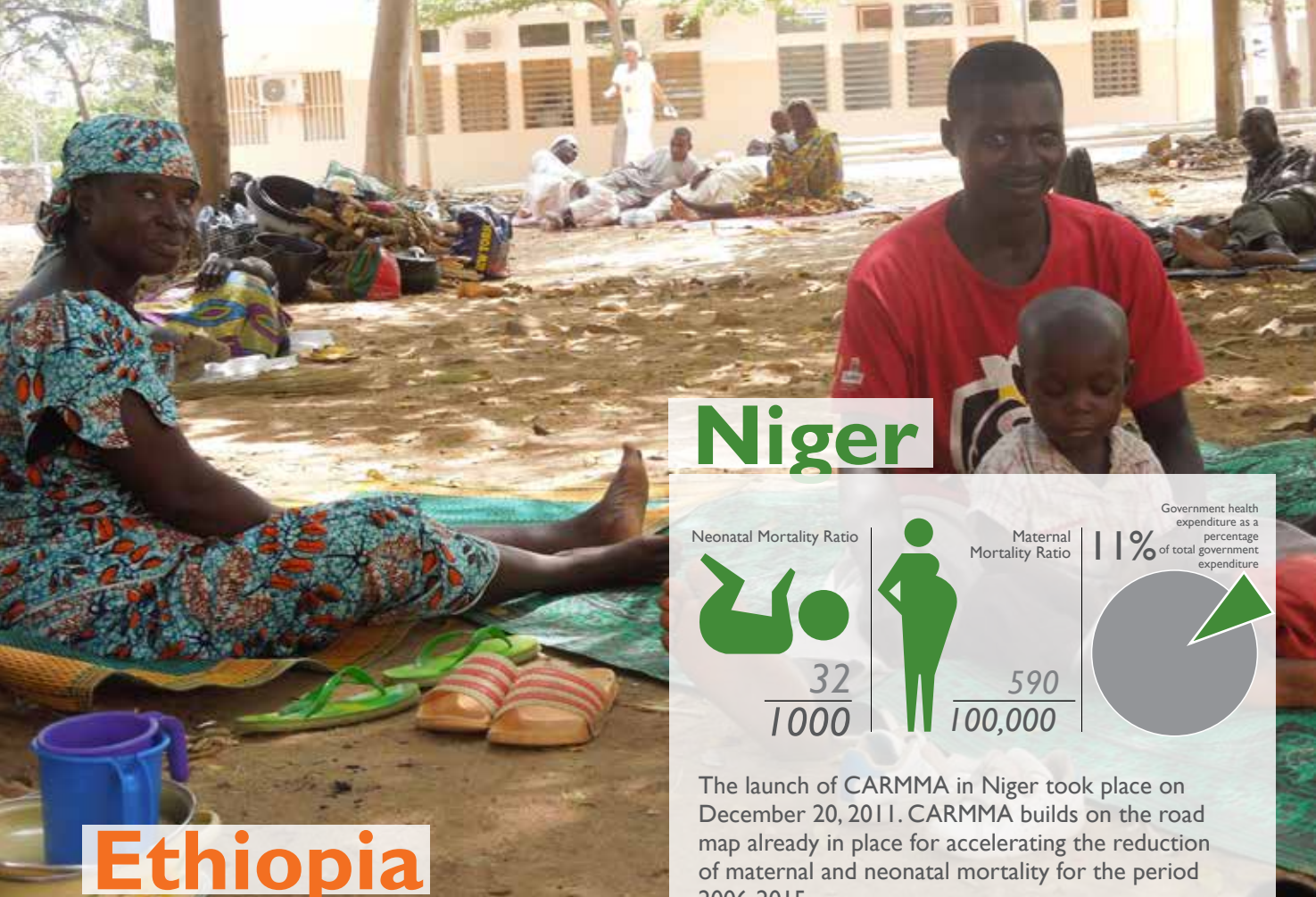
Following the launch of CARMMA in 2011, the Ministry of Health, working through the Safe Motherhood Initiative Programme and its Public Relations Section, has collaborated actively with the media to enhance the public profile of the campaign. One of Botswana's most successful maternal mortality reduction efforts has been in the very active and public work of her CARMMA champions. Botswana has started special training programmes that involve doctors, midwives, and nurses, in a variety of subjects and skills.

Cameroon



Following the launch of CARMMA by the First Lady, Mrs. Chantal Biya, on May 8, 2010, the government developed the 2011-2013 national strategic plan on CARMMA, based on the Maputo Plan of Action. To support the Ministry of Public Health in implementing the Plan of Action, UNFPA led the development of the H4+ Joint Programme to implement CARMMA in Cameroon – the first of its kind in Cameroon. A first concrete result of CARMMA and its supporting programme frameworks is the decision by the Government of Cameroon to open eight midwifery training schools across the country – the last midwife in Cameroon previously having graduated in 1987. The second wave of 200 students is currently being trained as midwives. Among other recent developments is a project in the North region to make obstetric kits (for deliveries and Caesarians) available to pregnant women at a fixed price. This increased the number of monthly deliveries, during a six-month period, by about 70 per cent in participating health facilities. UNFPA Cameroon also benefited from the first debt-for-health Sectoral Wide approach from the Government of Cameroon, with debt relief funding from France. The programme provides for an innovative and large-scale training scheme for health personnel on delivery of emergency obstetric and neo-natal care, including prevention of mother-to-child transmission of HIV in Cameroon's three northern regions.





Niger

Neonatal Mortality Ratio

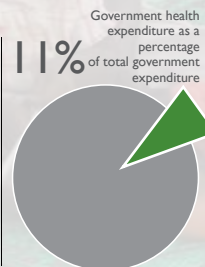


$\frac{32}{1000}$

Maternal Mortality Ratio



$\frac{590}{100,000}$



The launch of CARMMA in Niger took place on December 20, 2011. CARMMA builds on the road map already in place for accelerating the reduction of maternal and neonatal mortality for the period 2006-2015.

Since the launch there has also been a mobilization of resources with partners such as UNFPA, UNICEF, WHO and a variety of local organizations such as Animas SUTURA; Association Nigerienne pour le Bien Etre Familial (ANBEF); Societé Nigerienne des Produits Petroliers (SONIDEP); Loterie Nationale du Niger (LOLANI); and Rimbo Transport Passengers. Also involved are a lot of associations and groups, including religious, women's and youth groups. In the area of health systems strengthening, Niger has undertaken massive recruitment and allocation of health care providers, including 536 doctors; ordered equipment and materials; purchased an ambulance for emergency cases, and enhanced communication within the system using SSB radios. Childbirth and Caesarean section kits have also been provided in health facilities. With reference to the development of monitoring & evaluation systems, there are efforts to strengthen supervision, and monitoring of care providers. Currently, clinical audits of maternal deaths take place at health facility level, but there is institutionalization of clinical auditing in the new PDS 2011–2015, including training of trainers on clinical audit across the country. In the implementation of the Maputo PoA in the context of the African Health Strategy, Niger has so far seen a reduction of maternal mortality by 14 per cent between 2006 and 2010, and infant mortality by 34 per cent.

Ethiopia

Neonatal Mortality Rate

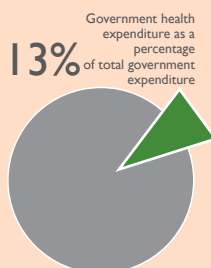


$\frac{31}{1000}$

Maternal Mortality Ratio

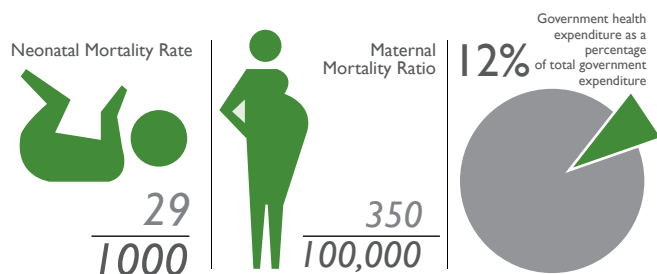


$\frac{350}{100,000}$



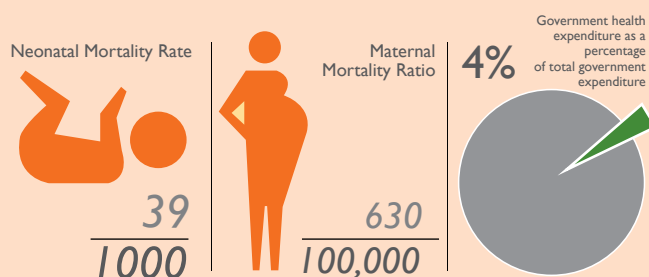
During the launch of CARMMA on 23 February 2010, the Minister of Health, Hon. Tedros Adhanom, pointed out the importance of having facility-based interventions in addition to community-based ones. CARMMA has led to special services on maternal mortality reduction, as an integral part of the Health Sector Development Programme and the Maternal and Newborn Health road map. Among the most significant developments is that the month of December is now recognized and dedicated nationally to advocacy of the reduction of maternal mortality.

