SYNTHESIS ANNUAL REPORT
FSP MUSKOKA 2016

For the reduction of maternal, neonatal and child mortality in ten French speaking countries of Africa.
Aïcha narrates her recovery after the trauma of a dreadful delivery.

Aïcha Hamid was born 28 years ago on a remote island of Lake Chad in the department of Dagana. A childhood of village life like so many others, before a difficult adolescence. “My family married me at the age of 14 and I got pregnant just after, she says. During the delivery, the labour was very hard. I stayed several days at home without being able to give birth despite the contractions. After a week, I was taken to the hospital in Dagana in a cart. I stayed there in labour for three additional days. The doctors said my pelvis was too small. When the child finally came out, he was stillborn.”

When healing Aïcha, the midwives noticed that urine flowed continuously through her vagina. The prolonged pressure of the baby’s head against the birth canal stopped the blood flow into the tissues that separate the bladder from the vagina and the rectum. Which resulted in necrosis and then a crack. In medical terms, it is an obstetric fistula. “Practices like child marriage and early pregnancies are the cause of the obstetric fistula, because the body of these girls is not ready to receive a child yet”, explains Micheline Youfoudji, Ambassador at the National Fistula Treatment Centre in N’Djamena. A structure that performs operations on more than 130 Chadian women with fistula every year.

Not having the skills to perform a reconstruction operation in Dagana, the midwives advise Aïcha to travel to the capital, where the surgery will be free. The family is against it. The trip is expensive. A car has to be rent for 50,000 CFA francs (76 Euros). For three months, Aïcha remains at home, where she is quarantined in an isolated hut, for the fistula has engendered chronic incontinence. Her family says it no longer «supports the smells». «They said it was not the fistula that troubled me and that, I could not be cured anyway», she argues. In traditional circles, fistula is often considered the punishment of God for adultery or the result of a curse, not a complicated juvenile delivery.

“After three months, the pain was still severe and I still could not stand”. To put a stop on the family debates, Aïcha’s mother decides to sell all her dish in the village to pay her daughter the way to N’Djamena. Once in the capital, Aïcha spends a month with her aunt. They manage to make an appointment at the Hôpital de la liberté. The intervention is a success and she will not need to come back, which is quite rare in cases of fistula.

Understanding her difficult family situation, the nurses offered her to stay in N’Djamena to integrate a rehabilitation workshop where she could learn sewing, earn a little money and start a new life in the capital. Aïcha accepts and moves to her aunt’s house. Her husband, who remained in the village, is worried that his wife would leave like this. He decides to join her. She accepts and a year later she gets pregnant again. “When I told him that because of the fistula I would not be able to have a vaginal delivery again but rather, give birth by cesarean, he got angry”, says Aïcha.”He said he thought I was cured, but that if I was having another operation, he would rather leave. And that’s what he did”. «She squeezes her thumb in her fist: “You know, it’s the principles of the village”.

For her 18 years, Aïcha gives birth to Fatime, which she raises alone. Today Fatime is 10 years old and when she is in school, Aïcha takes the opportunity to go to a new sewing workshop of the Association for the reinsertion of women victims of fistula.

Single mother, she is quite tempted to remarry. And she did, but the day Aïcha dared to tell her husband her story and that she would not give birth in a traditional way, he did not accept her and divorced, she recalled bitterly: “Even cured, many people still consider me a woman with fistula and avoid me”. Thinking of her mother who sold everything to save her comforts her. «I carry her in my heart,» she said simply.
The French Muskoka Fund (FFM) is a funding provided by France, created in 2010, in response to an urgent call for action to improve the health of mothers, newborns, children, adolescents and young people. The call was launched during the G8 Summit in Canada to accelerate the achievement, in 2015, of MDGs 4 and 5 related to maternal and child health.

- An innovative mechanism for coordination, technical support and implementation at regional and national levels.
- Initially planned for 5 years, extended for 2 additional years, (2017 et 2018).
- Brings together the complementary mandates and the distinct comparative advantages of 4 UN agencies.

**PARTNERS**

<table>
<thead>
<tr>
<th></th>
<th>Benin</th>
<th>Burkina Faso</th>
<th>Côte d’Ivoire</th>
<th>Guinea</th>
<th>Mali</th>
<th>Niger</th>
<th>DR Congo</th>
</tr>
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<td>x</td>
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<td>x</td>
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</tbody>
</table>

**RECIPIENT STATES**

- **Flagship**
- **Non-Flagship**

Each year, approximately:
- 55,000 maternal deaths
- 838,000 child deaths
death of children < 5 years old, of which 40% newborn

**CONTENT**

I. The French Muskoka Fund (FFM)
II. Objectives and Areas of Intervention
III. Budget and financial statement
IV. Global Evolution in FFM Flagship Countries
V. The Results at Regional and National Levels
VI. Muskoka, a label and influence tool SRMIA in the region
VII. The Perspectives
FFM implements **high impact targeted interventions to improve the health mothers, children and young people.** It aligns with the national policies, supports coordination mechanisms, ensures synchronization of inter-country activities and offers synergies with regional initiatives.

