SAVING THE LIVES OF MOTHERS AND NEWBORNS

PROMISING PRACTICES FROM THE ARAB REGION

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CONTENTS

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Acronyms

AAPF	Algerian Association for Family Planning
EPI	Expanded Programme of Immunization
FEC	Femmes Cadres
FP	Family Planning
ICPD	International Conference for Population and Development
IQRAA	Association Algerienne d'analphabetisme et l'Illettrisme
MDGs	Millennium Development Goals
MDSR	Maternal Deaths Surveillance and Response
MICS	Multi Indicator Cluster Survey
MoH	Ministry of Health
MoRA	Ministry of Religious Affairs
MMR	Maternal Mortality Ratio
OSOG	Omani Society of Obstetrics and Gynecology
PoA	Programme of Action of the ICPD
PPE	Personal Protective Equipment
SDGs	Sustainable Development Goals
SFD	Social Fund for Development
SMEPS	Small and Micro Enterprise Promotion Service
SRH/RR	Sexual and Reproductive Health & Reproductive Rights
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Between 1990 and 2015, the global maternal mortality ratio (MMR) decreased by 44%, from 385 to 216 maternal deaths per 100,000 live births, while the Arab region's average maternal mortality ratio has decreased from 238 per 100,000 live births in 2000 to 156 per 100,000 live births in 2015. Despite this progress, most of the countries still fell far short of the Millennium Development Goals target of a 75% reduction in the MMR by 2015. For this reason, maternal mortality reduction remained and will remain a priority for international development and is included in the Sustainable Development Goals (SDGs), namely goal 3: "Ensure healthy lives and promote well-being for all at all ages," and its target 3.1: "reduce the global MMR to less than 70 per 100,000 live births by 2030."[1]

In 1994, 179 UN Member States adopted the International Conference on Population and Development's (ICPD) Programme of Action (PoA). The PoA stressed the importance of sexual and reproductive health and reproductive rights including the right to family planning (FP) and maternal health, as a precondition for women's empowerment. It also called for an end to gender based violence and harmful traditional practices.[2]

To date, the ICPD remains the foundation of UNFPA's work. Its three transformative objectives include ending preventable maternal deaths by 2030. UNFPA aims to reduce the number of preventable maternal deaths through strategic interventions that reduce inequities, improve access to quality sexual, reproductive, maternal and newborn health care, ensuring universal health coverage that includes sexual and reproductive health care, and strengthening health systems.

1 Maternal Health Task Force, 2020. The Sustainable Development Goals and Maternal Mortality. Accessed at: 5 November 2020. Available at: https://www.mhtf.org/topics/the-sustainable-development-goals-and-maternal-mortality/

2 UNFPA, 2020. International Conference on Population and Development. Accessed at: 5 November 2020. Available at: https://www.unfpa.org/icpd#:~:text=The%20ICPD%20Programme%20of%20Action,of%20the%20global%20development%20agenda

UNFPA three transformative results are:

ZERO *preventable maternal deaths*
ZERO *unmet need for family planning*
ZERO *gender-based violence and harmful practices*

The Nairobi summit, celebrating 25 years after the adoption of the ICPD PoA, was an important step to reaffirm UNFPA commitments. At the 2019 Nairobi Summit, UNFPA commemorated and reiterated the importance of the ICPD Programme of Action in today's political environment, as well as to plan for the way ahead to fully achieve the ICPD and the SDGs by 2030. One of the main formulated commitments at the summit was to achieve universal health coverage and ending preventable maternal deaths, which is in line with SDGs 3 and 5.

"Thanks to the work of UNFPA and its partners, fewer women are dying giving life, and more women than ever before are using modern contraceptives. Now we need to speed up these efforts to reach a future where zero is the only acceptable number: zero preventable maternal deaths, zero unmet need for family planning, and zero violence and harmful practices against women and girls."
Natalia Kanem, Executive Director, UNFPA

Most maternal deaths are preventable.[3] In 2017, an estimated 295,000 women, more than 800 per day, died of causes related to pregnancy or childbirth. The majority died from severe bleeding, sepsis, eclampsia, obstructed labour and the consequences of unsafe abortions – all causes for which there are highly effective interventions. Significant reductions in maternal mortality are possible, and are being implemented. In many countries, maternal deaths have fallen as women have gained access to family planning and skilled birth attendance with backup emergency obstetric care. The global maternal mortality ratio has fallen from 342 maternal deaths per 100,000 live births in 2000 to 211 deaths per 100,000 live births in 2017. But much more is yet to be done, as high rates of maternal mortality persist, particularly in impoverished and rural communities.[4]

Despite the decrease of the MMR in the Arab region from 238 per 100,000 live births in 2000 to 156 per 100,000 live births in 2015, many states are not yet on track of achieving their national target of reducing MMR by two-thirds. Additionally, the majority of countries covered by the UNFPA Arab States Regional Office[5] (ASRO) experience a humanitarian crisis and the majority are protracted crises (Iraq, Libya, Palestine, Somalia, Sudan, Syria, Yemen), whereas other countries are addressing the needs of refugees, including Jordan, Lebanon, Djibouti, and Egypt. Vulnerabilities to natural disasters such as seasonal flooding and drought further exacerbate the challenges. All of this has left a major impact on the health systems in the countries, especially on maternal health programmes. To add to the multitude of complex and fragile settings in the countries of the region, the COVID-19 pandemic added an additional burden to the already complicated context, and is negatively affecting the already strained health structures.

3 WHO, 2019. Maternal Morality. Accessed on 5 November 2020. Available at: https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality
4 UNFPA, 2020. Maternal Mortality. Accessed on 31 October 2020. Available at: https://www.unfpa.org/maternal-health
5 The UNFPA Arab States Regional Office covers, Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kingdom of Saudi Arabia, Kuwait, Lebanon, Libya, Morocco, Palestine, Somalia, Sudan, Syria, Tunisia, Oman, Qatar, United Arab Emirates and Yemen

There is currently limited scientific evidence on the effects of COVID-19 on, and especially on maternal health. The world will still discover issues related to risks of transmission of the virus between mother and child pre and post-natal, the effects, if any, on fetal development, the effects that may occur during future pregnancies for women who were infected, and other issues yet to emerge. A recent study on the indirect impacts of COVID-19 on maternal and child mortality in low-income and middle-income countries, highlights potential consequences of disruptions to routine health care and decreased access to food.[6] Other contributing factors that result from the COVID-19 pandemic may include workforce reductions (as staff are quarantined, ill, or reallocated), unemployment, interrupted supply chains, and decreases in service use, not to mention the ability of fragile health systems to offset the pandemic while maintaining their SRH services.
WHO issued interim guidance on maternal health that includes less visits to clinics, early discharge, COVID-19 screening upon admission, and quarantining suspected cases until proven negative. However, the response is undermined by low testing capacity, delays in obtaining results, constraints in infrastructure, and staffing shortages. Also, because COVID-19 symptoms may mimic some obstetric emergencies, triaging women with concomitant complications might be delayed.

UNFPA-ASRO strives to support countries in the region with their programmes to advance the mandate of the organization and support national governments in meeting their SDG commitments, which includes avoidance of preventable maternal deaths. A regional competition was launched to capture and compile maternal health best practices, to document the countrys' experiences and learn from their successes.

Through this compilation of best practices, we delve into the experiences of five Arab countries with their unique circumstances and specific contexts. However, all of them are united with their programmes to advance maternal health and work towards the elimination of preventable maternal deaths fulfilling women's right to the best accessible maternity care. From the experience of Algeria, we witness how the advocacy efforts and coordination with the national government has provided an alternative approach to raise awareness of the local communities on sexual and reproductive health and reproductive rights (SRH/RR) through training of female religious educators (mourchidat). Moving to Morocco, the UNFPA Country Office successfully implemented an initiative with the local government to certify midwives through an official accreditation programme. Following, we travel to Oman where they established a hotline for women on SRH during the time of COVID-19 lockdown, to ensure remote counseling and referral to those in need. In Tunisia, we look at the importance of strong coordination mechanisms between the different stakeholders to ensure continuity of services, including SRH-services, during the lockdown. Finally, we witness the work in Yemen during the ongoing conflict to ensure the availability of basic maternal health services in remote communities affected by the protracted crisis. The objective of this document is to capture and document best and promising practices in maternal health programming in the Arab region.

6 Bush-Hallen, et al., 2020. Impact of COVID-19 on maternal and child health. Available at: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30327-2/fulltext

Algeria

Engaging female religious educators to promote family planning and reduce maternal mortality and morbidity

Context

Algeria is a middle-income country with a population of 43.9 million, of which 11 million are women of reproductive age (15-49 years). Between 1962 and 1985 Algeria experienced a vast population growth. In 1970 the fertility rate was 8.4 children per woman, but due to a comprehensive approach of family planning and strategic SRH direction, it started to decline to approximately 6 children per woman in 1985, and currently stands at 3 children per woman.

Earlier, the response consisted of establishment of a birth spacing center in 1967, as 60% of births took place at home, which is a risk-factor due to unforeseen complications that may occur during birth. Two years later, regional family planning centers were opened with the aim to provide pre- and post-natal consultations, as well as newborn care and to monitor the child's development up to the age of six. Currently, a large network of maternal and child protection centers covers the entire country, including in the most remote areas. The government has always considered maternal health as a public health priority and made mother and child health programmes/services free, to date.

In the late 1960s, the Ministry of Health approached the High Islamic Council, requesting a religious ruling on family planning. In 1968, the Council promulgated a fatwa that allowed birth spacing. A second fatwa was promulgated in 1982, as the Council unanimously agreed that birth spacing and family planning are an individual choice.