Ghana



Under the guidance of the then First Lady, Mrs. Ernestina Naadu Mills, CARMMA made tremendous strides in Ghana after the national launch in 2009. She also formed a technical team from among staff in the Ghana Health Service, UNFPA and her office, which was tasked with formulating a concept paper that enabled her to take the message to the nation's 10 administrative regions, which include 170 districts and 33 sub metros. She ensured that the traditional authorities were included because they wield a lot of power and have a critical role to play in reducing maternal deaths. At the launches, Municipal and District Assemblies made a variety of maternal health commitments that include the development of basic infrastructure, transportation, provision of equipment, personnel training, free ambulance services, CHPS compounds and antenatal clinics. Each region and district of Ghana has pledged to make commitments and contributions to reduce maternal mortality by ensuring the provision of services and infrastructure (including transport) that has a direct bearing on reducing maternal deaths within their respective districts and municipalities. These commitments are reviewed yearly as part of the MDG Acceleration Framework (MAF) – Ghana Action Plan.

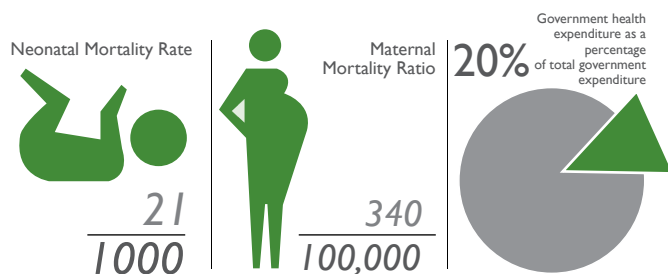
Nigeria



Nigeria launched CARMMA in October 2009, with a focus on aligning and integrating CARMMA within its existing programmes, especially the Integrated Maternal, Newborn and Child (IMNCH) Strategy. CARMMA in Nigeria focuses on partnerships at the three tiers of Government – Federal, State and Local Government – in collaboration with development partners. It aims to improve maternal health with the introduction of the Midwives Scheme and the rural posting of resident doctors or medical officers to improve skilled birth attendants, the provision of contraceptives and other life-saving commodities for Maternal, Newborn and Child Health, and increase budgetary support to MNCH.

Nigeria has reduced the Maternal Mortality Ratio (MMR) from 1100 per 100,000 live births in 1990 to the current figure of 545 per 100,000, according to Nigeria's latest Demographic and Health Survey (DHS 2008). Since the launch of CARMMA, Nigeria has developed a National Strategic Health Development Plan and adopted a National Road Map for CARMMA. It has also seen increases in resources for reproductive health. For example, in addition to several investments into MNCH, the Nigerian Government provided about \$3 million for contraceptives in 2012. There is continued engagement of all stakeholders, especially policy makers, as well as collaboration among maternal, newborn and child health partners, including civil society organizations. Nigeria reported a pilot study on community-based access to injectable contraceptives; promotion of the use of anti-shock garments, Misoprostol and magnesium sulphate in the management of post-partum haemorrhage and eclampsia; and free distribution of contraceptive commodities at Government health facilities. President Goodluck Ebele Jonathan, as a leading voice for health improvement in Africa and through his work as Co-Chair of the United Nations Commission on Life-Saving Commodities for Women and Children, as well as his Saving One Million Lives Initiative, has reaffirmed his commitment to intensify maternal health and newborn interventions in Nigeria. He is also committed to mobilizing other African Heads of State and Government to provide fresh impetus to CARMMA and its follow-up implementation.

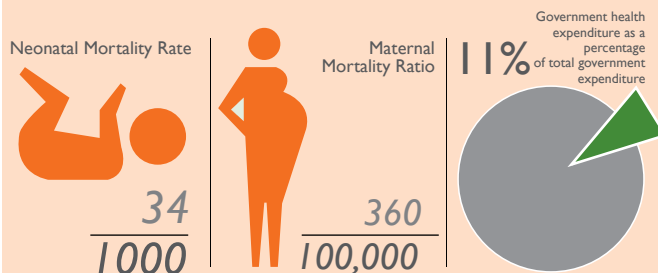
Rwanda



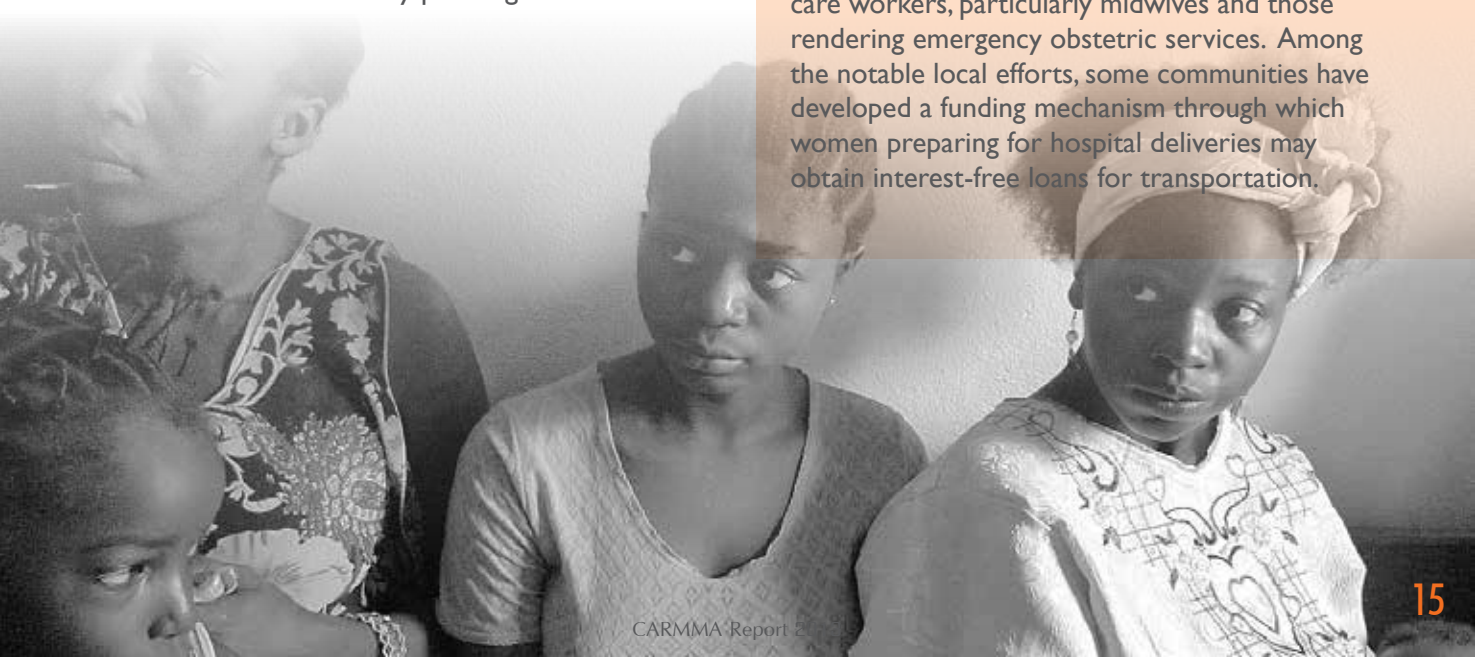
Rwanda has made remarkable strides in maternal mortality reduction. The Maternal Mortality Rate in 2010 was 487 per 100,000 live births, which is high, but only five years earlier, it stood at 750 per 100,000. Similarly, in 2007/2008, the Infant Mortality Ratio in Rwanda was 62 per 1000 while in 2010 it was 50 per 1000. CARMMA in Rwanda is coupled with the White Ribbon Alliance (WRA) Initiative, which was launched in 2009 with the objective of completing national efforts to reduce maternal mortality and morbidity.

The WRA strategic plan (2010-2015) is being implemented and it has a key role in uniting the multiple programmes in support of safe motherhood around one framework of action. The role and commitment of the First Lady, H.E Mrs. Jeannette Kagame, who launched CARMMA in 2010 and brought together many stakeholders, is significant in the overall drive to reduce maternal and newborn deaths in the country. With Mrs. Kagame as patron, WRA's board of high level decision makers and representatives from diverse areas can influence policies and laws in support of safe motherhood as a human right. As part of the national efforts, on 11 November 2011, WRA organized a one-day workshop to increase media awareness of safe motherhood and equip journalists on the subjects of maternal health and family planning.

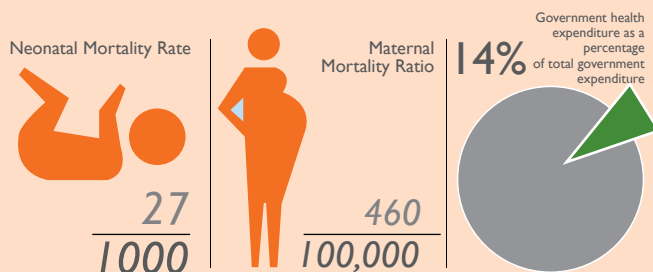
The Gambia



Development of the National Road Map for the Implementation of CARMMA in The Gambia is being undertaken by the National Assembly Select Committee on Health. The launch of the campaign on 24 July 2010 by Her Excellency, Dr. Isatou Njie Saidy, the Vice-President, has been followed in four regions with social mobilization, behaviour change communication/Information Education Counselling, publicity, awareness-raising and community sensitization activities. These activities have involved the regional governors as well as women's groups and staff of the Ministry of Health. Some of the activities in the regions involved resource mobilization and partnership with the private sector, civil society and other agencies, cofunded by UNFPA and regional authorities. The government has pledged to continue to support activities on maternal mortality, and there is funding from The Global Fund to strengthen the health systems through capacity building. Since 2010, hospitals have been carrying out maternal death audits, funded by UNFPA, and this has been expanded to all the regional hospitals and the main referral hospital. With the support of UNFPA, WHO and the Global Fund, efforts are underway to improve the capacity of health care workers, particularly midwives and those rendering emergency obstetric services. Among the notable local efforts, some communities have developed a funding mechanism through which women preparing for hospital deliveries may obtain interest-free loans for transportation.