**IMPROVED MATERNAL, NEWBORN, CHILDREN AND TEENAGERS HEALTH**

- Agenda 2063 – Health Strategy – Maputo Plan of Action –
- Catalytic framework to put an end to Aids, tuberculosis and malaria –
- African Union Road map on the demographic dividend –

**STRENGTHENING OF HEALTH SYSTEMS**

- MEDICAL PRODUCTS AND MEDICINE
  - Quality, availability
- Skilled HEALTH WORKERS
  - Motivated and well distributed
- STRATEGIC INFORMATION
  - M&E - Knowledge Management

**GOVERNANCE**

**FUNDING**

**APPROACH BASED ON HUMAN RIGHTS AND GENDER**
III. BUDGET AND FINANCIAL STATEMENT

BUDGETS DISAGGREGATED BASED ON HIGH IMPACT INTERVENTIONS FOR YEAR 5

PER ACTIVITY

<table>
<thead>
<tr>
<th>Country</th>
<th>ERD</th>
<th>SRAHYP</th>
<th>NUTRITION</th>
<th>MNCH - FP</th>
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<tr>
<td>Benin</td>
<td>16%</td>
<td>35%</td>
<td>31%</td>
<td>1%</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Guinea</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Mali</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Niger</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Senegal</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Chad</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Togo</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Other countries</td>
<td>17%</td>
<td>31%</td>
<td>38%</td>
<td>8%</td>
</tr>
</tbody>
</table>

PER FLAGSHIP

TOGO

CHAD

SENEGAL

NIGER

MALI

GUINEA

CÔTE D’IVOIRE

BENIN

PER TARGET AUDIENCE

Child and Newborn 44%

Teenagers 16%

Mothers 38%

DISTRIBUTION OF THE FUNDING PER COUNTRY AND PER AGENCY (2016)

<table>
<thead>
<tr>
<th>Country</th>
<th>unicef</th>
<th>UNFPA</th>
<th>Population Health A&amp;I</th>
<th>Total per country</th>
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<tbody>
<tr>
<td>Benin</td>
<td>599 375</td>
<td></td>
<td>400 000</td>
<td>1 229 704</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>150 000</td>
<td></td>
<td>150 000</td>
<td>662 596</td>
</tr>
<tr>
<td>Guinea</td>
<td>810 185</td>
<td></td>
<td>450 000</td>
<td>1 662 481</td>
</tr>
<tr>
<td>Mali</td>
<td>707 083</td>
<td></td>
<td>346 666</td>
<td>1 487 013</td>
</tr>
<tr>
<td>Niger</td>
<td>675 250</td>
<td></td>
<td>400 000</td>
<td>1 413 933</td>
</tr>
<tr>
<td>Senegal</td>
<td>150 000</td>
<td></td>
<td>120 000</td>
<td>507 938</td>
</tr>
<tr>
<td>Chad</td>
<td>817 160</td>
<td></td>
<td>400 000</td>
<td>1 548 499</td>
</tr>
<tr>
<td>Togo</td>
<td>777 200</td>
<td></td>
<td>400 000</td>
<td>1 410 650</td>
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<tr>
<td>Other countries</td>
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<td></td>
<td>29 071</td>
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<tr>
<td>Total Component 1</td>
<td>4 686 253</td>
<td>2 666 666</td>
<td>2 080 516</td>
<td>9 951 885</td>
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<td>Component 3</td>
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<td></td>
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<td>Administrative costs</td>
<td>462 963</td>
<td>266 667</td>
<td>425 864</td>
<td>1 207 144</td>
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<tr>
<td>Total year</td>
<td>6 250 000</td>
<td>3 600 000</td>
<td>3 700 000</td>
<td>14 250 000</td>
</tr>
</tbody>
</table>

The details on the use of the fund are in the Global report, year 5 of the FFM

FFM ADDED VALUE

- Joint programming at regional and national levels
- Technical assistance to countries harmonized and evidenced-based
- Accountability and traceability of the funding at regional and national levels
- Joint monitoring and reporting of the expenses, activities and results
- Documentation of the best practices and stimulation of the South-South
- Better external communication and visibility
- Joint development of regional strategies
- Leverage effect: mobilization of partners and resources

FFM Added Value

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Joint development of regional strategies

Leverage effect: mobilization of partners and resources
Maternal mortality and under-five mortality reduced in sub-Saharan Africa on the MDGs period (1990-2015) but at an insufficient pace to achieve the millennium goals, except for Niger which is the only country that achieved MDG 4. In the country targeted by FFM, 1.755 maternal deaths and 64.000 child deaths have been avoided between 20110 and 2015 attesting their efforts that FFM contributed to strengthen since 2012.

**IV. GLOBAL EVOLUTION IN MUSKOKA FLAGSHIP COUNTRIES**

**MATERNAL MORTALITY**

In 8 FFM flagship countries, the maternal mortality ratio has decreased from 942 to 549 for 100 000 live births between 1990 and 2015, that is a 40% decrease²

= 2 X Global rates
= 60 X rate of industrialized countries

The risk of maternal deaths is very different from one country to another. In 2015:

- Chad > 1 in 18
- SSA > 1 in 36
- Senegal > 1 in 61

**CHILD SURVIVAL**

The under-five mortality rate has decreased by 55% between 1990 and 2015, from 213/1000 to 96/1000, despite all challenges faced by this region (political instability, conflicts, Ebola virus outbreak, recurrent epidemic peaks, cholera, measles, meningitis, etc.).

Niger (which is the second poorest country in the world), is part of the very rare countries of sub-Saharan.

**PREVALENCE OF MODERN CONTRACEPTION**

Although the level of use of modern contraception remain low compared to other regions of the world, encouraging evolutions can be noted in all FFM countries the last 5 years.

Between 2012 and 2016, the cumulated number of new users of modern FP methods amounts to 1.149.000.

In 2030, the 8 recipient countries will have 182,9 million inhabitants, with an average growth rate of 52%, higher than the one of sub-Saharan Africa, 45%. The region will account for 13% of the total population of the SSA.

The under 18 will be 95.4 million (52% of the total population) and the under 5, 32.3 million (18% of the total population).