The Millennium Development Goals (MDGs) offered another opportunity to further advance maternal health in Algeria, and although the country did not achieve MDG 5a on reduction of maternal mortality, significant progress was made between 2000 and 2015. The maternal mortality ratio (MMR) was 117/100,000 in 1999, and decreased to 64/100,000 in 2017.[7] This progress was achieved due to the improvement of pregnancy risk monitoring where 93% of pregnant women had at least 4 antenatal care visits, and 97% of the births were attended by skilled health personnel.[8]

In 2013, the results of the Multi Indicator Cluster Survey (MICS) 4, and the preparation of the report for MDGs for 2015, triggered the revitalization of maternal health and family planning programmes. It was the joint advocacy of UNFPA, UNICEF and WHO that prompted the Ministry of Health to develop the National Plan for the Accelerated Reduction of Maternal Mortality, carry out an analysis of the situation based on the identification of bottlenecks, and establish a committee to oversee the implementation of the national plan, to which UNFPA, UNICEF and WHO provided technical support. The National Plan identifies two main challenges, firstly the high fertility rate that could be attributed to underutilization of family planning services and supplies. Secondly, unstructured and unsystematic SRH communication and messaging by various stakeholders. At the moment, there is no uniform communication strategy, and therefore the Algerian population is receiving inconsistent messages from stakeholders such as the government, civil society, academia and the private sector.

7 SWOP 2020 https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2020_EN_State_of_World_Population.pdf
8 MICS4 survey (2012-2013)
https://mics-surveys-prod.s3.amazonaws.com/MICS4/Middle%20East%20and%20North%20Africa/Algeria/2012-2013/Final/Algeria%202012-13%20MICS_French.pdf

These actions are based on the international development frameworks that Algeria has committed to, such as the SDGs as part of the 2030 agenda, the ICPD and its Programme of Action, which commitments were reaffirmed in November 2019 at the Nairobi Summit to celebrate the 25th anniversary of the ICPD PoA, and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

It is for these reasons that UNFPA Algeria CO's 5th country programme (2012-2016) as well as its current country programme (2017-2021) support the Algerian Ministry of Health with the following interventions. i) The audit of maternal deaths; ii) Development of the national plan for accelerated reduction of maternal mortality; iii) Development of the family planning roadmap, which includes an external communication campaign (radio spots), as well as a new initiative, the capacity building of mourchidates (female faith leaders) in RH and FP counseling. It is the latter initiative that we wish to highlight, together with the establishment of a mourchidate network, as best-practice to reduce maternal mortality.

This activity is based on the recommendation that increased family planning (FP) uptake leads to a decrease in MMR. A high fertility has a detrimental effect on the women themselves, they will have less access to education and economic opportunities and negative effects on their health especially if there is little spacing between the pregnancies. Moreover, a slow FP uptake is likely to influence population growth exponentially, for example, if the fertility rate was to increase by 0.5, reaching a total of 3.5 children per woman, the Algerian population would reach 72.4 million individuals by 2050 leading to a high dependency ratio. In turn, this leads to reduced economic opportunities, and losing the opportunity to benefit from the demographic dividend.[9] Potentially, this may lead to a deterioration of the national health system and more particularly the infrastructures and services dedicated to mothers and children, which in turn will negatively affect the availability of RH/FP services, particularly in terms of access and quality of care. As we saw earlier, this will negatively impact the results made to date with respect to maternal and infant mortality indicators.

9 Demographic dividend is the accelerated economic growth that can result from improved reproductive health, a rapid decline in fertility, and the subsequent shift in population age structure. With fewer births each year, a country's working-age population grows larger relative to the young dependent population. With more people in the labor force and fewer children to support, a country has a window of opportunity for economic growth if the right social and economic investments and policies are made in health, education, governance, and the economy. https://demographicdividend.org/

Solutions

Mourchidates play an important role in Algerian society. They provide religious and literacy education to women and children and support religious activities in the community. They are part of the local communities and are key-trust persons for women and girls. Their knowledge and convening power is well regarded throughout Algerian society.

The status of mourchidates stipulates that they receive many questions from (young) mothers on family planning, maternal, newborn and child health when conducting their religious tasks. Therefore, MoH and UNFPA requested the involvement of mourchidates in the framework of partnership and be trained in family planning counselling and information sharing. It is for this reason that UNFPA, in collaboration with the Ministry of Health and the Ministry of Religious Affairs trained approximately 100 mourchidates in family planning counseling. In turn, the mourchidates formed a network to support reducing maternal mortality. Currently, they play a vital role in outreach and awareness raising activities, targeting in particular women and young girls. The role of mourchidates in Algeria can be compared to that of community health workers in other countries. Algeria undertook the following parallel steps:

Step 1: Creating synergies for RH/FP

Firstly, UNFPA convened relevant stakeholders that supported the increased responsibilities of the mourchidates. The Algerian Association for Family Planning (AAPF), under a 2017 framework agreement with the MoH, is in charge of introducing the essential package of integrated quality RH services in 10 pilot reference centers in targeted governorates (wilayas). This grass-roots initiative, initiated by the mourchidates themselves, is new and allows for a participatory approach and multi-stakeholders engagement while also maintaining a flexible and adaptable approach.

Secondly, in order to create uniform messaging on RH/FP and population issues, the Ministry of Communication, in coordination with the Ministry of Health, supported the training of journalists. The ministries also promoted maternal health and RH/FP services in national and local media. Moreover, three radio spots were broadcasted on the local and national levels in February 2020. These interventions gradually contribute to creating synergies around the RH/FP structures, and a space for collaboration that will increase access to services.

Step 2: Advocacy for reproductive and maternal health

In order to promote and inform stakeholders on the additional responsibilities of the mourchidates, UNFPA advocated with the decision-makers of the MoH, and Ministry of Religious Affairs (MoRA). More specifically, UNFPA supported the celebration with parliamentarians through the parliamentary days in 2017, 2018 and 2019. In doing so the parliamentary days focused on reproductive and maternal health. UNFPA also advocated for maternal health, GBV prevention, and empowerment of women with AAPF, Femmes Cadres (FEC), and the Association Algerienne d'analphabetisme et l'illettrisme (IQRAA), which resulted in a uniform approach and development of partnership agreements.

Step 3: Training of mourchidates

As part of the introduction of essential services, the mourchidates needed to be trained in family planning information and services as well as reproductive and maternal health. At this point, the MoH and the MoRA adopted the programme (see step 5), and were interested in training the mourchidates. MoH and MoRA took responsibility for the training and UNFPA's role changed from coordinating the initiative, to supporting the ministries technically. UNFPA's expertise on RH/FP and population issues added value and strengthened the overall initiative and may have led to the expansion of the programme.Currently, the programme is being expanded with the introduction of a network to better coordinate between mourchidates and RH/FP service providers. This can improve communication between the different stakeholders.

Step 4: Enabling legal environment

In 2018 the "health law" came into force, which created a favourable environment for the participation of civil society. It also encouraged the promotion of maternal, child and adolescent health as well as the distribution of information, education and communication materials.

Step 5: Embodiment by MoH and MoRA

From 2014 onwards, the MoRA and MoH roles shifted from supporting the initiative, to leading the training of the mourchidates. The ownership of the programme by the MoH and MoRA ensured political buy-in. For example, it created a space to discuss more controversial public health topics with the mourchidates and imams.

Moreover, as this was a grassroots initiative, decision-making processes differed slightly from the usual top-down approach, as recommendations came from the operational level.

Key partners

UNFPA: UNFPA has contributed technically and financially to build capacities of 100 mourchidates at the national level, focusing on RH/FP counseling. Moreover, UNFPA supported the evaluation workshop of the mourchidates training, which recommended the need for networking between mourchidate and RH/FP service providers.

The Ministry of Health: The MoH's Population Directorate approached the Ministry of Religious Affairs to identify mourchidates for participation in the RH/FP counseling workshop. Secondly, the MoH invited the MoRA to coordinate the network of mourchidates and RH/FP service providers.

The National Population Committee: is a national multi-sectoral committee chaired by the Minister of Health. It was created in 2002 and is represented in the 58 governorates. The National Population Committee is responsible for the communication between the religious sector and MoH to promote and coordinate this initiative.

The Ministry of Religious Affairs: sensitizes mourchidates on RH/FP and maternal health, in order to strengthen social and family wellbeing. More specifically, the MoRA identifies mourchidates to participate in the workshop, and be included in the network of mourchidates RH/FP service providers. Additionally, MoRA is a member of the National Population Committee.

Mourchidates: In addition to their usual religious tasks, they promote family planning services to reduce maternal mortality and morbidity. They saw a need in the society for this, and explored opportunities to be capacitated and support the community.

Civil society organizations: Support the MoH. More specifically, the AAPF supported the training and enabled the network at a local level (the 10 governorates where the programme was piloted).

Results

For years, UNFPA has advocated to engage mourchdates in RH/FP activities, as they are well-regarded in society and reach many women and girls in rural areas. Therefore, the main result achieved was that the MoH and MoRA saw the importance of the programme, and integrated the programme in the annual and multi-year plans and strategies. The involvement of civil society and the innovative character of the initiative are catalysts for its duplication.

Due to the global COVID-19 pandemic and the economic situation in Algeria, recent actions (establishment of the network) has been significantly delayed. Regardless, the UNFPA CO managed to achieve the following results:

1. Ten pilot centers have been identified to train the mourchidates in targeted governorates.
2. 100 mourchidates have been trained and initiated group discussions with women and girls on RH/FP in the local mosques. Moreover, they have been sensitized on the need to liaise with RH/FP service providers and are aware of the need to create a network with the local health structures.
3. In coordination with MoH, MoRA, AAPF and UNFPA, a RH/FP service providers' network was established to coordinate with local health structures.
4. Due to the challenges stated above, the results of the unified communication strategy could not yet be measured.

Lessons Learned

1. There was a misunderstanding and confusion on the role of the mourchidates in RH/FP information provision by the RH/FP service providers. UNFPA advocated with the MoH to provide an instruction clarifying the role and responsibilities of mourchidates in terms of RH/FP information and counseling towards women and girls in the mosques.
2. Cabinet reshuffles and COVID-19 caused delays in the activation of the national network between mourchidates and RH/FP service providers. This has allowed for an assessment of the mourchidates commitment, to better understand their individual experiences.
   In turn, this has pushed UNFPA to invite the MoH to consider a change in strategy, and establish a pilot in only 10 governorates.
3. In order to ensure buy-in, it is important to involve all stakeholders as early as possible and on a structural basis, as well as to divide tasks accordingly.
4. The mourchidate interventions should be considered by stakeholders a good practice and can be scaled-up in Algeria or duplicated in other countries.