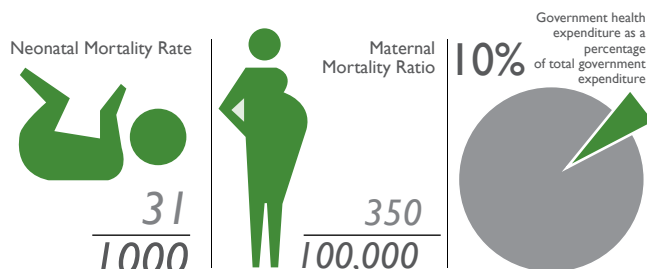


Malawi

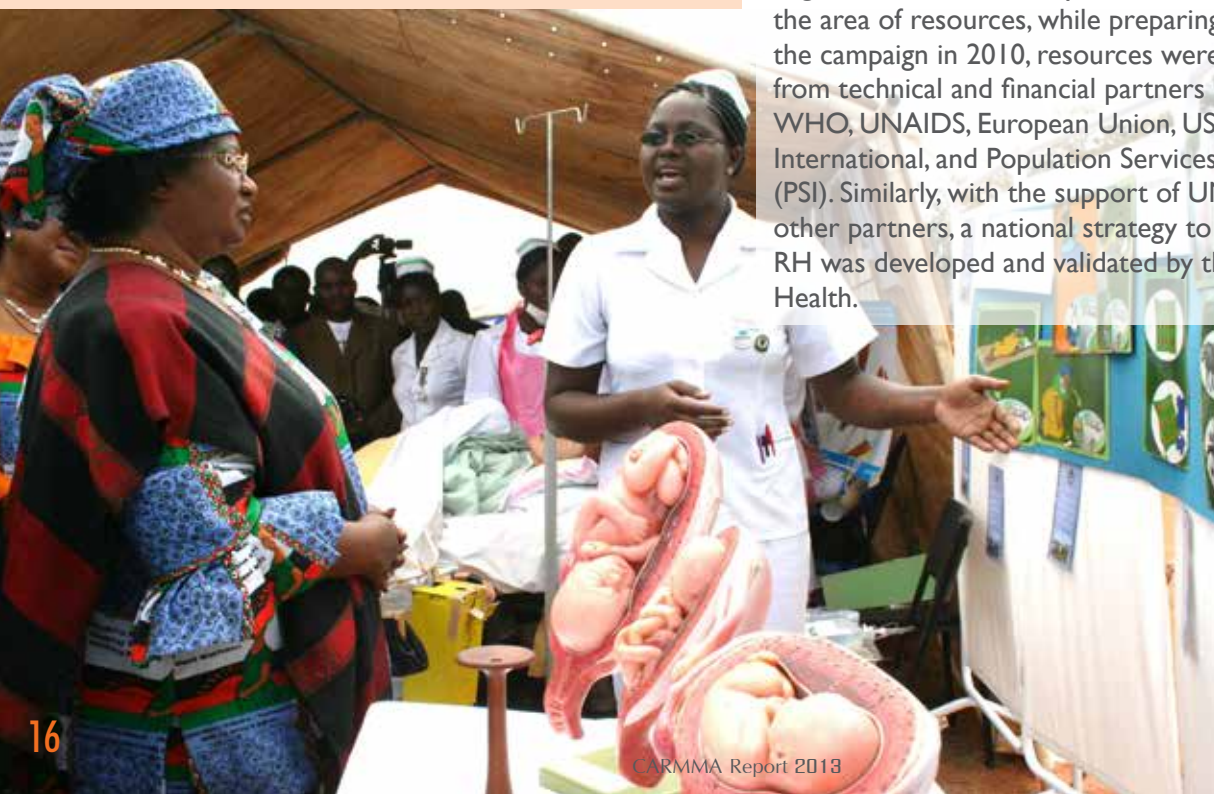


Malawi was one of the first countries to launch CARMMA, on 7 August 2009. It was launched by President Joyce Banda (then Vice President). A number of CARMMA campaign activities, with Maternal and Newborn Health messages, are being disseminated by radio and television. UNFPA, in collaboration with implementing partners, has set up a Media Network on Population and Development (MENPOD), which continuously advocates and increases awareness on CARMMA-related issues. Malawi has a revised Road Map on accelerating the reduction of maternal and neonatal morbidity and mortality in the country, and the Reproductive Health strategy also has a component on reduction of maternal mortality through improved maternal health. CARMMA is making a significant impact in the country because it is bringing services closer to the community, and promoting access to Sexual and Reproductive Health services. The training of more midwives is improving skilled attendance at birth, despite transfers and the movements of medical workers, thereby leading to lobbying for more donor support for Maternal and Neonatal Health interventions.

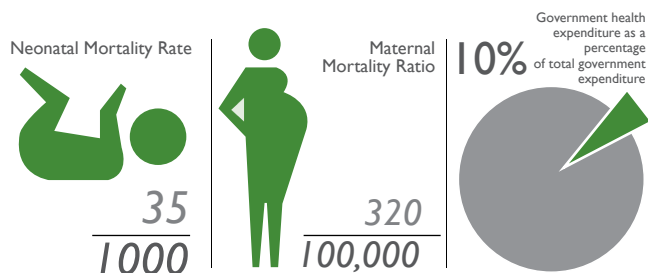
Republic of Benin



CARMMA was launched in Benin on 27 October 2010, and a National Road Map was developed and implemented for the duration of the campaign in that year. During CARMMA week in 2011, that roadmap was revised. Different strategies have been adopted in the social mobilization campaign, including free offer of contraceptives and voluntary testing for HIV; interaction with young people; spotlight on reducing maternal mortality; dissemination of messages through community radio stations; use of billboards across the country to display messages; and development of a short film on the fight against maternal mortality. Most of these activities were extended during the CARMMA week in 2011. CARMMA has had a very positive impact in the country, enjoying the support of many activities by partners, government institutions, traditional leaders, religious organizations, civil society and communities. In the area of resources, while preparing to launch the campaign in 2010, resources were mobilized from technical and financial partners (UNFPA, WHO, UNAIDS, European Union, USAID, Care International, and Population Services International (PSI). Similarly, with the support of UNFPA and other partners, a national strategy to integrate HIV/ RH was developed and validated by the Ministry of Health.

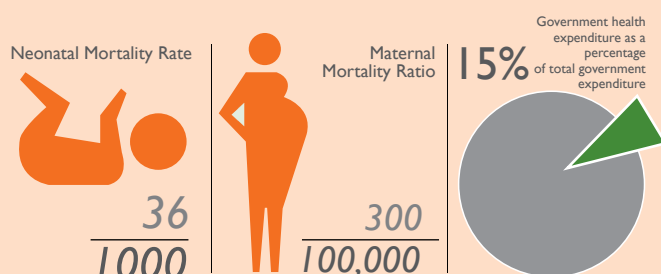


Swaziland



In 2009, Swaziland made history by becoming one of Africa's first nations to launch CARMMA. An implementation framework is now in place, and CARMMA activities have been incorporated into the National Sexual and Reproductive Health (SRH) programme Annual Work Plan. A dialogue for Members of Parliament on the implementation of the Maputo Plan of Action resulted in Parliament pressurizing the Ministry of Health to develop a national SRH Policy, which is now at the finalization stage. Since 2011, several regional dialogues in support of CARMMA have been undertaken by the Reproductive Health programme of the Ministry of Health. Political commitment in support of maternal health has been initiated by the Ministry of Health. Among others, it hosted a national symposium on sustainable financing for reproductive, maternal, newborn and child health in the country, procured for the six hospitals that provide maternity services. Prevention of Mother-To-Child Transmission equipment and testing reagents for CD4 cell machine were also procured. Swaziland has also developed a quarterly review system, followed by an annual review. A triennial report (2008-2010) was published in 2011.

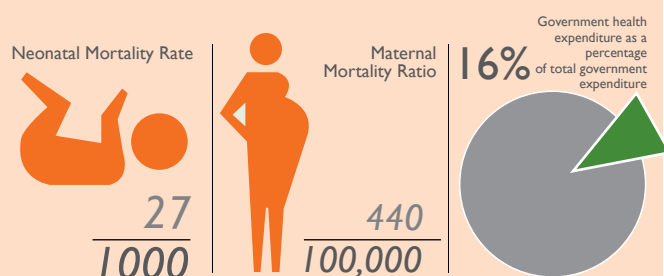
Togo



Following the launch of CARMMA by the Republic of Togo on 14 September 2010, a framework for accelerating Millenium Development Goals 4 and 5 was developed. The nation then embarked on developing a new Health Development Plan as the central axis of maternal health. The national launch of CARMMA was followed by the establishment of "committees of men to support the health of mothers and children." Togo is also developing a new coordination mechanism for financing the health sector, through its membership of the International Health Partnership (IHP) and is currently receiving funding from the French Government, through the G-8 MUSKOKA Initiative on Maternal, Newborn and Child Health, to support maternal health. The campaign has had a very positive impact in Togo, with many activities receiving the support of partners, Government institutions, traditional and religious leaders and communities. CARMMA has become a gateway to many stakeholders in the field of promoting women's rights.