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4. FP2020
MATERNAL, NEONATAL AND CHILD HEALTH
DEVELOPMENT OF EMERGENCY OBSTETRIC AND NEONATAL CARE (EMONC)

The accessibility and availability of services offering quality Emergency Obstetric and Neonatal Care is the cornerstone of reducing maternal and neonatal mortality. The EmONC play a decisive role in cases of complications during pregnancy, delivery and its consequences, to save the life of the mother as well as that of the child.

The strategy deployed consists of developing and implementing a network of EmONC functional maternities in each country, with the aim of taking care of the greatest number of obstetric and neonatal emergencies and essential care for newborns.

The availability of data is essential to know the availability of the EmONC offer and to take the necessary corrective measures. Innovative methods have been developed and implemented: the development of a rapid survey methodology for the identification of EmONC needs, immediately applied in several «Muskoka countries» after feasibility tests in 2015 (Benin, Niger, Senegal, Chad) and extended to other countries in the region. A real-time monitoring system is tested in Togo.

TOGO

End 2016, the essential functions of the EmONC have been integrated in 69 out of 109 health training, that is a coverage of 65% reached in 4 years: 9% in 2012, 30% in 2014, 46% 2015.

- ESurvey/inventory of EmONC and their operational status + Mapping of the potential health facilities EmONC
- Development of a repository for the implementation of the EmONC
- Upgrading of the infrastructure, equipment and human resources
- Validation of the EmONC monitoring tool.

NIGER

The availability of the EmONC has increased from 83 facilities providing emergency obstetric and neonatal care to 102, out of a minimum of 192 expected in 2015 (that is 43%) and out of 200 expected (51%) in 2016. In the first semester of 2016, 898 cesarean sections were performed and 25617 assisted delivery.

- Quick evaluation of the EmONC performed (2015)
- EmONC material and medicines supplied to 207 maternity wards distributed throughout the country, including 107 maternity wards thanks to FFM and 100 with RMNCH funds (2016)
- Provision of cesarean kits and essential care for newborns (2016).

Bleeding remains the leading cause of maternal mortality. Access to blood transfusion is crucial to save lives.

- In Niger, in 2016, 967 blood bags were collected, including 583 bags for the Niamey region and 384 bags for the Zinder region.
- In Côte d’Ivoire, 3456 blood bags were acquired and 900 blood products were made available to the blood deposit of the Regional Hospital Center of Bouaflé from June to December 2016.
V.

MATERNAL DEATH SURVEILLANCE AND RESPONSE (MDSR)

MDSR routinely performs the identification, reporting, quantification and determination of the causes of maternal deaths and the possibilities of avoiding them. This information makes it possible to put in place corrective, immediate and long-term, prevention of death actions, and therefore actions for the reduction of maternal mortality.

It is essential to know the number of women who die, where and why they die, information that is not usually available in a satisfactory way.

The main areas of intervention in the field of maternal health are closely linked: the establishment of a functional network of EmONC maternity wards cannot be achieved without the concomitant establishment of the MDSR, the two activities being linked in the reduction of maternal mortality. Assess the scope of maternal mortality and provide appropriate multisectoral responses. The objective is to translate health data into political language and to feed advocacy for maternal health.

Agencies work towards:
- the effectiveness of the call for action launched by the Commission of the African Union in 2013. Member States need to ensure that MDSR is integrated into the existing Integrated Disease Surveillance and Response System (IDSR) and is institutionalized at all levels of the health system.

SENEGAL

> The National Multi-Sectoral Conference on MDSR, chaired by the Minister of Health and funded by the FFM, recorded the participation of the 14 medical regions and enabled a more detailed analysis of the data, which shows that (i) 74% of audit committees are functional, (ii) 66% of deaths are reported (384/578), and (iii) 57% of reported deaths have been reviewed (218/384).

In 2016, the FFM covered the training of 421 providers on the MDSR in Dakar and in 5 regions of Senegal, enabling providers to understand the strategy and share the tool for auditing maternal deaths. This facilitated:
> Scaling up of the notification of maternal deaths in 14 medical regions of the country,
> Identification of common recommendations including (i) systematic transmission of reporting and auditing sheets at central level, (ii) systematization of Community reporting of maternal deaths, (iii) systematization of the reviews, (iv) monitoring of the implementation of recommendations, (v) systematic integration of the MDSR as a priority issue in the CRDs chaired by the Regional Governors for a better multisectoral response, (vi) institutionalization of the National Multi-Sectoral Conference on MDSR, and (vii) periodic dissemination of a MDSR newsletter. Moreover, this activity was recognized as a good health practice at the 2nd WAHO Forum in Abidjan in October 2016.

These country activities are directly correlated to the regional training activities of the MDSR.

In 2016, capacity-building activities in quality of care for mothers, newborns and children were implemented in Niger and Chad. For each country, a multidisciplinary team of about fifty people has been mobilized in health care facilities: pediatricians, obstetrician-gynecologists and midwives, and reproductive health program managers in the Ministry of Health.
FAMILY PLANNING (FP)

One of the more efficient interventions to improve maternal and child health. Family planning helps to plan births, prevent unwanted pregnancies and reduce the number of unsafe abortions. It is estimated that about 30% of maternal deaths can be prevented through family planning services.

In the affected countries in the region, access to family planning services is still limited for many sexually active women who wish to avoid pregnancy and do not use contraceptive methods because of cultural constraints or community disapproval, costs of modern contraceptive methods, long distances travel to access family planning services, lack of access to information, and the frequent stock-outs that providers face.

More generally, FP helps to ensure better maternal health, women’s equity, child survival, HIV and STD prevention, women’s development and family well-being.