Recommendations

Replication of this initiative is possible, if religious institutions are supportive and willing to play their role of sensitization and health promotion in society. The training can be extended to Imams to target men and boys. By seeking collaboration, innovation and the involvement of diverse stakeholders, one can strengthen the capacities of religious leaders. More specifically, we recommend considering the following in the planning of similar intervention:

- To put in place a solid inter-sectoral coordination platform and mechanisms for clear communication between the central and local levels. For example, to develop rewarding measures and strengthen team cohesion, i.e. regular meetings, training and scientific events participation.
- To set up a flexible plan, which is context-specific and adaptable. Moreover, periodic monitoring and evaluations should be included in the plan. It is recommended to designate a coordinator to supervise and report on the initiative outcomes. In turn, stakeholders should ensure to address the challenges as soon as they are identified and reported by the coordinator.
- To utilize user-centered design, meaning to have active feedback on the experiences of the mourchidates, in order to adjust the programme and systematically document various interventions.
- To institutionalize the mourchidates and service providers network, especially ensuring clear task distribution. Moreover, it is recommended to develop synergies and complementarities at the operational level in the health sector and outside the sector.

MOROCCO

Midwives ensure elimination of preventable maternal deaths through strong regulatory mechanisms

Context

Morocco is a middle-income country with an estimated total population of 33.8 million. The country has made notable achievements in recent years. The fertility rate is 2.2 children per woman and the contraceptive prevalence rate is 70.8%. Additionally, the maternal mortality ratio (MMR) has decreased from 332/100,000 in 1992 to 112/100,000 in 2010 and to 73/100,000 in 2018. The main causes for maternal deaths are, hemorrhages (54%), hypertensive disorders (24.2%), infections (8.1%) and post-abortion complications (5.6%). Regardless of the progress today, 93% of the maternal deaths are preventable and 73% occur in a health facility. Large inequalities remain between urban and rural areas. More than a third of the women in rural areas do not attend all recommended antenatal care visits, and nearly half of them still give birth at home. Poverty and education level of Moroccan women also influence reproductive health service uptake. At the same time, there are many barriers affecting access to SRH and maternal health services.

1. Governance: weak information systems.
2. Demand: economic and cultural barriers.
3. Quality of services: accessibility, skills of health professionals, availability of equipment and supplies, compliance with procedures and protocols for quality service.

Morocco has a favorable governance context regarding maternal health, based on international frameworks such as the SDGs, and the ICPD PoA. The national frameworks are:

- The 2011 Constitution, in particular Article 31 on the right to health.
- A call for action by His Majesty King Mohammed VI at the 2nd National Conference on Health (Marrakech, July 1-3, 2013) to develop the charter and acquire sufficient human resources.
- The development and implementation of the Health Plan 2025, which focuses on the health of mother and child.[10]

In order to address the aforementioned challenges and fulfill the SDGs, especially SDG 3 (target 3.1) and UNFPA's first transformative result of zero preventable maternal deaths, the Moroccan Ministry of Health decided to strengthen and reposition midwifery education, through utilizing a participatory and integrated approach.

10 Morocco's Health Plan 2025

Solutions

This maternal health best practice highlights the efforts of the Moroccan health authorities and their partners, particularly UNFPA, to strengthen the repositioning of midwives to eliminate preventable maternal deaths. Given that the number of gynecologists is limited, repositioning midwives by increasing their responsibilities and autonomy proved to be an effective solution. In doing so, adequate maternal health services could be provided to women and girls in remote communities. A review process took place assessing two factors, the partnership between the Ministry of Health (MoH) and the midwifery associations, as well as the partnership between UNFPA and the midwifery associations.

Firstly, regarding the partnership with the MoH and the National Midwifery Associations: due to various reasons, Morocco has two national midwifery associations, the relationship and trust between the two presidents has been paramount for creating an enabling environment for collaboration. This cooperation, supported by UNFPA, was a key factor in successfully working with the Ministry of Health. Four milestones can be identified, which have been central to the success of professionalisation of midwifery education in Morocco.

1. Expanding responsibilities of midwives

Although it took extended advocacy efforts by a wide range of stakeholders, including UNFPA, to establish a law exclusively dedicated to the practice of the profession of midwife, nevertheless, the new law (Law No. 44-13, June 2016)[11] redefined the midwifery profession, and expanded their responsibilities and skills. For example, previously midwives could not administer medication, but under the new law, they can do so for example duringa critical situation, such as emergency obstetrics. In such urgent situations it is essential that medication is administered promptly. If a midwife will have to seek a medical doctor to administer the medication, it is often too late for the woman undergoing birth.

Even though the law (44-13) was promulgated, the bylaws stipulating how the law would be implemented, still had to be written. Therefore, in 2017 and 2018 the UNFPA CO hired two new staff members with a legal expertise, who worked with the MoH and the midwifery associations to write the bylaws. UNFPA would provide a draft of the text, and simultaneously, the midwifery associations organized workshops with the MoH, in which they reviewed the bylaws. This ensured that the bylaws had buy-in from the MoH. When finalized, they were swiftly adopted and internalized. Finally, on 23 January 2020 the bylaws were presented to the Minister of Health.

2. Establishing an Order of Midwives

Since 1955, there was already a law allowing for professional orders in Morocco. In recent years, however, this law has fallen into disuse.[12] Through effective lobbying of the two national midwifery

11 Dahir n ° 1-16-83 of 16 Ramadan 1437 (June 22, 2016) promulgating law n ° 44-13 relating to the practice of the profession of midwife. B.O: 6500-1 (15-9-2016).
12 Dahir of February 21, 1955 (27 Joumada II 1374) relating to the order of midwives. B.O No 2214 of April 1,1955.

associations, Article 34 of the new law (Law No. 44-13, June 2016) also stipulates that an Order of Midwives could be established.[13] The Moroccan midwifery associations could not take-up this role as they are civil society organizations, and their mission differs from what was envisioned for the Order. The objective of the Order of Midwives was to establish a curriculum or repository containing essential knowledge and skills every midwife should have. Additionally, the Order would be responsible for the quality assurance of individual midwives, and will be contacted in case of medical malpractice of the midwife. This vision of the Order of the Midwives is in line with the recommendations of the International Confederation of Midwives.

3. Broadening the autonomy of midwives

In 2020, Decree No. 2.19.794 gave midwives more freedom to practice their profession and decreed that they are under the responsibility of MoH. This has the advantage of better aligning the responsibilities of midwives with that of other cadres. It also exemplifies the willingness of public authorities to professionalize midwifery, similar to other medical professions, such as nurses.

4. Increasing academic opportunities for midwives

In 2013, the MoH reformed the training system for professionals, and the midwifery sector was one of the five selected sectors. In addition to a bachelor degree, it is now possible to obtain a midwifery masters and doctorate degree at one of the higher educational institutes for nursing and health care professionals.[14] This was a longstanding objective of the national midwifery associations, and several midwives are already pursuing a doctoral degree, in different disciplines. Increasing academic opportunities has improved the image and attractiveness of the midwifery profession in Morocco. Moreover, the quality and number of students applying to become a midwife has increased in recent years.

During the current COVID-19 pandemic, the midwives demonstrated professionalism and remarkable selflessness. UNFPA, with the support of the midwifery associations, continued building the capacity of the midwives and provided them with constant support on the operational level. For example, holding webinars on how to manage stress and anxiety in order to reduce the emotional burden of midwives, contributing to improved quality of care.

13 Dahir n° 1-16-82 du 16 ramadan 1437 (22 juin 2016) portant promulgation de la loi n° 44-13 relative à l'exercice des professions infirmières B.O : 6500- (1 5-9-2016).
14 Décret n°2.13.658 du 30 septembre 2013 relatif aux Instituts supérieurs des Professions de Santé « ISPITS » B.O n°6195 bis du 15-9-2020.

Key partners

UNFPA: Provided technical and financial support to this initiative.
Ministry of Health: Was responsible for ensuring the competencies were well-captured in the updated midwifery curriculum. Legislation was drafted and implemented as well as workshops for the midwives and overall policy direction.
Ministry of Education: Is responsible for reviewing and approving the diplomas of the midwives, and works in close collaboration with the MoH.
Moroccan Association of Midwives and National Association of Midwives in Morocco: Were responsible for community mobilization, advocating for public issues in accordance with the Constitution,[15] advocacy for regulations, and the establishment of the order of midwives.

Results

1. Development and dissemination of the professional repository for midwives

At the initiative of the Ministry of Health and with the technical support of UNFPA, midwives in Morocco now have a new repository of professional activities, competencies and skills in particular, prerogatives, places of practice, the conditions of access to midwifery studies and the qualities required of them. This repository is governed by the Order of Midwives and presents a reference platform for all stakeholders, in terms of regulation of the practice, basic and continuing training, and supervision. This repository is a dynamic regularly updated tool.[16]

> *"The repository is essential to improve the quality of midwifery practices in Morocco" (UNFPA, 2014)*

The repository is in line with expectations of midwives themselves, as it describes essential knowledge and skills necessary for their clinical practice. It strengthens professional values, and contributes to their professional identity. The repository was designed in such a way that it can also be used to update the training curriculum.

2. Increased responsibilities for midwives

One of the issues midwives in Morocco experienced, is that they were not allowed to prescribe medications. This was especially a problem in the rural areas where physicians who are qualified to do so, are often far away. It is for this reason that UNFPA and the national associations of midwives cooperated to amend the laws. Article 2 currently states: "The roles of midwives are set-out in a list

15 According to the Moroccan Constitution, civil society has the responsibility of advocating for public relevance issues and mobilize communities towards addressing these issues head on.
16 Reference guide for midwifery skills in Morocco (Ministry of Health).

of responsibilities established by "the Administration" after consultations with the professional midwifery association, if it exists, as established by article 34 of the current law, or after consultations with the national council of physicians' association".[17]

3. Promulgation of the Law and establishing the Order of Midwives

In parallel with the efforts made by the two Moroccan national associations of midwives to bring about the success of Law No. 44-13 relating to the exercise of the profession of midwifery and its implementing texts, UNFPA has provided them with technical assistance in the form of legal expertise to support the preparation of the bylaws for the creation of the Order of Midwives in Morocco. In accordance with the terms of reference of the consultation, a deliverable validated by the two professional associations of midwives was submitted to the Ministry of Health for its examination, appropriation and implementation as a bill. This bill on the National Order of Midwives will have a considerable impact on the socio-professional status of the entire community of midwives and will contribute to strengthening the professional identity, ethical and deontological principles on the one hand, and the improvement of the quantitative and qualitative indicators of maternal and child health programmes on the other hand.