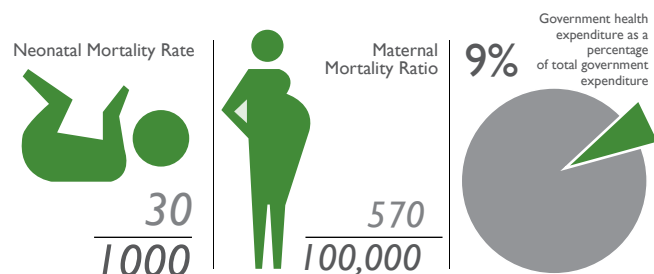


Zambia



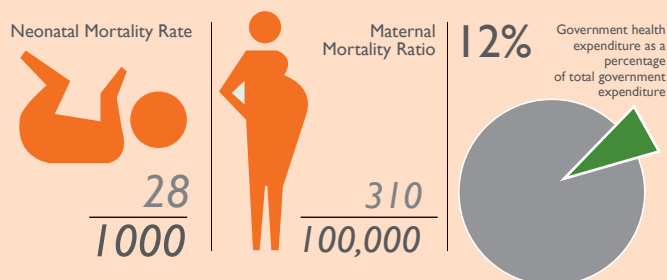
When President Rupiah Bwezani of Zambia launched CARMMA on 12 June 2010, he made history by being the first African Head of State to be personally and directly involved in such a launch. CARMMA has contributed to increased government commitment for Maternal Neonatal and Child Health (MNCH) and increased resources from the Government and donors. There have been increased referrals for Sexual and Reproductive Health (SRH) and delivery, and local chiefs are now champions for Maternal Health. Most multilateral and bilateral donors that pledged support before the launch have increased resources for MNCH. Among them, USAID procures contraceptives; DfID has initiated a Maternal Health programme, Mobilizing Access to Maternal Health Services in Zambia (MAMAZ); UN H4+, in partnership and collaboration with the Ministry of Health, has secured funding from the Canadian International Development Agency (CIDA) for Maternal Health; and the Ministry has increased the contraceptive procurement budget line. The Ministry of Health has also introduced mentorships for MNCH in order to strengthen the skills of providers. With support from UNFPA and the EU, the Ministry of Health is promoting integrated HIV/ AIDS and Reproductive and Family Services, through the implementation of a programme to strengthen SRH/HIV linkages.

Zimbabwe



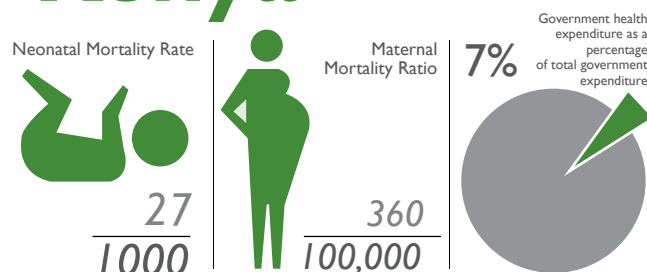
CARMMA is being implemented within the nation's Maternal and Neonatal Road Map (2007- 2015). The national task force, charged with advocating and monitoring the implementation of the campaign, has mobilized resources for Maternal and Neonatal Health (MNH). It is also advocating for increased funding for health on the basis of the Abuja target of 15 per cent. The Ministry of Health and Child Welfare has also set up a Health Transition Fund (HTF). Some of the major areas of support by the HTF involve health systems strengthening, as well as the removal or subsidizing of user fees for maternal health, which has been one of the barriers to accessing maternal health. The Ministry of Health, with support from development partners, has scaled up support to 18 active midwifery schools through the procurement of midwifery teaching models and textbooks. More than 200 nurses have been trained in Emergency Obstetric and Neonatal Care (EmONC) by the Ministry of Health since the launch of CARMMA. Some strategies have been vital for CARMMA in Zimbabwe. They include the integration of CARMMA into existing MNH strategies, which is critical for the sustainability and visibility of the campaign, by ensuring Government ownership of the campaign. Another important factor is the development and implementation of an integrated plan towards MNH, Nutrition, Family Planning, HIV and Malaria to ensure meaningful utilization of limited resources. Despite these, CARMMA has had a positive impact, especially the increased commitment of the Government towards maternal and neonatal health issues, evidence of which may be seen in the implementation of the UN strategy on Women's and Children's health, which is aligned to CARMMA.

Uganda



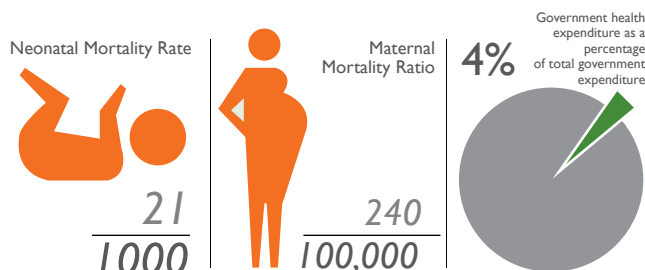
CARMMA is having a positive impact on the visibility of maternal and neonatal health issues in Uganda. It enjoys parliamentary support. Religious and cultural institutions have been mobilized, and there are signed commitments with 12 of the 15 cultural institutions in the country. The UNFPA Country Office has developed and implemented a resource mobilization plan that has yielded over USD 15 million for Sexual and Reproductive Health in the last 2 years. The Ministry of Health also created an alternative distribution channel for Reproductive Health Commodities, including contraceptives, through a public-private partnership with the Uganda Health Marketing Group, a social marketing organization. Towards the provision of sustainable funding, Uganda is in the process of establishing a National Health Insurance Scheme as a health financing mechanism. The Government acquired a World Bank Loan of USD 130 million for health. Towards strengthening the health system, a bursary scheme for the training of midwives has been introduced with support from development partners, including the Danish International Development Agency and UNFPA, as a strategy to improve staffing and retention of staff in hard-to-reach and underserved districts. A community-based Health Information Management System has been put in place. The Government has also made maternal death a notifiable condition, and Maternal and Peri-natal Death Reviews have been institutionalized with notification to the Ministry of Health required within 24 hours.

Kenya



The launch of CARMMA in Kenya, in November 2010, led to increased publicity and donor engagement on Maternal and Newborn Health. Prior to the launch of CARMMA in the country, in August 2010, the Government launched a Maternal and Newborn Health (MNH) Road Map, the objective of which is the achievement of the Millenium Development Goals. At the primary and referral levels, hospital reforms are continuing. Monitoring and evaluation systems have also been strengthened. An annual national maternal mortality audit has not been carried out yet, but Maternal Death Surveillance and Response is being implemented. Reorientation of some health facility staff was undertaken during the first half of 2012 to ensure that regular reviews are conducted and reports submitted.

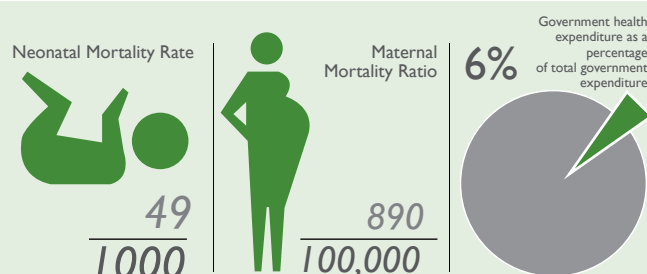
Eritrea



At the launch of CARMMA in Eritrea, in September 2010, the Hon. Minister of Health, Ms.

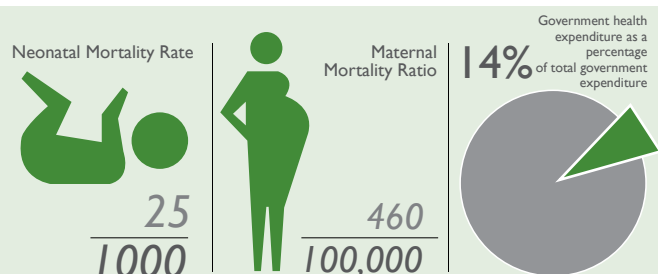
Amina Nurhussien, pledged the commitment of her Ministry to the accelerated reduction of maternal and perinatal mortality in Eritrea. The focus of the Ministry of Health is on such effective strategies as awareness of clients, families and communities to make preparations for delivery by skilled birth attendants in health facilities; expanding maternity waiting homes; improving access to fully functional basic and comprehensive emergency obstetric care facilities; ensuring availability of equipment, supplies, drugs and human resources; introducing life-saving drugs such as Magnesium sulphate and Misoprostol; expanding postpartum home visits within 24 hours and three days of delivery; and strengthening the programme on fistula prevention, treatment and reintegration. The programme is strengthening the health system by empowering young doctors to provide Emergency Obstetric and Neonatal Care, including caesarean deliveries. Also, strategic health centres are being upgraded to community hospitals to enable them to perform Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) functions. In terms of capacity building, in-service training is being given to midwives and other health care providers, as well as to young doctors, in the provision of CEmONC services.