At the regional level, the gradual scaling up over the last 4 years of high-quality postpartum family planning (PPFP)

2013 - Intensive and hands-on training of FP counseling providers and hands-on training on IUD from 6 countries (Benin, Côte d’Ivoire, Guinea, Niger, Senegal, Chad).

2014 - Follow-up and strengthening of the in-situ practice of the teams trained in 2013 in the 6 countries as well as identification of those who will join the pool of regional trainers during the year 2015. Also in 2014, among these six countries, two (Benin and Niger) have benefited from support for the extension of this training to maternity wards in rural areas.

2015 - Creation of the regional pool of trainers and training workshop for these 18 providers (Obstetricians-Gynecologists, Surgeons-Gynecologists and Midwives) trainers on the insertion of the Postpartum Intrauterine Device (IUD) from five countries in the region Benin, Côte d’Ivoire, Niger, Senegal, Togo.

2016 - Qualification of trainers through in situ visits and practical exercises evaluated in two countries (Togo and Benin) at this stage.

<table>
<thead>
<tr>
<th>NUMBER OF INSERTED IUDS</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER OF INSERTED IUDS</td>
<td>1 515</td>
<td>801</td>
<td>194</td>
<td>2 510</td>
</tr>
<tr>
<td>Number of years protection-coupled * thanks to PPFP</td>
<td>5 302,5</td>
<td>2 803,5</td>
<td>679</td>
<td>8 785</td>
</tr>
</tbody>
</table>

* Cumulative data for all sites covered/all partners, calculated by MCH/FPP

The development of community-based services

The availability of complete ranges of modern contraceptives

MALI

> Home visits enabled to reached 10,000 people, including 79% of women and 21% of men,

> The activities carried out by the 352 Relays (talks, counseling, home visits) reached over 9,100 people, 79% of whom were women and 21% were men

> The ardent defenders have, based on the same approaches, touched nearly 6,400 people of which 73% women and 27% men.

Through this intervention, the aim is to guarantee the rights of users; Including emergency contraception and postpartum FP in health training.
Prevention and Management of Violence Against Women and Girls

In Mali, 1,125 pupils, of whom about 80% were girls, participated in GBV awareness sessions and panel discussions in schools in the regions of Mopti, Ségou, Sikasso and Bamako. These pupils were designated as focal points for the sensitization of their pairs to prevent violence against girls, including early marriages and pregnancies, female genital mutilation and physical violence in schools.

The implementation in 2016 in Mali was also marked by the extension of the toll-free number 80 333, available to the population for the prevention and denunciation of GBV. This toll-free number is operational in the 8 main cities and on both telephone networks of the country. It recorded between January and August 2016, more than 1,000 calls, including 398 cases of GBV throughout the territory (225 cases of domestic violence and 81 cases of early and forced marriages).

The exploratory study on violence against women in reproductive health services in hospitals, funded by the FFM highlighted high levels of violence against women in the Reproductive Health services. These include inter alia:

- refusal to inform patients about their current morbid condition and the precautions to be taken to avoid it (66%),
- the abandonment of parturient women on the delivery bed (58%),
- patients’ difficulties in obtaining medicines in the hospitals’ pharmacies (31%),
- non-observance by the midwife of the order of arrival of pregnant and parturient women (29%),
- parallel payment to providers of care despite free admission (14%), neglect during postnatal visits (13%),
- poor patient reception (14%).

The recommendations from this study focus on the training and awareness of health workers, including midwives. To this end, it is planned for 2017, the establishment of a pool of trainers of midwives’ trainers on the theme «Gender and human rights» and the revision of the training curricula used in training schools of midwives to integrate gender and human rights aspects.

The availability of complete ranges of modern contraceptives

BENIN

> The number of women using a modern method of contraception is steadily increasing. Contraceptives acquired in 2016 represent almost 858,000 Couple Years of Protection (CYP) that can enable to prevent more than 90,000 unwanted pregnancies (against 75,000 in 2014), 45,000 unwanted births (against 37,000 in 2014), 32 500 clandestine abortions (against 27 000 in 2014) and nearly 200 maternal death (against 192 in 2014).

TOGO

> The CYP obtained through innovative and routine strategies is more than 214,500 in 2016. The prevalence of modern contraception is estimated at 18.7%. A total of 420 CHWs are equipped to distribute the three FP methods (pill, injectable and condom) in the seven health districts where this strategy is implemented.
COMMUNITY-BASED APPROACHES
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI) AT COMMUNITY LEVEL

To reduce infant and child mortality, access to care must be facilitated. The IMCI strategy gives community health workers (CHWs) the skills needed to deliver community care, significantly reducing morbidity and mortality in the under-five population.

This strategy effectively addresses the problem of accessibility to care for a large proportion of the population living in remote or hard-to-reach locations, a major challenge for most countries where child morbidity and mortality is high.