4. New academic opportunities for midwives

The midwifery education reform was adopted in Morocco in 2013, and constituted an opportunity to integrate the training of midwives into the bachelor, master's and post-graduate degree model. The reform launched in 2020 by the Ministry of Higher Education is currently being implemented by the universities and allows for more responsibilities for midwives in relation to other medical cadres.


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17 Dahir n° 1-16-83 du 16 ramadan 1437 (22 juin 2016) portant promulgation de la loi n° 44-13 relative à l'exercice de la profession de sage-femme. B.O : 6500-1 (15-9-2016).

Lessons learned

The Moroccan experience can serve as a model for other countries. Some of the lessons learned throughout the process are:

- Encourage positive collaboration between government officials and civil society and incorporate the spirit of the Moroccan Constitution of 2011 (Article 21) which supports civil society as follows: "the association of civil society and non-governmental organizations are formed and exercise their activities in complete freedom..."
- Promote the participation of health professionals in parliamentary bodies in order to interact "from the inside" with the socio-political stakeholders.
- Strengthen professional networking between midwives with strategic and operational players in health systems.
- Ensure the presence and commitment of Moroccan national associations of midwives in forums, scientific days and national and international meetings concerned with sexual and reproductive health policies and strategies.
- Develop community mobilization in local, national and international initiatives aimed at promoting sexual and reproductive health; the actions carried out by the Moroccan national associations within the framework of the national human development initiative "INDH"
- constitute an exemplary model of partnership oriented towards the fight against social precariousness.
  Develop a culture of volunteerism to support the national sexual and reproductive health programme, particularly in times of major health crises, such as the one caused by the
- COVID-19 pandemic. The two associations have demonstrated exceptional maturity through their strong involvement in supporting pregnant women and working midwives.
  Maintain and consolidate partnerships with UN organizations, such as WHO, UNFPA,
- UN Women, as well as international associations such as the International Confederation of Midwives.
- Coordinate the efforts of Moroccan national associations through a federation or even a professional coalition in the service of the midwifery profession. This coalition will constitute an opportunity for optimization of resources, development of positive advocacy, pooling and considerable mobilization of resources, both technical and logistical, necessary to carry out a synergistic associative work of midwives.

Recommendations

The Moroccan maternal health best practice shows how strong regulatory mechanisms improved the quality of midwifery service, which is central to ensure the elimination of preventable maternal deaths through strong structures and systems. Below are recommendations for other countries that are interested in developing a similar programme.

1. Establish midwife autonomy

Public authorities are encouraged to perceive midwives as qualified health professionals to enable them to be autonomous practitioners, who aim to provide high quality services with the well-being of mother and child at the center, similar to their international counterparts. Midwives are trained according to a curriculum providing them with the required knowledge and skills to ensure safe pregnancies, childbirth and postnatal interventions. The autonomy of midwives has to be designed according to a public health approach based on complementarity, and professional interdependence.

2. Establishment of the national order of midwives

Like all regulated professions in Morocco, the midwifery profession was subject to French-inspired regulations, since the beginning of the 20th century. In fact, some texts date back to 1916, and provide regulations for doctors, pharmacists, dentists, and midwives.[18] The establishment of a National Order of Midwives presented an opportunity to ensure good governance and prepare for a gradual transition to professional autonomy. Moreover, the Order will provide a legal framework for the application of the principles of probity and moralization essential to the exercise of the health


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18 Dahir du 12 avril 1916 (8 joumada II 1334) portant réglementation de l'exercice des professions de médecin, pharmacien, dentiste et sage-femme : B.O n° 183 du 19 Avril 1916 page 468.

professions, and of observation by all members of the profession of professional duties and rules, enacted by ethical and deontological principles.
The requirements of the professionalization of the profession of midwives presupposes a permanent concern of the supervisory department to put at their disposal the appropriate resources in order to allow them to exercise their profession in adapted, humanized and secure socio-professional conditions. The Order is well positioned to facilitate this professionalization.

3. Meaningful participation of midwives in decision-making

The involvement of midwives in the formulation of strategic orientations and in the development of sectoral health strategies has become evident due to the impact of reproductive and sexual health in the implementation of the priorities of the SDGs and the 'improvement of indicators' linked to maternal and infant mortality. According to a statement from Dr. Anthony Costello, Director of the Department of Maternal, Newborn, Child and Adolescent Health at WHO,*"It is time to recognize the crucial role midwives play in the survival of mothers and newborns. For too long, they have failed to make their voices heard and have been denied a seat at the decision-making table."*

4. Promotion of post-graduate degrees in midwifery

Providing alternatives for strengthening professional and academic capacities remains one of the solutions enabling midwives to contribute to the enhancement of national health programs for maternal and child health. According to the WHO and UNFPA, *"Midwives are essential for providing quality maternal and newborn care that is respectful of the individual. They are able to prevent and manage many complications of pregnancy and childbirth and play a crucial role in ending preventable infant, child and maternal deaths."*
The reform of the Bachelor-Master-Doctorate system is already will prepare better-trained cadres in the midwifery profession. It also promotes international mobility and is an overall improvement of the quality of Moroccan tertiary education.

Oman

Pioneering telemedicine helpline for pregnant and lactating women during COVID-19 pandemic

Context

Oman is an Arab country in the Arabian Gulf with a total population of 5.1 million, of which approximately 75,000 are women of reproductive age (15-49 years).[19] The global COVID-19 pandemic has disproportionately affected women and other vulnerable groups, and has significantly limited women's access to SRH services. This has negatively impacted both women's physical and mental wellbeing and especially women of reproductive age, as well as pregnant and lactating women.[20] Oman was no exception.

The government of Oman implemented preventative measures meant to contain the spread of COVID-19, including lockdowns, curfews and social distancing requirements, which significantly limited women's access to SRH care. Therefore, the UNFPA and WHO collaborated to develop a multi-stakeholder partnership between the government, the UN agencies and civil society to address the needs of women **to receive SRH services during the time of COVID-19 through the launch of the telemedicine helpline.**

The primary health service provider in Oman is the Omani Ministry of Health (MoH). The project was developed with MoH and the Omani Society of Obstetrics and Gynecology (OSOG), which is a specialized NGO hub for Ob/Gyn experts.

The project was designed to address the MoH and Oman's vital national policies and priorities through out the implementation phase. The initiative aimed to foster the country's efforts in achieving SDG3; Good Health and Wellbeing, targeting reduced maternal mortality ratio, ensuring access to sexual and reproductive healthcare services, including birth spacing, information and education, integration of reproductive health and for achieving SDG5 on gender equality.

19 https://www.unfpa.org/data/world-population/OM
20 https://arabstates.unfpa.org/en/publications/impact-public-health-emergencies-sexual-and-reproductive-health-and-reproductive-rights

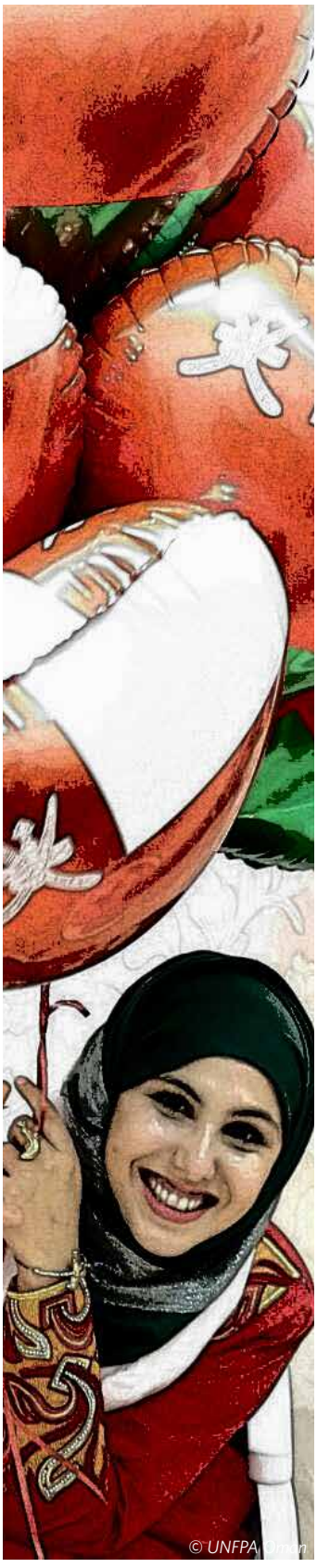
Solutions

Through a dedicated helpline, which operates from Sunday to Thursday between 10.00 and 16.00, women received medical and psychological support, which allowed life-saving intervention for 3 pregnant women. The project's impact on the target group has been very positive. *"This project has increased community trust in the services; some women even sent messages and called the helpline and MoH to express their appreciation,"* said the Director of the Women and Child Health Department, at the MoH. Additionally, by integrating the helpline service with the existing MoH helpline, the project exceeded the desired outcomes, doubling the intended reach over 2 months.

The project aimed to achieve several goals, including reducing women's exposure to COVID-19, and support with maternal health related questions. By screening all calls by the hotline focal point (midwife/nurse) to identify the urgency; which questions or concerns can be addressed over the phone by the midwife or consulting doctor, or do they need if necessary to refer those women who require immediate emergency medical attention and have to be referred to the nearest hospital or health care center (more than 45% of cases were diverted to doctors during 2 months of the project duration). Although women are encouraged to continue to receive the required antenatal, postnatal or reproductive healthcare services by their physicians, the hotline provides an opportunity for the women to have their questions and concerns addressed between appointments.

As the main MoH partner, UNFPA reaped the outcome of partnership and coordination. The well-established relationship of the UNFPA office in Oman with various relevant stakeholders within the Sultanate of Oman has made it the agency of choice for addressing issues related to SRH and maternal health. The collaboration with WHO has also paved the way for the successful implementation of the project. In parallel, UNFPA/WHO formed a solid partnership with the MoH and the Omani Society of Obstetrics and Gynecology (OSOG) as the professional hub for SRH experts in Oman. Moreover, to ensure close coordination and continuous follow-up, all engaged partners met at least once a week to ensure smooth implementation and to mitigate any challenges.