Sierra Leone



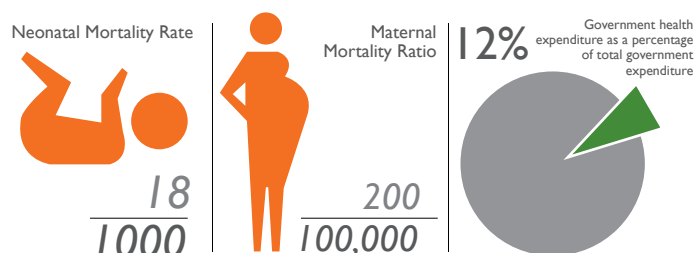
The launching of CARMMA in March 2010 was strongly supported by President Ernest Bai Koroma, who, the following month, launched a CARMMA-related free health service of health care facilities for pregnant and breastfeeding women, and for children under five years old. The Government, for the first time, made a pledge to provide contraceptives costing \$165,000 per year. Strengthening of health systems was identified in the National Health Sector Strategic Plan 2010-2015 as an important objective, and assessment of health systems is now being done and strategies are being put in place to address areas that need to be strengthened. In the area of capacity building of health workers, a growing partnership consisting of the government, UN agencies and NGOs is coordinating capacity building of health workers. Among other initiatives, the Canadian International Development Agency initiative is sponsoring 100 student midwives per annum for three consecutive years. The Maternal Health Thematic Fund and the Global Programme to Enhance Reproductive Health Commodity Security have also been supporting the training of midwives and strengthening of the Midwifery Association. In February 2012, 55 State-registered Nurses graduated from the National Midwifery School Freetown campus, while 75 State-enrolled Community Nurses graduated from the Makeni Midwifery school campus in April 2012.

Tanzania



The introduction of CARMMA in Tanzania strengthened the nation's efforts and provided an opportunity for reflection on achievements made towards achieving MDG 5. CARMMA has provided visibility for national planning and priority setting on issues related to maternal health. The Health Sector Strategic Plan is designed to focus on maternal health as a means of measuring the health sector performance. The Government under Sector Wide Approach (SWAp) is currently formulating the national health sector financial strategy. In collaboration with UNFPA, the Ministry of Health and Social Welfare undertook an assessment of the midwifery situation in Tanzania. That report is guiding different interventions in the country, including development of the midwifery programme. The Maputo Plan of Action has been domesticated in different national plans, including the National Road Map for Accelerating reduction of Newborn and Maternal Deaths.

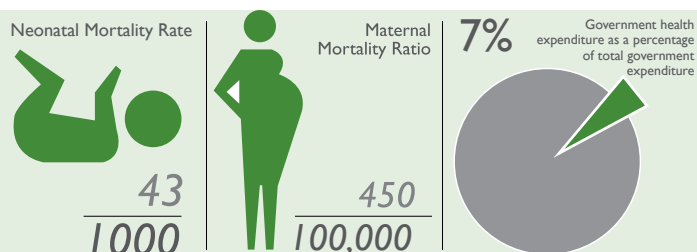
Namibia



Namibia was one of the first countries to launch CARMMA, in December 2009. Since the launch, the political commitment of the First Lady Mrs. Penelope Pohamba, evident through her involvement as Patron of the maternal health agenda, has proved to be one of the most important strategies of the campaign. More partners have become aware of the need to address maternal health issues. There has also been inter-sectoral collaboration at the national level, marked by the involvement of various ministries and civil society in the national coordination mechanism, as well as the institutionalization of maternal, perinatal and neonatal death review. Maternal death review tools have been launched and the review has been institutionalized in all district hospitals. Resources have been made available to fund vacancies for nurses and midwives, but unavailability of manpower has hindered the process. The Government is negotiating with other countries to get nurses and doctors into the country to fill vacant positions. CARMMA in Namibia is facing a number of challenges, including inadequate financial resources and health system strengthening at the primary level to deliver Basic Emergency Obstetric Care services.

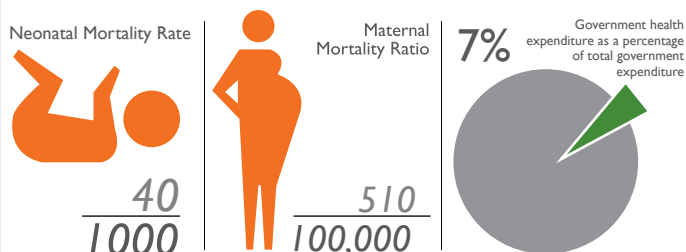


Angola



The Government of Angola launched CARMMA in August 2010. It was launched by the Vice President of Angola, Fernando da Piedade Dias dos Santos, with the participation of ministers and vice ministers of key sectors (Health, Family and Women's Promotion, and the Interior), Provincial Vice-Governors and Representatives of the African Union. The WHO Regional Director for Africa, Dr. Luis Sambo, and Representatives of key UN Agencies (UNFPA, UNICEF and WHO) were also in attendance. At the launch the Government of Angola created an inter-sectoral committee for the accelerated reduction of maternal and infant mortality, under the chairmanship of the Minister for the Promotion of Family and Women. UNFPA, UNICEF and WHO worked in partnership to support the Government in the launch and committed to provide support in terms of follow-up actions. The Vice President has regularly made reference to CARMMA, including at the Second Inter-Ministerial Conference on Health and Environment in Africa, in Luanda, in November 2010, during which he called for multi-sectoral support for maternal mortality reduction.

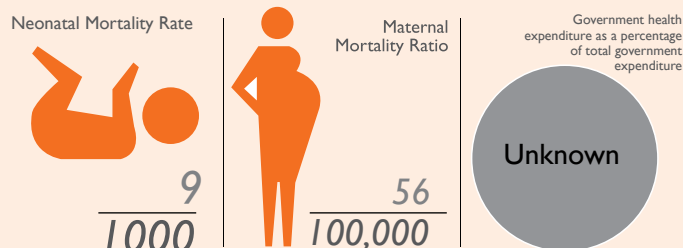
Mauritania



Under the high patronage of the President of the Republic, CARMMA was launched by the Minister of Health, Dr. Cheikh El Moctar Ould Horma Babana at a ceremony that marked the National Week of Reproductive Health. The Minister announced that the Government had decided to increase investment in the health sector to at least 15 per cent of the national budget within the following three years. The launch was followed by a debate on the best ways of deploying CARMMA as an advocacy strategy for the promotion of maternal and newborn health, in order to achieve quick and significant results. Participants included parliamentarians, religious and community leaders, journalists, leaders of civil society organizations, policy makers and technical executives in health.

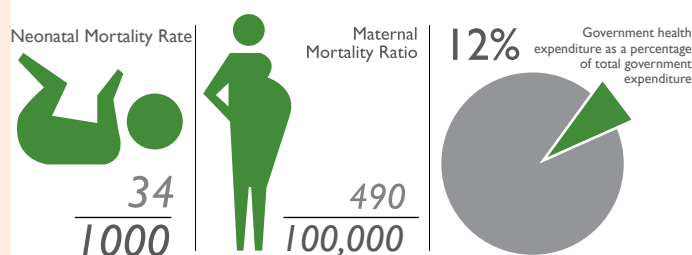


Tunisia



In November 2011, Tunisia became the first North African country to launch CARMMA, with the aim of sharing the country's experience in reducing maternal mortality with other countries in Africa. Tunisia is known for its progressive policies towards women's rights, the capacity to promote the status of women and improving the physical and financial access of the population to basic health services as of the early 1970s until the present, in addition to its active role in South-South cooperation in population and development.

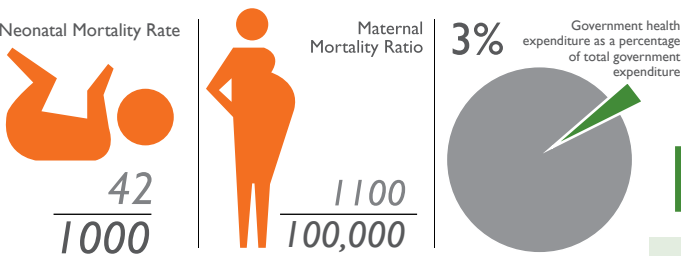
Mozambique



The launch of CARMMA in Mozambique was led by the Ministry of Health, under the patronage of the First Lady, Mrs. Maria da Luz Guebuza. The event was attended by the AU Commissioner for Social Affairs, members of the UN system present in Maputo, and key national stakeholders such as ministries, NGOs, the private sector, and parliamentarians. The event demonstrated the Government's commitment to improving maternal health and intensifying efforts needed in this regard.

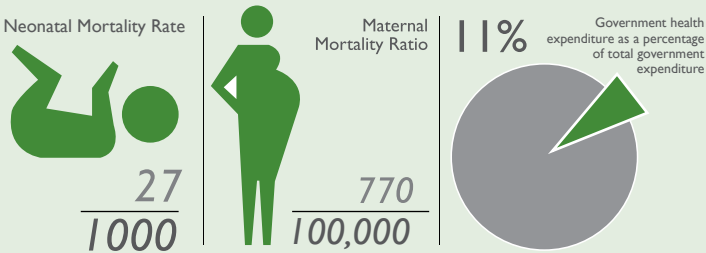


Chad



The launch of CARMMA in Chad was organized under the auspices of the First Lady, Mrs. Hinda Deby Itno. She expressed a desire to see CARMMA yielding a new Chad where fewer women die while giving birth. In order to ensure a rigorous follow up of the commitments and the Action Plan, which covers a period of three years, Mrs. Hinda Deby Itno nominated the first Chadian midwife, the late Mrs. Achta Toné Gossingar, as Goodwill Ambassador of CARMMA. Speaking at the ceremony, the then UNFPA's Deputy Executive Director for Programmes, Mrs. Purnima Mane, reaffirmed the commitment of UNFPA to support the efforts of Chad to reduce maternal mortality.