Main causes of death among children under 5 in Africa, as a%:

<table>
<thead>
<tr>
<th>Cause</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal</td>
<td>31</td>
</tr>
<tr>
<td>Malaria</td>
<td>16</td>
</tr>
<tr>
<td>TMN</td>
<td>10</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>9</td>
</tr>
<tr>
<td>Meningitis</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
</tr>
</tbody>
</table>

GUINEA

Skills development of Community Health Workers in 2016:
> 526 community health workers benefited from capacity building on newborn care at home and on referral of severe cases
> 288 health workers have been strengthened in essential care and resuscitation of the newborn, in preventive maintenance of equipment and have benefited from the provision of materials and equipment
> 136 community health workers have benefited from capacity building on malnutrition screening and management
> 2,961 CHWs have been strengthened with community-based IMCI on Essential Family Practices

Management of Malaria, Diarrhea and pneumonia:
> Around 173,000 children have been treated in 2016
  34 400 (20%) for malaria, 15 600 (9%) for diarrhea,
  14 300 (8%) for cough/pneumonia, 1 150 (1%) malnutrition cases detected

TOGO

Over the past three years, Muskoka investments have enabled CHWs to manage:
> 217 252 cases of malaria (24%, 22% et 33% of expected cases)
> 217 252 cases of diarrhea (24%, 22% et 49% of expected episodes)
> 217 252 cases of pneumonia (24%, 22% et 60% of expected cases)

BENIN

Le nombre de relais formés, équipés et dotés en médicaments, outils de gestion et de communication est passé de 3 234 à 3 818 entre 2015 et 2016. Ces relais communautaires ont contribué à prendre en charge les cas de paludisme (31%), de diarrhée (39%) et de pneumonie (28%).

Six Muskoka flagship countries (Togo, Senegal, Côte d’Ivoire, Guinea, Mali and Niger) participated in a conference on the institutionalization of community health, organized by USAID and UNICEF (in collaboration with WHO and the Bill and Melinda Gates Foundation) in March 2017 in Johannesburg.

The experiences supported by the FFM have enabled contribution to the establishment of ten core principles to institutionalize community health through strong and evidence-based policies, greater funding, firm community involvement, clarification and strengthening of community health workers, reduction of gender inequalities, and improvement of the data collection systems.
ESSENTIAL FAMILY PRACTICES
(Supported by an additional funding from the UNICEF French Committee) to promote the use of available services and the adoption of Essential Family Practices (EFP) for child survival and development.

Promotion at family and community level of Essential Family Practices (EFP) aims to promote the use of available services and the adoption of Essential Family Practices for child survival and development.

The activities implemented contributed to all Muskoka countries:
- to conduct studies on barriers and facilitating factors for the adoption of positive behaviors to MNCH,
- to the development of national strategies for the promotion of EFP,
- to the capacity building of the actor at local level (local authorities, leaders, community relays and media),
- to the promotion of EFP at scale through a mix of local media and interpersonal communication (educational talks and home visits).

TOGO
> In the two most disadvantaged regions, where FFM interventions focus, 76% of children are breast-fed (2015 CYP survey), against 58% at the national level (DHS 2013-2014)

NEONATAL MORTALITY

Neonatal mortality represents 35% of the mortality of children under-five in the region. It remains the highest in the world despite a slow decline since 1990. A global program to fight against neonatal mortality was launched in 2013 «Every Newborn Action Plan». Thanks to Muskoka, the four agencies organized in November 2016 in Dakar an Inter-Agency Forum on Newborn Health in order to advance the «Every Newborn» Action Plan in the region.

All the partners, Muskoka agencies, USAID, Bill & Melinda Gates Foundation, JHPIEGO, Save the Children, LSHTM have decided to create a Regional Task Force on Neonatal Health, based on the Muskoka experience, in order to push this agenda in the region. Five Muskoka flagship countries are developing «Every Newborn» plans (Côte d’Ivoire, Togo, Benin, Chad and Mali).

NIGER
> Capacity building in newborn and maternal care of agents and matrons of targeted health huts
> Strengthening of the technical facilities of the health huts by standardized and appropriate equipment
> Mobilization of communities for the use of maternal and newborn health services offered by health huts
> Mobilization of communities for the adoption of key practices supportive for maternal and child health (Communication for Behavior Change)
> Strengthening partnerships with other actors involved in maternal and neonatal health
> Provide regular supervision of Community Health Workers

Scaling up community care for mothers and newborns: (from 45 health huts (CDS) in 3 health districts in 2014 to 188 CDS in 15 health districts in 2015.
STRENGTHENING OF HEALTH SYSTEMS
EQUAL ACCESS TO SKILLED PERSONNEL

At the global level, the FFM has contributed to the advocacy for investment in health human resources as a pillar of economic growth. The FFM brought together representatives from 20 French-speaking countries during a consultation in Côte d’Ivoire in June 2016. This consultation made it possible to formulate key messages to be addressed to the «Commission on Employment and Economic Growth» which included them in its report submitted in September to the Secretary General of the UN.

On average, under optimal conditions, a midwife can take care of about 500 pregnant women each year.

Evolution of skilled personnel during delivery since 1990

To strengthen the human resources of health in our region, three areas have been particularly developed:

I. Adoption of accreditation mechanisms for midwives and nursing training schools
II. Assessment of the labor market and productivity of health workers
III. Improvement in the practice of health professionals involved in maternal and child health services.

In-country training was either initial or skills upgrading training and the different areas of the RMNCH were covered (FP, EmONC, IMCI, Nutrition, PMTCT, GBV).

CHAD

Since the beginning of the FFM, 1,875,000 children under-five years of age and 2,450,000 women of childbearing age have benefited from qualitative and basic health care services through premium payments to 300 paramedics made available to the Ministry of Health.

GUINEA

In 2016, 140 midwives and 3 obstetricians-gynecologists were recruited and deployed in 70 health centers, maternity wards and hospitals in the regions of Kindia, Kankan, Labé Faranah and N’Zérékoré. This enabled 34,666 pregnant women to benefit from CPN4 out of 47,178 expected pregnancies and 32,315 deliveries made in health facilities by these midwives.
ACCESS TO ESSENTIAL MEDICINE AND HEALTH PRODUCTS FOR MATERNAL, NEONATAL AND CHILD HEALTH

Through its programs, the FFM provides direct support to Ministries of Health in the implementation of their pharmaceutical policies to guarantee access to quality essential drugs that are affordable to the population, as well as their rational use. These ministries also work closely with the Ministries of Finance and partners to secure the funding needed for procurement. It also supports the strengthening of the legal and regulatory framework and the compliance with norms and standards for the production, distribution, access and rational use of medicines.