UNFPA/WHO appreciated that the multi-dimensional partnership with the continuous discussions and coordination efforts helped achieve the successful implementation of the project and the ability to face challenges



during implementation. Also, the continuous follow-up and coordination allowed the teams to exchange ideas and improve results over the short period of the project; 2 months.

To ensure successful implementation, UNFPA developed a sequence of key activities. Planning was an essential part of this successful path. Hence, UNFPA concentrated on developing a well-tailored concept note for the project, detailed and robust Terms of References (ToRs) for the midwife who is the MoH hotline focal point and the consultant doctors, in addition to developing the project log-frame, media plan, and project budget. These efforts led to the campaign's success, alongside the monitoring of the consultants and the focal point who also helped to make necessary changes in the media plan to ensure maximum outreach. The MoH designated a specially trained midwife to address women's inquiries and concerns and to provide them with medical and mental health support as well as to refer their concerns to a consulting doctor if needed. MoH and OSOG helped identify both Human Resource Staff and Frontliners (HRSF physicians and the midwife) who can support women who have complicated issues related to sexual and reproductive health and reproductive rights.

The Founder and Chairman of Oman Society of Obstetrics and Gynecology explained that: *"assigning two doctors with the focal point midwife made it easy to coordinate and exchange information, but more importantly gave us the chance to coordinate between our clinics' work while responding to the beneficiaries via the telemedicine helpline, so the consultation was available for women."*

Although the service is new, the project succeeded in integrating comprehensive service support for women. The hotline provided various services and information to callers, including medical information, testing locations for COVID-19, triage and redirecting, consultation, diagnosis identification, referral to next level, treatment, and comprehensive counseling. The focal point of the hotline declared that they provide comprehensive consultations, where women's inquiries are addressed. *"The calls included not only medical consultations and guidance to the next level , but also mental support for women, especially pregnant women who have doubts on the baby's condition during COVID-19, some calls took up to 30 minutes until we made sure that women are confident and mentally comfortable,"* said the hotline's focal point.

The program's effective media campaign achieved excellent results even though COVID-19 limited the campaign's channels since printed brochures and newspapers had to be avoided as means of outreach because they could contribute to the spread of the virus. Nonetheless, the partners were able to announce the service via alternative media channels, including local online newspapers, Short Messaging Service (SMS) messages, social media channels, and most importantly, through coverage in the local official TV where they had a chance to explain the service being offered. The media campaign also targeted two of the most popular radio programs in Oman, one that aired in the morning and then during the evening news.

Key partners

UNFPA: Developed the project documents including: the concept note, budget, ToRs for the consultants, media plan, and most importantly ensuring the gender-sensitive representation through all the phases of the project including planning, implementation and monitoring (as the project team was made up entirely of women). UNFPA regularly tracked developments and updates from the consultants and hotline focal point (midwife) to update media plans and to make necessary changes in order to ensure maximum outreach. In parallel, UNFPA facilitated the process by developing agreements between the several partners, to harmonize and structure the stakeholders' relations and ensure seamlessness of the implementation, in addition to logistical support for the project implementation and its promotion through UNFPA's social media platforms.

WHO: Contributed with securing financial resources for the project, provided technical guidance and advice to the programme discussions and consultations, and coordinated closely with their counterparts at MoH from the start of the project idea. Furthermore, WHO intensively advertised the service on their social media platforms and channels to increase the project outreach.

Government - Ministry of Health: Contributed through the Woman and Child Health Department by identifying physicians and the midwife who provided the project beneficiaries with information and consultations. In addition, they integrated and hosted the helpline through the MoH's helpline, and provided logistical and technical support in coordination with the IT department at the Ministry. Moreover, the MoH continuously contributed to the regular discussions and participated in the project's media campaign.

NGOs - Omani Society of Obstetrics and Gynecology (OSOG): Contributed in identifying physicians, also provided information and consultation for beneficiaries linked to them through the midwife, and supported the midwife in the consultations. Moreover, they also participated in the regular programme meetings, discussions, as well as the promotion of the media campaign.

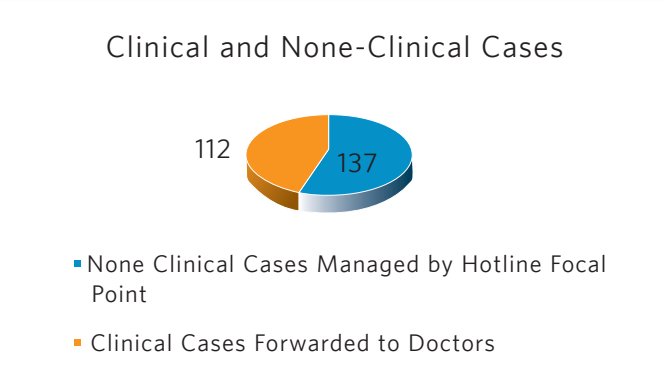
Results

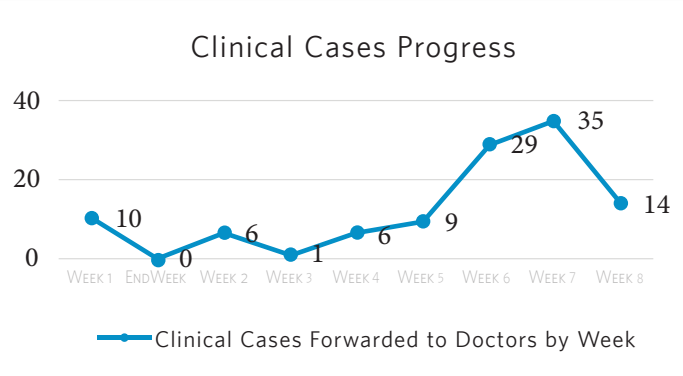
The most important result of the project is the establishment of the hotline providing medical and mental health support to women during COVID-19 by offering a variety of services that help women safely survive these critical times, particularly if they are pregnant. The hotline was established as part of the MoH's hotline, as an added service.

The Director of Women and Child Health Department at MoH confirmed that the service was in line with the MoH's policies and goals as reflected in the Ministry's Five-Year Plan and 2050 Strategy including the deployment of technology. There had always been plans to establish a proper channel to communicate better with women, but prior to the implementation of this project which created the hotline for women during COVID-19, no specific model was developed.

The project exceeded the desired outcomes and goals set in the beginning. For example, the project estimated it would be able to reach 150 women through the hotline, but in fact, more than 249 women actually benefited from the hotline within a period of two months (18 May – 17 July 2020). The duration of most calls averaged 15 – 20 minutes. However, some women required emotional in addition to medical support and those calls lasted as long as 30 minutes.

The outreach of the project was a direct result of the launch of a successful media campaign, which was modified according to the feedback of all stakeholders and partners that was received during the regular meetings. As a result of several TV interviews and a successful SMS campaign, the doctor received 35 calls in one week (5 working days).





Women were asked to provide feedback on the quality of the service and support they received through the hotline. The feedback received from many of the beneficiaries is a clear indication that the project's impact on the target group has been very positive. *"Some women even took the initiative to send messages and call the hotline and MoH to express their appreciation,"* declared the Director of Women and Child Health Department at MoH.

One of the most significant outcomes of this project was that it helped save the lives of three pregnant women. The midwife who answered their calls identified that they were in a critical situation and that they required emergency medical attention, and as such she referred their call to a consultant doctor who advised them to go to the hospital immediately. The focal point of the hotline quickly assessed their situation and acted promptly and that saved the lives of the mothers and their unborn babies. The hotline's focal point said, *"the hotline has helped encourage women to care for themselves properly and to get the medical care that they need to have a healthy pregnancy and safe delivery."*

This project had a significant impact, in that it helped to build the capacities of all partners as well as to refine the partners' experiences, especially considering that it was the first time that such a project has been implemented to provide specialized services. Many lessons have been learned throughout this journey, even though it was launched in a short period of time in response to COVID-19 to minimize its impact on pregnant women. Both OSOG and MoH found the experience to be highly motivating and believe that it should be scaled up and replicated to include other target groups.

The Director of Women and Child Health Department at MoH identified an unintended outcome of the project, which is a better understanding of women's major health concerns. Consequently, health workers (nurses and midwives) training should commensurate with women's inquiries and counseling.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Lessons learned

Partnership: This project was a success as a direct result of the strong commitment displayed by all partners and the continuous interaction of all stakeholders during the development phase. WHO Country Office project team attributed this success to the continued commitment of all partners and felt that partners' competencies complemented each other.

MOH *The project increased trust in MOH services, therefore, the hotline should continue with the same commitment from partners, and continued support from UNFPA and WHO.*

OSOG *Valuable experience during the 2 months, which should continue and build on the achievements. However, the hotline should be sustained with the same level of commitment from the project partners.*

WHO *The project succeeded with partners commitment, continuous discussions, and exchange of ideas. Moreover, the project should be scaled up and the service should continue with the same level of commitment from the partners.*

UNFPA *The multi-dimensional partnership with the continuous discussions and coordination efforts helped achieve a successful implementation of the project and the ability to face challenges during implementation.*

Commitment of partners is key to success and sustainability

All stakeholders contributed to the cost-effective implementation of the project, and they continue to participate in the follow up meetings to discuss the progress of the campaign. OSOG sees the commitment of the stakeholders as a key pillar in the success of this project.

Front-line service: all partners (WHO, UNFPA, MoH, OSOG) acknowledged the high commitment and capacity of the hotline focal point who has contributed significantly towards the success of the project and has gained the satisfaction of women who used the service by providing them with quality medical and emotional support.

The midwife who responds to calls should have skills to deal with a variety of different cases, and that minimizes the pressure on the consultant doctors and helps to make the project more efficient. For example, the midwife was able to successfully answer 137 out of 249 calls, (55% of all received calls) without needing to refer the call to a consultant doctor. This does not make the clinical consultation with a doctor less important. However, it shows the efficiency of the service and increased trust in the MoH hotline. MoH explained that *"this project has increased community trust in the services."*

Project design: the project is designed to build on the MoH hotline and ensure institutionalization of the service, which has made the project cost-efficient and has also integrated it into the major health

services provided in Oman. Hence, hosting the hotline by MoH is not only a first step towards the sustainability of the hotline, but also provided the project with high-level support from the ministry departments and increased ownership by the MoH, which provided great support for the hotline including technical and IT support which was an essential component of creating the hotline.