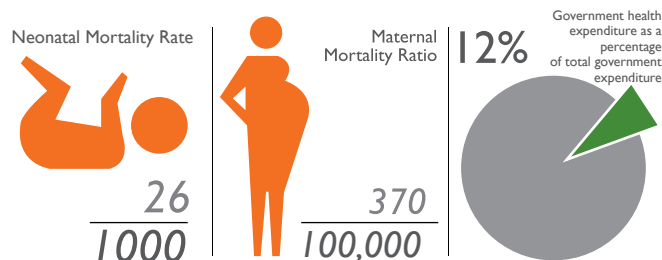
Liberia



The Campaign on Accelerated Reduction of Maternal Mortality in Liberia (CARMML) was launched by the Superintendent of Grand Bassa County, Mrs. Duncan Cassel, on behalf of Mrs. Ellen Johnson Sirleaf, President of the Republic of Liberia, during the Country's 4th National Health Fair held in Buchanan City, Grand Bassa County on 1 December 2010. The theme of the launch was "The nation thrives when mother survives - we must strive to keep them alive." The launch focused on promoting maternal health care, raising awareness, and the need for concerted action by the Government, donors, communities and the beneficiaries themselves, to improve health outcomes for pregnant women.

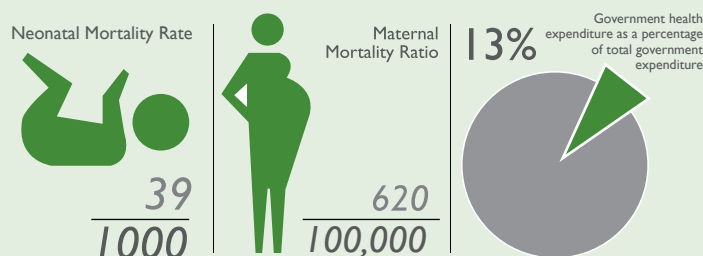


Senegal



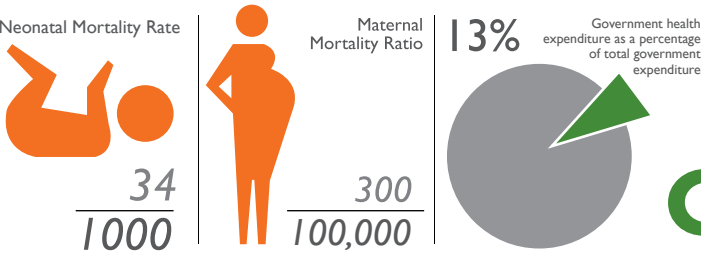
Senegal launched CARMMA in Dakar in July 2010. The event was chaired by the Prime Minister, Mr. Souleymane Ndéné Ndiaye. He was accompanied by the Minister of State in charge of Family Affairs, the Minister of Health and Prevention, the Director of the UNFPA Sub-Regional Office in Dakar, and the Resident Representative of WHO. The theme of the ceremony was “Bajenu Gox Programme: Community Response to Maternal, Newborn and Child Mortality Reduction”. Initiated by President Abdoulaye Wade, Bajenu Gox is a community programme to promote maternal, newborn and child health by women leaders in their neighborhoods. Bajenu is a Wolof term which means father’s godmother. They are a respected group which can therefore positively influence the community to encourage women to use health facilities during pregnancy, as well as during and after childbirth. The Bajenu Gox came from all 14 regions of Senegal to support the launch of CARMMA. The Prime Minister described maternal and neonatal mortality as being among the core priorities of Senegal, and renewed the commitment of the Government not only to consolidate its achievements, but also to increase its support for programmes aimed at reducing maternal and neonatal mortality.

Lesotho



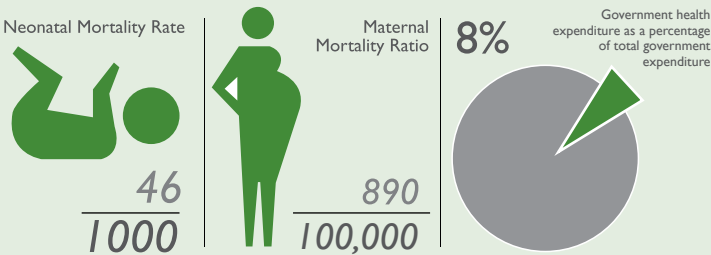
In May 2010, the Lesotho Parliamentary Session was devoted to the launch of CARMMA by the Minister of Health and Social Welfare, Dr. Mphu Ramatlapeng, and parliamentarians pledged their support to the Campaign. Dr. Ramatlapeng, who highlighted the need for interventions for reducing maternal and newborn morbidity and mortality, appealed to members of parliament to sensitize communities on the prevention of maternal and newborn morbidity and mortality and also to advocate with community councils for the revival of village health committees. The Minister pleaded with parliamentarians to advocate for sexual and reproductive health and rights with men and women, including mothers-in-law. “We should talk to mothers-in-law, pregnant mothers and others to encourage attendance at prenatal clinic and advocate for deliveries at health facilities.” Parliamentarians should also mobilize the business community to provide support for transportation of pregnant mothers to health facilities timeously during emergencies. He urged them to promote HIV testing in their constituencies and advocate for male involvement in the prevention of maternal deaths. “CARMMA hopes to bring on board communities and decision makers to ensure that no woman should die giving life,” he said. As one of many parliamentarians who were passionate in their support for CARMMA at the launch, the speaker of the National Assembly, Ms. Nthloi Motsamai, asked, “Why should women die when giving birth? It is time we vow that no woman dies when giving birth. The situation is totally unacceptable. We have a special responsibility as Parliament to allocate funds that will go towards sexual and reproductive health programmes.” Another Member of Parliament, Mr. Lekhetso Rakuoane, said, “This is the holiest issue to be discussed in Parliament.”

Burkina Faso



The launch ceremony of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in Burkina Faso was chaired by Mrs. Traoré Clémence from the Ministry of the Promotion of the Woman, and attended by UNFPA Representative Mr. Mamadou Kanté, Mr. Traoré Adama of the Ministry of Health, Mr. Jean-Christophe Ilboudo, Assistant to the Mayor of the city of Ouagadougou and Mrs. Djamila Cabral, representative of the WHO. The end of the ceremony was marked by the delivery of sanitary equipment and contraceptive products.

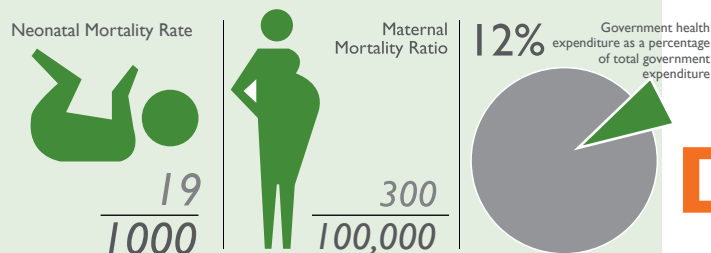
Central African Republic



CARMMA was launched in the CAR in April 2010 by President François Bozizé, thereby demonstrating his Government's commitment at the highest level to the improvement of maternal health. The launch was done with the participation of high-level Government officials and policy makers, parliamentarians, diplomats, professional associations (journalists, medical associations), civil society (including White Ribbon Alliance) and community members. UN Secretary General Special Representative to CAR, Mrs. Sahle Work Zewde, spoke on behalf of the UN System. The aim of CARMMA in CAR is to ensure that every pregnant woman delivers in a health facility.



South Africa

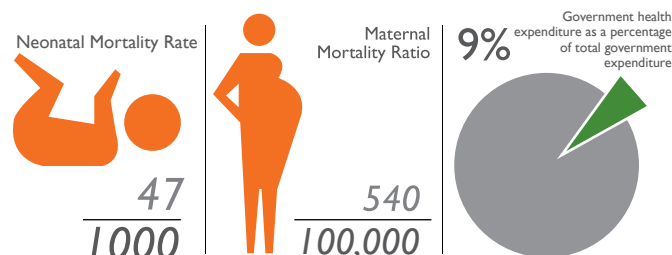


The former African Union Commissioner for Social Affairs, Advocate Bience Gawanas, launched CARMMA in South Africa in conjunction with the Minister of Health, Dr. Aaron Motsoaledi. The former First Lady of South Africa, Mrs. Graca Machel, was the keynote speaker. The launch of the CARMMA strategy formed part of the implementation plan of the Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa 2012-2016. The key elements of the CARMMA strategy for South Africa include: strengthening family planning services, elimination of mother-to-child transmission of HIV, improving access to maternity services (e.g. dedicated obstetric ambulances and maternity waiting homes), training of doctors and nurses in maternity units in managing obstetric emergencies, training of additional midwives, supporting mothers to breastfeed exclusively and to strengthen immunization coverage, and to strengthen neonatal services.

The aim of the South African government is to accelerate efforts by all role-players to reduce maternal, neonatal, infant and under five mortality. Key to achieving the goals of CARMMA is universal coverage – the National Health Insurance model has been adopted to achieve this.

To strengthen service delivery, the Ministry of Health is re-engineering primary health care. Interventions include the launch of provincial strategies, a National CARMMA Strategy and compliance assessment tool, a national CARMMA dashboard tool to monitor progress, and a revised contraceptive policy and complementary updated clinical guidelines.