All health development partners benefit from the normative role played by the FFM through, inter alia, WHO actions. These normative actions serve as a basis for UNFPA and UNICEF actions in their interventions to increase the availability of medicines and health products available for maternal and child health in health facilities.

FFM provides its support for:

- **The strengthening of the coordination of procurement** and a better tracking of product availability in health facilities: Côte d’Ivoire, Guinea, Niger, Mali, Senegal.
- **The revision of the lists of essential medicines**: Guinea and Niger.
- **Improvement of the rational use of priority medicines for the mother and the child**: Côte d’Ivoire and Niger.

CÔTE D’IVOIRE

The study on the structuring of the medicine prices has enable to analyze the key sources of information on medicine pricing at points of sale of medicines and to follow it throughout the distribution chain. The study indicates that from the implementation of better price controls it is possible to reduce the prices of medicines by about 3 to 15%.
More than in any other region in the world, SRHYPA is a public health priority and a key area of intervention for reducing maternal, neonatal, infant and adolescent mortality. West and Central Africa has more than 65% of the population under 24 years of age, 32% between 10 and 24 years old. It is also the region where the percentage of delivery among girls under 15 is the highest (6%), given that they (girls 14 and under) are the most vulnerable and the most at risk of complications and deaths following pregnancy.

At the regional level, COTECH has initiated a process leading in 2016 to the adoption of the first regional interagency strategic framework for combating early pregnancies.

Comprehensive Sexuality Education for (CSE) is recognized as a major key intervention in the area of SRHYPA. Several countries in the region are currently structuring and institutionalizing their CSE approach by developing curricula.

In support of this development, technical support work was provided in 2016 to Benin, Côte d’Ivoire, Senegal and Togo:

- Documentation of the process in the 4 countries
- Production of an operational scaling guide for the region
- Identification of the good practices
- Development of a booklet for promotional, intervention and resource mobilization purposes

2. For more information, visit the UNFPA dashboard: http://dashboard.unfpaopendata.org/ay/index.php
THE MAIN INTERVENTIONS IMPLEMENTED IN THE COUNTRIES

I. Making school health centers/nursing wards welcoming, user-friendly and of quality for A & YP to increase attendance

II. Create a protective and supportive environment for young girls and boys in schools and within the communities, in particular through the implementation of an CES program

III. Impulse a lasting change in social habits and more favorable laws for girls, especially in situations of vulnerability

GUINEA

> 31,500 adolescents have benefited from awareness in sexual and reproductive health.
> 98,000 young people have used sexual and reproductive health services, including nearly 87,600 girls for family planning, sexual violence and HIV screening.
> 22,000 young people have consulted for sexually transmitted infections (STIs), more than 5,300 for family planning, including nearly 1,100 new acceptors and 29 for sexual violence.
> 978 young people had access to voluntary HIV screening, including 412 girls. A total of 29 cases were HIV-positive, including 17 girls aged 14-24 years old; All cases detected are treated and under ARV treatment.

CÔTE D’IVOIRE

With the «Zero Pregnancy in Schools» campaign (campagne « Zéro grossesse à l’école »), the percentage of young people and adolescents attending sex education classes has significantly increased, from 38% in 2015 to 62% in 2016 and the number of early pregnancies tends to decline (3,828 in 2015 to 3,690 in 2016).

CHAD

At the girls’ high school in N’Djamena, the 2,000 high school girls have had access to sexual and reproductive health information and services; 13 teachers were trained in Comprehensive Sexuality Education (CSE); 12 girls were trained to be young leaders in CSE and a blog dedicated to young girls was also created (http://lesambassadricesesc.blogspot.com).

SENEGAL

The hot-line called GiNDIMA (Enlighten Me) 200 365 offers to adolescents/young people complete and adapted information on SRHYPHA integrating STI/HIV-AIDS. Launched on August 12, 2016 by the Ministry of Youth, the hot-line aims to increase access to sexual and reproductive health information and services for adolescents/young people through the establishment of a remote assistance relationship based on Information and Communication Technologies. The line is free for the user, 24/7/365, information accessible in French and Wolof, and able to ensure confidentiality and data protection. As of November 17, 2016, 24,639 calls were registered and only 10,000 calls were screened.

TOGO

The provision of health care in schools (school nursing wards) is now a central concern. Measures have been taken at the strategic level, with the provision in school and university nursing wards of a reference document and at the operational level, with the reinforcement of 25 nursing wards for the management of SRH. Teaching of SRH, HIV and GBV has been integrated into 80 secondary schools; And more than 200 villages and 100 institutions have received integrated SRH services targeting adolescents and young people.
NUTRITION

Malnutrition is associated with almost half of the deaths of children under five years old (nearly 400,000 deaths for Muskoka countries). This is related to the lack of means of the families but also to the non-optimal nutritional practices of newborns and young children.

Improving the practice of early and exclusive breastfeeding can reduce the number of infant deaths by more than 10%. A better complementary feeding beyond 6 months of exclusive breastfeeding can prevent more than 10% of deaths resulting from diarrhea or acute respiratory infections. It can also increase resistance to diseases, including measles. Children suffering from malnutrition in their early years have more difficulties to complete schooling, to grow normally, and then to lead an active adult life. The health of the child is closely linked to that of the mother. A poor health condition of future mothers compromises the future of unborn children.