Adaptive Management: the project was promptly launched as an immediate response to the pandemic, and as such continuous follow up, discussions and consultation between the stakeholders was essential for the successful implementation of the project, as well as an important tool to help adjust or avoid any disruption during implementation. For example, the hotline calls decreased during the Eid holiday, which required a contingency plan to launch a more effective media campaign (through television talk shows) in order to increase awareness and outreach to the community. As a result of this campaign, calls increased dramatically and reached as high as 27 calls in one day.

Recommendations

Scaling-up the project to ensure that more women benefit and to sustain the service has become a priority for the MoH in Oman upon witnessing the success and positive interactions from beneficiaries. However, to scale up the project, MoH and OSOG will require the continued support from UNFPA and WHO.

Service expansion would be achieved by the recruitment of more nurses, midwives and health workers, who would be trained to respond to women's inquiries received through the hotline, to meet the increasing demand on the service and reach out to more women in Oman. The Director of Women and Child Health Department at MoH sees that, *"this project pinpointed accurately the issues that concern women; therefore, the training should reflect these concerns."*

Upgrade of the hotline technology to replace manual transfer of received calls, the director of the hotline at MoH explained that upgrading the hotline's technical level would increase the service efficiency by saving time and efforts, additionally; it ensures the unity of the service under the separate line. This would allow prompt automated questions measuring satisfaction with the programme, which would allow for easier monitoring and evaluation in the future and would not require contacting those women again in the future.

Partnership expansion to include a specialized media partner, mainly Oman TV and radio, since it is most trusted by the community and has the widest reach out capacity in the country. News coverage of the services offered through the project should be sustained on official public channels in parallel with well-developed thought-out social media campaigns.

Successful Replication of the project in other countries would require the following main pillars:

- Development of precise and comprehensive project documents to ensure robust planning.
- Engagement and development of the successful hotline similar to MoH Oman service.
- Partnership with local women's health specialized entities similar to OSOG.
- Management of partners' relationships through concrete agreements and contracts.
- Localization of implementation with close follow up from the UNCT members.

Tunisia

Sexual and reproductive health taskforce - maintaining quality care and establishing a new institutional coordination mechanism during the COVID-19 outbreak

Context

On March 2, 2020, Tunisia recorded the first local transmission of infection with COVID-19. The response of the country's authorities was swift and energetic, anticipating the evolutionary phases of the pandemic. The Prime Minister announced on March 16, the closure of land and air borders, and on March 17 decreed exceptional measures relating to the work of local government officials. This included the adoption of adjusted working hours and exemption for functionaries living with chronic diseases and other specific diseases.[21] On March 20, 2020, the President announced a general lockdown as well as the ban on travel between the 24 governorates of Tunisia.

The general context was marked by the panic which seized not only the population who fled the health facilities but also the health professionals for which the rate of contamination by COVID-19 reached as high as 13% at certain points in time. Many Primary Health Care Centers (PHCCs) have closed their doors in the absence of clearly defined anticipated patients' flow, or due to the shortage of personal protective equipment (PPE), at least at the start of the health crisis, and later because of the lacking human resources, as many health workers were confined because they were concerned by decree 153/2020, that prioritized all-COVID-19 related care and called for reduced professional activities for people with chronic diseases, while others were called upon to strengthen the secondary and tertiary lines of care.

To face this public health threat, a task force at a central level and regional committees were established with the support of UNFPA and WHO to coordinate and ensure the continuity of essential healthcare services. This includes sexual and reproductive health and vaccination services, under the leadership of the Directorate of Primary Health Care (DSSB) and the National Office of the Family and Population (ONFP).

Essential health services including SRH, EPI (Expanded Programme on Immunization), and management of non-communicable diseases (NCDs) at primary health care level were stopped or reduced depending on the geographical area. For example, the vaccination rate for certain diseases did not exceed 50% in some regions such as in Ariana. There was also an increase in complications related to childbirth in the regions of Siliana and Kairouan, a decrease in the delivery rate in the maternity ward in Sousse, as well as a dramatic increase in induced abortions in Tataouine. The phobia of COVID-19 affected peripheral maternity hospitals where midwives immediately transferred women in labour to regional maternity hospitals where gynecologists and midwives were overwhelmed with the excess workload.

21 Decret N°153/2020, March, 17th 2020.

In the face of this situation, UNFPA called for a meeting to activate a SRH task force at the end of March 2020 to discuss the impact of the pandemic and confinement measures on the continuity of care. By coordinating with different stakeholders, both at the national and regional levels, practical solutions for maintaining and resuming SRH services were proposed. UNFPA invited a range of partners including the Primary Health Care Directorate, Board of Family and Population, Tunisian Gynecological & Obstetrical Society, Tunisian Society of Pediatrics, representatives from university hospitals, PHCCs, civil society organizations and the private sector.

The task force was placed under the leadership of the Directorate of Primary Health Care (Direction des Soins de Santé de Base DSSB) and the National Office for Family and Population (ONFP) and was supported by relevant United Nations agencies in Tunisia and particularly UNFPA and WHO. At the instruction of the Minister of Health, the SRH task force ultimately merged with the NCD task force, onto a Continuity of Essential Services Working Group, given the uniqueness of the objectives, the target population, and the field of intervention.

Solutions

With reference to the WHO recommendations[22] and in consultation with the key stakeholders, the SRH task force has put in place, from early April 2020, the action plan outlined below.

The scope of the central coordination group was national. As a result, the regional working groups made up of health teams and particularly those in charge of primary health care services as well as the regional teams of the ONFP,were invited to the implementation and monitoring of the operational plan. The Regional Health Directors were to form regional working groups to assess and improve the delivery of essential health services, but the degree of involvement of the regional working groups as well as their implementation capacities varied from one region to another, because of factors that included, among others: mobilization of medical teams, community communication, patient flow, protection of health workers. The gateway to encouraging the regional working groups including the regional health teams and the regional teams of ONFP to take over essential health care services, and in particular SRH services, and the establishment of a governance mechanism. Below is the detailed governance mechanism, presented with commentary on its implementation on the ground.

Section 1: Establish simplified purpose-designed governance and coordination mechanisms to complement response protocols.

- **A.** Creation of national and sub-national coordination groups: the central coordination group was created at the beginning of April 2020 but it remained informal (without terms of reference or memorandum of formalization). As for the regional working groups, the majority have integrated "the essential health services" coordination onto the already existing COVID-19 crisis management committees. Their level of involvement depended on their responsiveness and their ability to mobilize teams and collaborate with partners. The ONFP of Bardo (region of Tunis) has set up a steering committee made up of a doctor, a midwife, and a psychologist to evaluate the availability of the comprehensive package of services and activate partnerships (civil society, Red Crescent, etc).
- **B.** Issuing a ministerial circular relating to maintaining the continuity of care in general and essential care in particular, including SRH care, vaccination, and management of NCDs. This circular has tangibly boosted the resumption of essential services.
- **C.** Establishment of a data collection and reporting system: attempts to survey the state of the SRH services and develop an assessment grid for PPE needs took place, but the assessment's outcome is yet to be produced.

22 WHO. COVID-19 Operational guidance for maintaining essential health services during an outbreak. Interim guidance 25 March 2020.

Section 2: Identify context-relevant essential services.

- **A.** Identification of essential SRH services: family planning, prenatal and post-natal care, childbirth, management of sexually transmitted infections (STIs), safe abortion care, and vaccination. However, GBV was not included in the identified package of care. This is because only few health care departments of primary health care level have the technical capacity to provide care for sexual assault survivors and Clinical Management of Rape kits are not available at primary health care level.
- **B.** UNFPA initiated a training of trainers programme to train the staff at primary health care level.
- **C.** Promote access to essential services while taking into consideration the evolution of the COVID-19 pandemic: this action was based on the recommendations of the national COVID-19 scientific commission and on the the realities on the ground. It should be noted that some regions have closed their PHCCs, others operated at 30% before the promulgation of Circular N ° 23/2020, while others took several initiatives that were shared with other regions during the sub-national meetings. In Manouba, teams organized home visits, following specific phone requests. In Ben Arous, families were contacted by telephone for vaccination. In Monastir, the districts of Tbolba, Jammel, and Moknine primary health care level took over the NCD patients from the 2nd and 3rd lines of medicine, the doctors of the 1st line ensured the renewal of prescriptions and family members came to collect medications for the elderly patients. In Tozeur and Tataouine, home consultations were conducted for women with high-risk pregnancies.
- **D.** Organize an awareness campaign at the national level (television, radio, social networks), on the importance of seeking care for SRH/NCD and EPI services. This was carried out with the contribution of all the key players and partners (DSSB, ONFP, WHO, UNFPA, UNICEF)

Section 3: Optimize service delivery settings and platforms.

A. Define the operating procedures of health facilities in terms of the allocation of human resources, the adaptation of opening hours, and the inclusion of the agreed-upon essential SRH services. As described above, the regional working groups have applied different operating modes according to their specificities without having developed clear and written procedures.
It should be noted that the ONFP reactivated the mobile clinic system and mobilized the facilitators and social workers for community outreach.
Initiatives for the establishment of a platform for telemedicine have not been successful in the absence of a legal framework regulating this option, and the potential conflict of interest with the private sector. In fact, several private medical networks tried to establish telemedicine mechanisms but the cost of the services (cost of the service and means of communication) was high, which means that only a small part of the population can benefit from it.

B. Enhance the public-private partnership (e.g. with laboratories, radiologists for obstetric ultrasounds, etc)This action was only partially carried out in few regions, based on previous agreements that were already established before the crisis. No breakthrough was made in this regard, despite the involvement of the National Medical Council at a later stage in the discussion at the central level.

Section 4: Establish a functional patient flow (screening, triage, and referral) at all levels. This consisted of establishing a functional patients' flow (screening, triage, and referral) at all levels and specifying the type of EPI to be used depending on the nature of the care provided. The protocols drafted by the National Health Assessment and Accreditation Authority (INEAS) were not tested at the level of the PHCCs before validation. The availability of EPI was an essential condition in the application of the patient flow and the ONFP was indeed a leader in the resumption of SRH care services because it succeeded in decentralizing the purchase of PPE. But in general, the monitoring and evaluation of the application of these protocols in the health structures were carried out remotely without supervision on the ground.