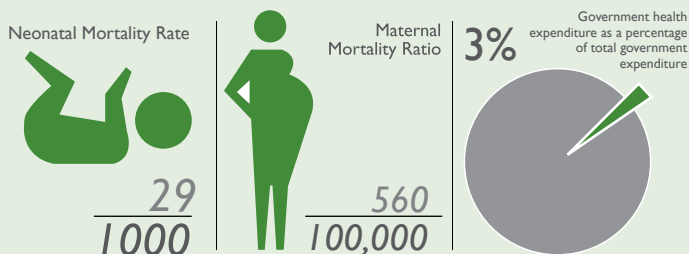
DRC



The Democratic Republic of Congo is one of three African countries and six countries worldwide that contributes to 50 per cent of the world's maternal mortality rate. As such it was expected that the DRC would be among the early adopters of the CARMMA programme. Following the visit of Mrs. Thoraya Obaid, former Executive Director of UNFPA and Mr. Michel Sidibé (ED of UNAIDS) to the DRC in May 2010, the Head of State, Mr. Joseph Kabila Kabangue, committed to launching an initiative towards an AIDS-free generation and combating maternal mortality. With the assistance of the Minister of Health, the high profile CARMMA launch event was held in April 2011 and was presided over by the First Lady, Mrs. Marie Olive Lemba Kabila. In her supportive address, the First Lady appealed to spouses to assist their partners before, during and after pregnancy and called on Government to increase the budget for the health sector; Parliament to enact laws to promote family planning; and local/provincial governments to mobilize resources for maternal and child health and launch CARMMA in their provinces.

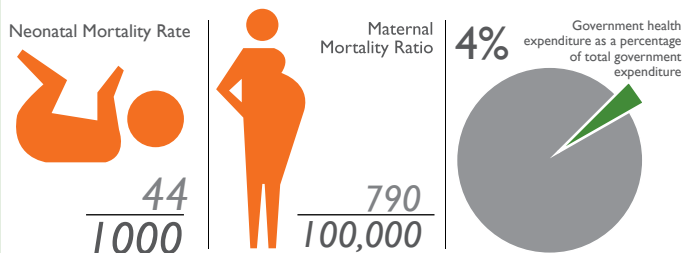


Congo



Under the leadership of the First Lady of the Republic of Congo, Mrs. Antoinette Sassou Nguesso, CARMMA was launched in October 2010 to accelerate the reduction of maternal death and disability. The Minister of Health, Prof. Georges Moyon, reaffirmed the Government's commitment to tackle maternal mortality as a top priority. "The Government has initiated a series of measures to reverse this trend," he explained. "We established a maternal health observatory and we are promoting public awareness about the importance of women and children's health. Caesarean sections are carried out free of charge in the public health system and we are committed to the campaign against obstetric fistula and the extension of the UNFPA programme on this issue." UNFPA Representative, Mr. David Lawson, affirmed UNFPA's support. "The extension of the fistula programme to two additional treatment centres in Pointe Noire and Owando is a key part of our contribution to CARMMA in the Congo." With as many as 140 cases already identified and potentially many more likely to be found in the near future, obstetric fistula is considered a serious public health issue in the country. The CARMMA launch focused on the eradication of obstetric fistula and the promotion of family planning.

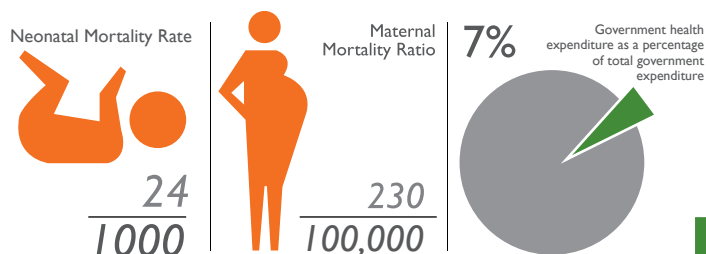
Guinée Bissau



The campaign was launched in Bissau under the theme, "Giving Life without Dying." The ceremony was chaired by the Minister of the Presidency of the Council of Ministers, who represented the Prime Minister. Present were parliamentarians, the Director-General of the West African Health Organization, members of Government, the Representative of the First Lady, members of the Diplomatic Corps, and international organizations, including UNFPA, WHO, and UNICEF. "Maternal mortality is one of the highest priorities of the Government," said the Minister, "and the launch of CARMMA shows once more the urgent need to mobilize the resources required to overcome the challenge and sensitize communities for their greater involvement." She pledged that the Government would do its best to improve working conditions for professionals in order to ensure the reduction of maternal and neonatal mortality.

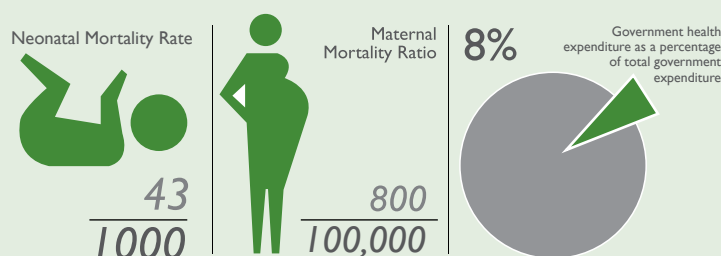


Gabon



The official launch of CARMMA in 2011 by the First Lady, Mrs. Sylvia Bongo Ondimba, has catapulted maternal and child health to the front and centre of the Gabonese national health agenda. As a renowned national champion for maternal and child health, Mrs. Bongo Ondimba has through her programme, Tous Unis pour la Santé maternelle (United for maternal and child health) embarked on the capacity building of hundreds of health workers from both the public and private sectors on sexual and reproductive health, including family planning. Thousands of delivery kits and mosquito nets were distributed to expectant mothers. The high profile 2012 The New York Forum hosted by Gabon devoted an entire day's session on action for improving health systems and maternal health, with the active participation of high-level speakers such as Ms. Edna Adan Ismail and Mrs. Nahid Toubia of White Ribbon Alliance Sudan. Gabon has since been positioning family planning with the development of a national family planning strategy. Other key initiatives include the revision of the road map for maternal mortality reduction, and a national survey on family planning and mass sensitization campaigns on family planning.

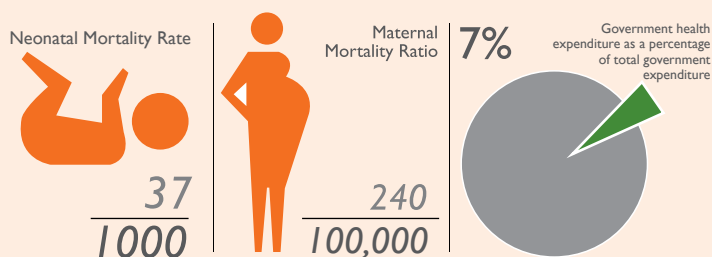
Burundi



To accelerate the reduction of maternal mortality, CARMMA was officially launched in July 2011 by the wife of the First Vice-President of the Republic of Burundi during the National Week of Reproductive Health, under the theme: "No woman should die giving birth: Family Planning for the well-being of families." CARMMA helped reposition family planning and a review of policy documents and programmes on reproductive health (introduction of maternal death audits, increase of government budget to help secure reproductive health products).



Equatorial Guinea



The Government and the First Lady of Equatorial Guinea, Mrs. Constanca Mangue de Obiang, organized the launch of CARMMA at a luncheon event before the Meeting of the Executive Committee of the Association of First Ladies Against HIV and AIDS in June 2011. UNFPA's Executive Director, Dr. Babatunde Osotomehin, was one of three keynote speakers, along with the Minister of Health, Mr. Antonio Martin Ndong Ntutumu, and the First Lady. The event attracted more than 500 people representing Government, civil society organizations, the private sector and international NGOs. It was a wake-up call and a reminder to all that although there is a road map for the improvement of maternal and child health and budgetary commitment from the Government, funds have yet to be made available to carry out activities.



CARMMA MAIN CHALLENGES

Inadequate human and financial resources

Inadequate health system strengthening

Poor health infrastructure

Stock-out of Emergency Obstetric and Neonatal Care (EmONC) commodities and supplies

low male involvement

High turnover of health providers

Gap in infrastructure and in using technologies

poor logistics management information system

Limited availability and quality of timely data

Religious and cultural barriers

competing priorities

Sustainability of the momentum

Ensuring quality and standardization of large-scale training

User fees

perception that the campaign is a duplication of efforts

Insufficient skilled service providers at facility level

weak referral system

high transaction costs

INTERSECTING VIEWS: UNFPA AND AFRICAN UNION

>>> How would you describe the current status and strategic significance of family planning in Africa?

Dr. Mustapha
Kaloko Sidiki

>>>

AU Commissioner for Social Affairs



MKS: Across the continent, progress in creating and meeting the demand for family planning has been uneven. The situation of married women - who represent the bulk of women with contraceptive needs - is on the increase in Africa, especially outside North Africa. Between 2008 and 2012, the proportion of married women using modern contraceptives increased from 20 per cent to 27 per cent in East Africa and from 54 per cent to 58 per cent in Southern Africa. There has been limited progress in West and Central Africa, with a prevalence of 9 per cent and 7 per cent, respectively. Nevertheless demand and utilization is still below the levels required to facilitate the development objectives we desire as a continent. With regards to strategic significance, family planning is a critical element required to address issues of gender

inequalities and maternal, newborn and child mortality and morbidity, as well as other key issues that impact on the development of human capital.

The demographic profile of the continent is at a stage where we should adequately invest in the development of human capital to ensure that we reap the optimal demographic dividend. In this regard, family planning is a critical element of the interventions necessary. Many African families still lack basic information on the access/use of family planning methods. Continued high birth rates, as seen in some parts of the continent, defy the demographic transition, proposing a need for renewed efforts. That means that family planning will continue to remain a key strategy to address the social and economic challenges of the population across the continent.

>>> Are African Union leaders aware of the significance of family planning? Are there supportive protocols and guidelines for family planning in Africa?