Interventions against malnutrition were carried out in the continuity of those of the previous year, focusing on:

- Improvement of Infant and Young Child Feeding (IYCF)
- Improvement supplementary food (supplementation with iron and folic acid, oral rehydration salts and zinc supplementation for children suffering from diarrhea, vitamin A supplementation for children under-five)
- Integrated Management of Childhood Illness (IMCI), including severe acute malnutrition, both at health training and community levels
**BENIN**

The training of agents, the supply of inputs and the equipment with materials of new centers have helped increase the treatment offer from 83% in 2015 to 85% by 2016. At the community level, more than 22,400 relays in 900 villages have also been trained or refreshed on screening and reference of severe acute malnutrition. The proportion of villages with relays trained has increased from 73% in 2015 to 76%.

The supply of inputs of 576 sites has enabled nearly 5,200 new cases out of a total of 6,650 expected, with a cure rate of 77%, 3% of deaths and 20% of abandonment. These results have been possible thanks to the complementarity with other actors such as Terre des Hommes and the Health System Support Program (PASS/SOUROU).

**GUINEA**

- More than 30,500 children under the age of 2 received micronutrient powders in the districts of the Faranah region and the prefecture of Mali.
- More than 63,500 people, including more than 39,000 women, have been sensitized on breastfeeding, complementary feeding and malaria prevention.
- More than 228,200 pregnant women have been supplemented with Folic Acid Iron and more than 647,500 children with vitamin A.
- More than 36,200 children under the age of 5 suffering from severe acute malnutrition have been treated in 410 Severe Acute Nutritional Rehabilitation Centers (CRENAS) of the country, of which 0.16% have been diagnosed with a positive HIV serology.
- More than 62,200 moderate malnourished children have been treated in Moderate Acute Nutritional Rehabilitation Centers (CRENAM). The performance of the Integrated Management of Acute Malnutrition (IMAM) Program is optimal according to WHO SPHERE standards with a cure rate of 83%, 5% of death and 12% of dropout.
- More than 1,500 children suffering from severe acute malnutrition with complications have been treated in Intensive Nutritional Rehabilitation Centers (CREN) with a cure rate of 84%.
CHILDREN, HEALTH CARE AND PEDIATRICS IN WEST AFRICA (ENSPEDIA)

The FFM provides national decision-makers and United Nations teams with strategic options to reduce major constraints observed at country level through multi-country operational research projects in MNCH.

One of these projects has been documented in 2016 on the occasion of the 2nd WAHO Good Health Practices Forum, Abidjan, October 2016.

ENSPEDIA is a «Research-Action» to contribute to improving the quality of care in pediatric services in West Africa (Benin, Burkina Faso, Guinea, Mali, Mauritania, Niger, Senegal, Togo).

Children are the most numerous «users» of the hospital where they come for various reasons. To born there first, and sometimes to survive in neonatal departments but also, on a daily basis, for many pathologies related to the ecological and social environments where they grow.

The care provided is «their» chance and often enables their healing, but they are also often the cause of other pains, such as injections, punctures, wound dressings, immobilizations, to which is added emotional distress when these children can’t express themselves or think they are an unnecessary burden on their parents.

and, in front of adults and caregivers, children often remain silent. They observe, listen, think, worry, suffer and wonder about their pathologies or the consequences of their trauma, but no one questions or interrogates them on what they feel, understand the care and the behavior of the adults.

Faced with this situation, the ENSPEDIA Program has set itself the following objectives:

- collect and analyze the words of the children about illness, care, pain and concerns,
- improve the quality of care by confronting the caregivers with what the children say, with the evaluation they thus submit about the care,
- circulate better techniques of care and relational conducts that are more respectful of the young patients, provide practical reflection on palliative care,
- improve the professional and socio-emotional situations of health workers faced with the suffering and death of children.
The ENSPEDIA team, working in 8 countries in West Africa (representing an annual “flow” between 40 and 50,000 children) is equally made up of researchers in anthropology and caregivers (pediatricians, and health care workers). The program is therefore interdisciplinary from its inception.

The methodologies largely follow rigorous qualitative researches but also incorporate various procedures combining anthropological and clinical approaches.

Several “moments” of research have built this program.
- In all the services, HSS researchers interviewed children about their pathologies, received care, their pain, feelings and relationships with other sick children and adults (families and caregivers).
- In a second stage, each team carried out case studies around certain usual technical gestures: injections, perfusions, punctures, wound care ...
- In a third stage, all the results were presented to the caregivers for them to better understand their patients and adapt their care behaviors to their requests.
- Finally, technical proposals (relaxation, hypnosis, gestures of care) as well as improvements in teamwork were presented at a training workshop. It is in situ that we can improve the interactions between children and caregivers.

A booklet reproducing thematically the children’s answers and their drawings was produced.

The second part of the booklet corresponds to proposals for improvements in behavior and practices. This text, together with the results of the surveys, was distributed and commented on during restitution sessions. These sessions were recorded and commented with the various health workers.

The ENSPEDIA team, gathered during a workshop in Dakar, 40 health practitioners per service, and trained them in relational techniques, technical care, medical relaxation-hypnosis. A support group to evoke the difficulties experienced in dealing with the patients, the suffering and possibly deaths has also been put in place.

The program has created an internal dynamic of service reform and contributed to an improvement in the provision of care.

At the end of the project, other care audit methodologies confirmed that quality care studies could not be carried out without asking the children, the main beneficiaries, what they thought.

Finally, specific technical and relational training is now being disseminated in services and is contributing to improve childcare, care and other attitudes towards child pain and death.

**V. MAINS RECOMMENDATIONS**

We cannot fully take care of a child without understanding him, and for this reason Social Sciences and Medical Sciences are complementary.