Section 5: Rapidly re-distribute health workforce capacity, including by re-assignment and task sharing. The resumption of activities depended mainly on the availability of competent human resources to manage SRH care services in the context of COVID-19.

A. Redeploy health professionals: this action was not carried out because it exceeded the capacities of the coordination group. Human resources were instead redeployed to strengthen the second and third lines of care by MoH.

B. Train health professionals: UNFPA has supported the realization of distance training sessions for midwives and developing a training guide for midwives that the Tunisian association of midwives (ATSF) used.

Section 6: Identify mechanisms to maintain the availability of essential medications, equipment, and supplies. This included actions to ensure the availability of essential medications, equipment, and supplies. Mechanisms for maintaining the availability of the latter already existed at the level of the institutions concerned, were functional before.

Key partners

The central coordination group is made up of representatives of: DSSB, ONFP, CNOM, STGO, College of Obstetric Gynecology, ATSF (Midwives Association) and its regional sections, Tunisian Society of Neonatology, Tawhida Becheikh Group (NGO), first line maternity and health practitioners, and UN agencies (UNFPA, WHO, UNICEF and UNAIDS).

It should be noted that in a pandemic context where health professionals were particularly exposed to the risk of infection, their unions were not involved in the committee or the regional working groups. One of the consequences of this non-involvement is that the union of ONFP health professionals issued a press release calling for all services to be suspended for lack of EPI, lack of clear guidelines, no triage area, etc.

Also, through the email exchanges carried out, participation in meetings, and according to the people interviewed, the level of involvement of key actors and partners in the work of the coordination group was different from one actor to another. UNFPA and WHO played a catalytic role and provided substantial support to the coordination group.

Results

The promulgation of Ministerial Circular N ° 23/2020 relating to the maintenance of the continuity of essential care, including SRH services, was essential in the resumption of activities at the level of first-line health structures (ONFP and CSB). In this regard, the UNFPA office has developed a monitoring matrix for the application of the Circular in which it has included four monitoring indicators: (i) Continuity of care; (ii) Availability of EPI; (iii) Availability of medical staff; (iv) Availability of medications and contraceptives.

The follow-up was carried out remotely to assess the impact of the Circular on the resumption of essential care. Indeed, apart from six regions (Béja, Gafsa, Kairouan, Le Kef, Médenine, Siliana and Zaghouan) which did not provide any information, the figures relating to the monitoring of the four indicators showed a positive impact of the Circular, particularly at the level of ONFP structures.

In addition to the circular, the midwives association organized online sensitization meetings with midwives for the resumption of SRH care services. According to the interviewed midwives, this action positively impacted their work attitude. It should be noted that collaboration with the COVID-19 Scientific Commission has been weak because the latter's work did not include "Non-COVID services".

Lessons learned

The most important lessons learned from this initiative in terms of success and failure are:

Political will: the publication of Ministerial Circular N ° 23/2020 following the disruption of essential health care services (SRH, vaccination, NCD) and the instructions given for the resumption of primary care activities as well as merging of coordination and essential care groups, were instrumental in the resumption of essential care.

Central coordination group: the central coordination group set up since the end of March 2020 has played a positive awareness-raising role at all levels and facilitated the resumption of care services at the level of the CSBs.

Leadership: multilateral partners, WHO and UNFPA, stimulated the establishment of the coordination group, but ensured national leadership through the DSSB and ONFP. However, the lack of a clear definition of the mission and role of each party has contributed to the weakness of this leadership.

Patient flow: a patient flow, developed according to a participatory approach in which front-line health professionals would have helped to manage potential stress and fears over contacting infection and better welcome patients.

Human resources management: management based on (i) the training of health workers, (ii) the rational supply of PPE following a user guide, and (iii) the redeployment of health workers taking into account the specific needs of each region. Such management would have helped alleviate the panic situation caused by COVID-19.

The decentralization of the procurement of EPI carried out by the ONFP has significantly contributed to the availability and the rapid continuation of activities in their regional structures.

Public-private partnerships: the partnership with the private sector has been weak. Many private doctors have closed their consultations during the COVID-19 outbreak. A synergic action, involving strengthening of public services with private practitioners could have been beneficial for the population. Advocacy is needed to operationalize this partnership.

Participation: representation of civil society, vulnerable populations, and health staff (including pharmacists) in coordination groups at the central and regional levels would have better reflected the needs of the different target groups as well as the feasibility of the patients' flow proposed by INEAS

When asked "what would you do differently if you had to do it all over again?", the responses of the interviewees[23] were as follows. (i) Be more proactive and prepare protocols and procedures in advance or early to avoid disruption of services; (ii) avoid creating parallel systems to national mechanisms such as, for example, the supply of EPI or the management of human resources; (iii) develop a simplified mobile application for monitoring and evaluating activities and needs; (iv) enhance inter-ministerial coordination, as several authorities at MoH need to be involved while respecting different roles and responsibilities.

Finally, it should be emphasized that while the central coordination group played an important role in the resumption of essential health care services, including in particular SRH and vaccination services, some members of the group were particularly proactive, such as representatives of UNFPA and WHO offices in Tunisia.

23 Interviews with key stake holders at the national committee and the regional committees were carried out by a consultant.

Recommendations

Following the general lockdown decreed by the Tunisian Government during the COVID-19 period, essential health care services including SRH care and vaccination have been interrupted in most regions. A central coordination group was set up fairly quickly to remedy this situation. The Minister immediately seized the opportunity and published a circular with clear instructions to the Regional Health Directors to resume essential care services. The effect of the circular has been immediate and positive in many regions. While the work is still ongoing, we can draw many lessons learned and to consolidate and develop it further, it is recommended to:

- Develop a clear structure for the governance of the continuity of care: terms of reference for coordination groups endorsed at central and regional levels, composition, mission sheets, internal regulations.
- Strengthen and advocate for diverse participation and decentralization.
- Be more realistic in the planning of activities.
- Set up a sub-working task forces specifically in charge of human resources: psychological assistance, protection by EPI, local training, listening to complaints, etc.
- Set up a monitoring and evaluation mechanism to remedy the striking lack of data on the status of human resources and capacities of healthcare professionals.
- Work on the emergency preparedness plans for disasters and epidemics before the second wave of COVID-19.
- Engage with the private sector with the aim to develop/sign a framework for a partnership (a chart) for a joint response in the time of crisis.
- Finally, it is recommended that the COVID-19 Scientific Commission guidelines also cover essential health services activities.


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YEMEN

Community midwives continue to deliver babies amidst a humanitarian crisis

Context

Overwhelming challenges and competing priorities have negatively affected maternal health in Yemen. Since 2015, the protracted emergency resulted in disrupted health services with several challenges facing accessibility and affordability of basic health interventions. Vulnerable groups of the population, including women and children, are suffering the most from the worn-out health systems and the consequential complications of communicable diseases, including the COVID-19 pandemic.

According to OCHA, 24 million people require some form of humanitarian assistance, two-thirds of all districts are already in pre-famine conditions, and one-third face a convergence of multiple acute vulnerabilities.[24]

Therefore, UNFPA prioritized life-saving interventions for maternal health to respond to the local needs ensuring optimal maternal and newborn care, especially for poor pregnant women who cannot access the health facilities. Through supporting the new establishment and activating clinics in 14 governorates in Yemen, UNFPA promoted accessible, acceptable, and affordable maternal and newborn quality services to respond to the critical challenges that are facing the national health system.

Adopting a performance-based financing scheme, UNFPA supported 370 Community Midwives (CMWs) with the needed training, equipment, medicines, and supplies to provide their communities with reproductive health and family planning (RH/FP) services, in addition to prevention and control capacity building during the time of COVID-19. Through these clinics, the continuation of care in the provision of RH/FP services during COVID-19 contributed to reducing the excess maternal and newborn morbidities and mortalities.

The clinics were timely established with efficient utilization of local resources and investing in trained midwives who have been waiting to be employed for several years. The initiative's main achievement is empowering midwives to practice their skills and save the lives of pregnant women and newborns. UNFPA's support was well-received by the hosting communities and the midwives became trusted healthcare providers facilitating informed decisions taken by the families regarding mothers' and children's health.

Before the war and conflict started in Yemen, UNFPA continually advocated to increase the percentage of deployment of midwives specially at the rural areas due to the high need. The government did not prioritize the deployment of CMWs because their graduation degree was not equivalent to diploma certificate. UNFPA and other development partners supported the High Institute for Health and Science in reviewing and developing a new curriculum for community midwives, including extending the programme to be for 3 years instead of 2 years, in order for graduates to be accepted by the civil

24 UNOCHA Yemen Crisis Overview, https://www.unocha.org/yemen/about-ocha-yemen

services as certified diploma holders. Meanwhile, UNFPA established and activated 164 home-based private clinics in 14 governorates for the unemployed midwives at their homes. For income generation and to support women and children at the community level and to provide RH services, immunization, refer complicated cases to closest EmONC facility as well as to identify GBV cases and refer them. Since the war started, the situation deteriorated, resulting in government staff including these deployed midwives and doctors not getting their salaries.

No single mortality was registered in any of the UNFPA community midwives supported clinics since the start of the initiative in early 2018, in a country where every day six women die due to maternal related causes. Complications identified at the clinics were referred to the closest health facility. Moreover, the clinics provided good quality service at affordable prices during emergencies.

During the time of COVID-19, health services have been compromised, except for the UNFPA supported clinics. In addition to taking standardized precautionary measures, the midwives provided health awareness to neighboring communities and continued delivering maternal and newborn services with no interruption. Other partners, mainly the Social Fund for Development, followed UNFPA's steps to progressively validate and respond to the needs of the targeted populations in delivering the maternal and newborn services, including through providing infrastructure support.

During the COVID-19 pandemic, UNFPA, MOPH and other partners within the RH working group, established a committee to develop a national guideline on the prevention of COVID-19 during the provision of RH services. UNFPA supported 76 ToT programmes nationwide and 235 midwives were trained on the COVID-19 national guidelines, including distribution of PPE. UNFPA continued to train 500 health workers through other partners on the prevention of COVID-19 at health facilities and support the health facilities with PPE.