MKS: Yes, the leaders are indeed aware and have endorsed a range of supportive protocols and policy documents that address the issue. The Continental Policy Framework on Sexual and Reproductive Health and Rights (2005) and the Maputo Plan of Action (2006) for its implementation, focused new attention on the critical role of family planning in reducing maternal mortality, improving gender equity and increasing socioeconomic development.

CARMMA has since been serving as an advocacy campaign of the Maputo Plan of Action (MPOA) and thus continues to promote, amongst others, family planning. CARMMA

has been launched in 37 AU Member States. The majority of these countries have structured road maps set to deliver on their CARMMA commitments, which include a repositioning of family planning.

The Kampala Assembly of African Union Heads of State and Government in 2010 extended the mandate of the MPoA and further focused continental attention on Maternal, Newborn and Child Health promotion programmes and interventions, of which family planning remains a central piece.

>>> What are the current challenges responsible for the gaps observed in family planning coverage?

MKS: There are no gaps in policies, but the gaps exist between policy and implementation. Africa has prioritized family planning since 2005 when the continent developed the continental policy framework on sexual and reproductive health and rights. The ideas, as espoused by the policies, are sufficient so we do not need new ideas or policies but what is required is a step up of implementation. However, Africans are very religious people and also have great respect for traditional customs. This to some extent affects how they address issues regarding their health,

especially with respect to family planning, which I must admit remains a controversial issue especially in the deeply traditional and religious societies.

Given the myriad development challenges that confront the African Union Member States, national governments have also been unable to adequately allocate resources to reposition family planning. There remains an over reliance on external sources of funding to maintain Reproductive Health Commodity Security (RHCS) as well as implement family planning programmes and services.

>>> Given the fact that conventional methods of promotion continue to benefit from the innovations of technology, do you believe that social media and the digital revolution sweeping across Africa can be used as a strong tool to reposition family planning on the continent?

MKS: Social media can serve as a means for evidence sharing, leverage audience networks to facilitate information dissemination, popularize a campaign and serve as a feedback process. I see a lot of online campaigns around HIV/AIDS issues, and cancer; with 'tweet meets' around these issues and several others. More people are more

aware of better health practices due to the ease of accessing this information online. So I believe that issues on family planning and MNCH can benefit from advocacy on these new media channels. In fact, it already is. Most international organizations have online platforms for getting the word out there, but a lot still needs to be done. Africa needs for

you, me and everyone to be involved. We must all put our hands to work in ensuring that maternal deaths are reduced to the barest minimum, with family planning playing a role.

>>> CARMMA has made impressive strides since it was launched. How would you describe the implementation phase so far?

BM: It has performed beyond expectation. There have been 37 launchings, often at the highest level, and every country has participated in discussions on CARMMA.

>>> The May 2012 report, *Trends in Maternal Mortality: 1990 to 2010*, brought good news for Africa, and for CARMMA. Are you satisfied with the progress being made, or do you think more can be done?

BM: We are only scratching the surface. The Maternal Mortality Rate in Africa is still very high, with some countries still having a lot of work to do. In South Sudan, for instance, the numbers are exceptionally high. We have a long way to go.

>>> Looking ahead to the post-2015 years, what can you share about ways in which Africa's maternal mortality objectives can continue to be pursued?

BM: There is the ICPD agenda. We are discussing, in various fora, countries and regions. Government plays a central role. Civil society is involved; the private sector is involved. We have to question whether what we are doing is yielding the results that we want, so that in the post-2015

>>> The introduction of CARMMA Week was an important decision taken by African leaders. How would you assess its impact thus far and its potential?

BM: The impact is in the reduction in maternal mortality. We should focus on moving to V2, which will be action and goal oriented, measuring progress, and accountability in that respect.

We should be thankful to the leaders, heads of state and governments, communities, First Ladies, Ministers, leaders in the United Nations environment, and the Champions of

agenda, we can pursue the Maternal Health agenda more meaningfully. In the ICPD post-2015 agenda, MDG 5 needs a big push, especially in Africa, where it has lagged behind. We should deepen the discussion in Africa, especially the family planning agenda.

CARMMA. They have made it happen. But we should not relent on the efforts.

I call on the mass media to continue to be advocates for reduction of maternal mortality and promotion of infant health. They can help by drawing attention to what is working and how others can replicate such successes, and they should educate the people.

>>>

Benoit Kalasa

Director, West and Central Africa Regional Office, UNFPA



>>> How does the contraceptive prevalence rate in West and Central Africa compare with other regions?

BK: The ability to decide when to have children, and how many, is one of the most significant social advances of recent decades. However, this profound revolution has not yet touched all parts of the world equally – especially in West and Central Africa, where modern contraceptive prevalence among married women aged 15-49 years is very low (9 per cent in West Africa and 7 per cent in Central Africa, compared to 58 per cent in South Africa and 88 per cent in Central Asia) and unmet family planning needs are very high.

>>> What is the unmet need for family planning in West and Central Africa? What is the effect of this?

BK: The unmet need for contraceptives is huge, despite the fact that there is almost universal agreement that access to family planning is a human right. Of the 58 million women in Africa aged 15-49 years with unmet need for modern family planning methods, 29 million are located in West and Central Africa – more than half of the unmet need on the continent. They largely comprise the poorest in the population, who want to use modern family planning methods but can't access them. This has a seriously damaging impact – not just on their lives but on the health and strength of their families and communities. Failure to enable women to make free and informed decisions about their own reproduction puts a serious brake on social and economic development.

>>> What does it mean when women don't have access to modern family planning methods?

BK: Over half a century after modern family planning programmes began to be extended widely across the globe, millions of women are still denied access to them due to socio-cultural, religious and financial barriers, difficulty in reaching rural areas and urban slums, and lack of access to the right method mix. The evidence is now overwhelming that enabling women to have children by choice rather than chance not only dramatically cuts infant and maternal deaths, but also improves the health of mothers and children. UNFPA will continue to support the African Union and its Members States in the quest to overcome these barriers to family planning.

>>> Bunmi Makinwa

Director, East and Southern Africa Regional Office, UNFPA





YOUTH FOR CARMMA

the way forward is the active participation and engagement of young people in CARMMA issues through the leveraging of social media.

The January 2013 African Union Heads of States Summit is expected to feature a renewal of commitment towards intensifying the implementation of the CARMMA campaign. Young people will be a critical part of this process through various social media channels.

One of the largest target groups for UNFPA programmes, especially on the African continent, is young people. The largest user base of social media today is also young people. And this base continues growing with increasing access to the Internet and education.

As an illustration of how they use social media to educate their peers on sexuality, in Senegal the 'Voice to Youth' initiative went into rural areas to build the capacity of young people in using social media in 'hands on' demonstrations.

Despite this kind of success, there are vast challenges in the African context. Of note is the lack of quality, disaggregated data and information on young people in Africa; currently, any data that does exist is fragmented. Within the area of Comprehensive Sexuality Education (CSE), a major challenge is making the information available to young girls, because of child marriage and the gender disparity in school attendance. A large section of young girls isn't being reached through the conventional delivery mechanisms (if and when CSE exists in the school system). In the area of access to SRH services a major barrier to access is the attitude of health practitioners towards young people, and the lack of 'youth-friendly' services acts as a disincentive to accessing SRH services even when they exist.

One of the ways forward for the CARMMA campaign is to identify, in consultation with the youth, a broad range of recommendations, core activities and deliverables, which can be adapted to country-specific situations; this process is almost complete. It is using the platform of the African Union Youth Volunteers. Young people consulted on youth for CARMMA identified four key objectives for the participation of young people in CARMMA.

- 1. Educating the target group on CARMMA (and CARMMA-related issues)**
- 2. Access to information and services (mobilizing young people)**
- 3. Holding leaders accountable**
- 4. Research on the subject matter**

'We have to be agents of change'. With the largest ever cohort of young people now living in Africa, it is pertinent that this generation move the development agenda forward through the identified objectives and the CARMMA campaign. With this in mind the way forward is the active participation and engagement of young people in CARMMA through the leveraging of social media, creating awareness, generating positive messages, documenting the successes, harnessing the power of the personal story, creating platforms for dialogue, and informing the youth of Africa that they all have a role to play in CARMMA and improving maternal and newborn health.

Join our Youth For CARMMA campaign at www.y4carmma.org



H. E. Dr. Nkosazana Dlamini-Zuma,
*Chairperson of the African Union
Commission*

“In 2013 (...), in terms of health, the Union will focus particularly on maternal and child health, under the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA).”

“The fact remains that one preventable maternal death is too many: hundreds of thousands are simply unacceptable.”



**H. E. Mr. Ban Ki-moon, Secretary-
General of the United Nations**



**H. E. Mr. Thomas Boni Yayi, President of
Benin and Current Chair of the African
Union**

“One of the major challenges our countries are still faced with is the heavy burden of maternal and infant mortality.

You will therefore understand the great importance that the African Union gives to the CARMMA, mainly designed to end the tragedy of high maternal mortality. It aims to strengthen the leadership and the commitment of political leaders in order to mobilize the resources and means required to significantly reduce the maternal and infant mortality at the country, region and continent levels.”

“UNFPA is working on the ground in many African countries to reduce maternal mortality. We initiated CARMMA together with the African Union because we have the technical wherewithal to speed up progress toward reducing maternal mortality on the ground.”



H. E. Dr. Babatunde Osotimehin,
*Executive Director of the
United Nations Population Fund, UNFPA*



MDG5:

**IMPROVE
MATERNAL
HEALTH**



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