Solutions

With the help of the UNFPA, maternal and newborn clinics were established in 2018 as part of the organization's initiative to provide accessible quality maternal and newborn health services as well as work opportunities for trained community midwives who could not find work for over five years. Among those midwives was one whose role would turn out to become far from normal. According to her, maternal health services in Shabwa are affected by different factors, including security, affordability and sometimes natural disasters. *"Even in ordinary circumstances, commuting to a health facility has been an issue. During the floods, traveling is impossible and many women with complicated pregnancies may lose their lives trying to reach the health facility,"* she said.

Within the current situation and the high need to provide humanitarian and emergency basic health services for the vulnerable IDPs (pregnant women and children), and in order to improve the health situation of IDPs, especially women, girls and newborns, midwives were identified and selected. The unemployed community midwives were graduated with UNFPA support, and a refresher training was conducted for those targeted unemployed midwives by the National Midwives Association on RH/EmONC. A mapping exercise was done to identify the women and girls at reproductive age who live in hard to reach areas to establish home based midwife's clinics at their homes as one room inside their house in rural districts. These were supported with basic equipment and commodities to improve and develop their skills and to enable them to provide lifesaving health services and health education activities for IDPs at the targeted governorates. The services they provided include the following:

1. Normal delivery
2. Pre and post-natal care
3. Family planning
4. Health education
5. Providing hygiene kits for infection prevention
6. First Aid treatment
7. Referral of complicated and GBV cases

Coming from a remote village in Shabwa in February 2020, a 36-year-old mother of five, arrived at the maternal health clinic in Jardan district, an area famous for high-quality honey which, unfortunately, doesn't reflect the situation of the wretched health services. Floods and heavy rains cut off the roads to the hospital, leaving the lady with only one choice: the clinic.

The clinics were established with full participation and support from local communities spreading awareness regarding the immediate response to maternal health, including adopting safety measures and seeking optimal health care through applying precautionary measures to prevent the spread of COVID-19. Local communities expressed their needs and discussed with UNFPA teams the recommended solutions.

With joint efforts by the UNFPA team, the initiative was successful in exploring alternatives and pragmatic solutions to make medical services more accessible for local communities. This started with the search for passionate and motivated midwives who were accessible to the communities and acceptable to them. One of the poorest and densely populated districts in Ibb Governorate is Al Qafr, meaning 'desolate' in Arabic, deriving from its long history of privation and hardship; an area that needed immediate action where the UNFPA team came across a midwife in her mid-thirties, who was motivated and determined to help the community. Unfortunately, her determination came at a high price: twenty years ago, her cousin died due to maternal health complications and the lack of a skilled birth attendant.

This initiative was derived by stories that UNFPA was keen to learn and respond to. *"Her eyes were filled with tears as she found out that the services in the clinic are provided free of charge for her and all those who are unable to afford them,"* said a UNFPA trained and supported community midwife who owns and runs a private antenatal, delivery and postnatal midwifery service clinic in Warazan, Dimnat Khadir District in Taiz Governorate.

The maternal health clinics helped in improving maternal and neonatal services in addition to providing the privacy that people demand for women in the community in emergency settings. This model deserves to be replicated in other countries especially those with similar circumstances.

Key partners

UNFPA inspired other partners to support the midwives' clinics. The National Social Fund for Development (SFD) was encouraged to extend the support through the Small and Micro Enterprise Promotion Service (SMEPS). This integration between partners is the way forward towards expanding midwifery services in Yemen and improving maternal and newborn health indicators.

Results

Since its establishment, UNFPA can proudly state that almost all pregnant women in the targeted areas visited the clinics for delivery. In 2020, despite fears of the COVID-19 pandemic, almost all pregnant women underwent successful deliveries without a single case of maternal mortality.

"I have been so fortunate to be able to help many mothers. Yemeni women are so much stronger than they seem. Among them was someone who embodied that nothing could stand in the face of motherhood. Her agony from an exhausting 20-hour walk was of minor importance to her. She needed to make sure her unborn baby was unaffected by the long journey," said a UNFPA trained and supported community midwife who owns and runs a private antenatal, delivery and postnatal midwifery service clinic in Warazan, Dimnat Khadir District in Taiz Governorate.

UNFPA's work is quite evident and the trained midwives are very well-respected and admired. One of the certified community midwives from Ibb governorate, Al Makhader District, has been running the clinic since 2018. After word had spread about the clinic and the services it offers, many pregnant women started to visit the clinic.

"In the past, permitting a pregnant woman to deliver in a health facility or outside her home was not preferred by the community," she said. *"However, things are changing now. This year alone I managed more than 20 deliveries in addition to over 100 antenatal and follow up cases"*, she added.

Through UNFPA support, community midwives have done so much for their communities and they are eager to do more. They are true heroes inspiring other development and humanitarian partners to invest in and expand UNFPA's initiative.

Lessons learned

Despite the overwhelming challenges facing maternal health in Yemen, affordable interventions applying best practices standards can make a positive change and save lives. *"Even during the darkest times, miracles happen"*, a beneficiary from Dimnat Khadir district in Taiz Governorate said.

A relationship of trust was forged between the passionate midwives and so many women who visited the clinics since its establishment in 2018. The lesson learned is that simplicity and a good understanding of the communities' needs is a game-changer.

"This is the change I have always longed to make in my community. Thanks to UNFPA, my dream has become a reality," a UNFPA trained and supported community midwife who owns and runs a private antenatal, delivery and postnatal midwifery service clinic in Warazan, Dimnat Khadir District in Taiz Governorate concluded.

Recommendations

1. Introducing Yemen's experience to other countries especially those facing emergencies.
2. Refresher trainings are needed for the midwives to maintain the success and expand the initiative.
3. Attending to the maternal needs of the communities and spare women the inaccessibility challenge to reach health facilities.
4. Fulfilling young women's goals in following their dreams of becoming midwives to help their communities.
5. Capacity building of midwives on Maternal Death Surveillance and Response (MDSR) for enhancing the national information system.
6. COVID-19 pandemic and other epidemics and outbreaks represent additional challenges requiring more hygienic education including physical distancing measures and availability of PPE to reduce infections.
7. Establishing a national coordination mechanism to institutionalize the initiative and expanded to all districts of Yemen.
8. Developing a technical guide for documenting the initiative with proper training to empower informed decisions and evidence-based practices.

Conclusion

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Conclusion

In this report we discussed five promising practices where countries committed to better maternal health through diverse and flexible interventions according to their different contexts. We saw how **Algeria** managed to spark the willingness of female religious leaders to promote family planning and reduce maternal mortality and morbidity. **Morocco**, where UNFPA and the midwifery associations advocated for legal adaptations that increased the autonomy and responsibilities of midwives. **Oman**, where a hotline was established to continue SRH-services during the COVID-19 pandemic. **Tunisia,** which rapidly established a taskforce to respond to the COVID-19 pandemic in an efficient and effective manner. Lastly, **Yemen,** where midwives ensure continuation of SRH services amidst the world's largest contemporary humanitarian crisis. These different case studies already show the diversity and vastness of maternal health best practices.

As previously mentioned, the main reasons contributing to MMR are severe bleeding, sepsis, eclampsia, obstructed labour and the consequences of unsafe abortions. In many countries, maternal deaths have fallen as women have gained access to family planning and skilled birth attendance with backup emergency obstetric care. The practice in **Morocco** shows that increased responsibility of midwives can improve the quality of services and may ensure skilled birth attendance, especially in rural areas. This is different from **Algeria,** where religious female leaders were trained to provide FP and RH information, to boost uptake of contraceptives and family planning services. In turn, these will decrease unintended and unwanted pregnancies, and thus contribute to a decrease in maternal mortality ratio.

The practices from Oman, Tunisia and Yemen showed new approaches to ensure continuation of services during a crisis situation, highlighting the importance to continue family planning and maternal health services in humanitarian contexts, and include sexual and reproductive health services into emergency preparedness plans. **Oman** provided remote SRH services via a hotline and the midwife who was taking the calls provided life-saving interventions to pregnant women on multiple occasions. **Tunisia** took a different approach, as the government established a task force with the support of UNFPA and WHO to coordinate and ensure the continuity of essential healthcare services, including in particular sexual and reproductive health and vaccination services. Where Oman and Tunisia responded to a public health emergency (COVID-19 pandemic), the situation in **Yemen** can be defined as a protracted conflict and emergency. In order to reach the most vulnerable populations, UNFPA established clinics managed by trained midwives in remote villages.

The best practices showed commonalities such as: Nearly all countries indicated that political willingness and a close collaboration with the government was essential for achieving the intended results. In Algeria, the government support increased over the years, to the extent of integrating the training of mourchidates in their planning. In Morocco, the effective cooperation with the government

on the bylaws paved the way for prompt acceptance of such regulations. In Tunisia, the coordination of the crisis taskforces was only possible as the government took the lead. In Oman, the cooperation with MoH ensured a smooth collaboration between the midwife and doctors.

Moreover, continued capacity building of staff is essential to ensure high quality services, as well as to ensure an adequate response to an emergency situation. In Algeria, the capacity building of the mourchidates led to their engagement in FP sensitization and information sharing. In Morocco, the possibilities to obtain a master and/or doctorate degree has led to changed perspectives within society of the midwifery profession, and has attracted increasingly qualified students for the midwifery bachelor programme. In Tunisia, the sensitization meetings with midwives for the resumption of SRH care services was essential for the continuation of services during the COVID-19 pandemic. In Yemen, the capacity building of midwives, provision of equipment, medicines, and supplies was essential for the provision of maternal and reproductive health as well as family planning services in the local communities.

To conclude, in order to eliminate preventable maternal deaths, it is essential to have an enabling policy environment, quality emergency obstetric and maternal health services, and availability of and access to family planning and reproductive health information, services and supplies. The proposed best practices may be a starting point, which ultimately will contribute to achieving the ICPD Programme of Action and the SDGs. Additionally, the programmes could be further strengthened by expanding the relationship with the private sector and integrate the concerned groups in a meaningful and empowering manner.

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