The main purpose of this work is not so much an analysis of service difficulties, but an analysis of what shared research can transform in health facilities.

The most comprehensive recommendation would therefore be not to initiate programs external to the services but to “start from” the endogenous dynamics and to support and disseminate them through programs using research as an action.
VISIBILITY

PRESS
One-year partnership with Le Monde Afrique

> 5 million visitors per month
> 10 million page views per month
> Visibility of the FFM logo on each of the pages the site www.lemonde.fr/afrique
> A summer TV show: “Un combat pour la vie” (a fight for life) through Senegal, Guinea, Mali, Burkina Faso, Niger and Chad
> 29 articles published, 1 million readers

MULTIMEDIA

> 9 portraits in French and English
> 11 videos in French sub-titled in English
> 5 videos from the HR Consultancy
> 40 photos from Grand format du Monde Afrique

> 4 RFI programmes “Priorité Santé” by Claire Hédon
> 2 documentaries France24
> About twenty articles and documentaries
> 2 Press Tours in Guinea and Senegal
PUBLICATIONS

- Development of a new booklet (French and English)
- Shipment of a kit to 8 countries and French Embassies
- 36 pages in the science journal «Médecine et Santé Tropicales»

DIGITAL COMMUNICATION

- Development and updating of the Website www.ffmuskoka.org
- 1400 followers on Twitter, animation of the account @ffmuskoka

EVENTS

- HR Consulting in Abidjan
- WAHO Forum on Good Practices in Abidjan
- ENAP Forum in Dakar
- SAGO Congress in Ouagadougou
- Field visits with the embassy of France in Togo and Benin
- Awareness campaigns and celebration of international days in Benin, Côte d’Ivoire, Guinea and Togo

AUDIOVISUAL PRODUCTION

- Partnership with RAES on “C’est la Viel”
  - Production of the 1st part of the 2nd season, 18 episodes
  - Development of a cross media campaign
  - Promotion and dissemination of season 1 through the media, a mobile cinema tour in Senegal, and presentation during regional and international events
A TV Show provided to countries to communicate, inform and sensitize in an innovative and entertaining way and to promote behavior change in reproductive, maternal, neonatal, child and adolescent health (RMNCAH).

Genuinely produced like the best TV shows of the moment, “C’est la Vie!” first objective is to raise awareness among a wide audience, both young people and older individuals, both female and male, on subjects such as early marriages and early pregnancy, reproductive health of young people, patients’ rights, gender-based violence, exclusive breastfeeding, etc.

The screenwriting is central. It consists:

- for the agencies of defining the thematic axes, the key messages, then of reviewing and validating the final scripts;
- for the RAES of developing the characters and intrigues related to the themes and distill the awareness messages.

A clever combination of intrigues, entertainment and awareness-raising content ensures the success of the TV show.

C’est la vie! is produced by the pan-African NGO RAES thanks to the convergence and synergy of technical, human and financial efforts of all the FFM agencies.
MAINS RESULTS

Availability of the TV show «C’est la vie» on the screens

**Season 1: 26 episodes** of 26 minutes
Broadcast on: **Canal+Afrique, TV5Monde and soon on about forty African national channels**, enabling to reach more than 100 million potential viewers.

The 36 episodes of season 2 are currently being shot.

The cross-media campaign, including on social networks

![TV5MONDE](image)

**TV5MONDE**
100,000 views per quarter

**YouTube**
300,000 views

**Facebook**
21,000 fans

and 18,000 views of the interviews and additional discussions

[www.cestlavietv.com](http://www.cestlavietv.com)
21,500 views on the website

Research shows that television has took precedence over radio as the main source of entertainment for those living in the urban areas of WCA. But the campaign has also reached rural areas with about 62% of viewers outside the cities.

The TV show and the cross-media campaign are already showing important results:

- Appreciation of the TV show by the general public as an innovative entertainment
- Effectiveness of the «TV show» format to develop messages on RMNCAH or on other themes,
- A tool adapted to stimulate debate and talk about taboos, behavior change, attitudes and knowledge
- Adolescents and young people targets, patients, caregivers, policy makers, vulnerable populations are affected
- Use of the cross-media campaign and in particular social networks to mobilize and engage adolescent and young people

The continuation of the national ownership process is essential to optimize the potential of the tool by aiming its integration into national strategic plans and national road maps for maternal, neonatal, child and adolescent mortality reduction.
The evaluation by Ernst & Young¹, commissioned by the General Directorate for Globalization, Development and Partnerships, demonstrated that the multilateral aspect of the Muskoka funding has created an effective regional collaborative arrangement between agencies.

The post-Muskoka perspective and the establishment of a new international health architecture led the FFM Technical Committee² to take a more active position as a regional mechanism in response to the new global health strategy for women, children and adolescent (Every Women Every Child) and the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (MDGs) 2030.

Thus, the FFM has in this regard intensified its strategic and technical positioning each year during the various global and regional meetings and in key partnerships in the region such as:

- La Communauté Economique des États d’Afrique de l’Ouest (CEDEAO) autour de la validation du module sur le genre et les violences dans les curricula des sage-femmes et infirmiers,

- The Economic Community of West African States (ECOWAS) on the validation of the module on gender and violence in the curricula of midwives and nurses,

- The West African Health Organization (WAHO) on the 2nd Forum on Good Health Practices in Abidjan in October 2016

- The African Society of Obstetrics and Gynecologists (SAGO) on its 16th Congress in Ouagadougou, November 2016

- The Regional Forum «Every Newborn» around the establishment of a regional ENAP Task Force based on the Muskoka experience extended to other partners

- The Youth Forum on the sidelines of the Africa France Summit (SAF) Bamako, in January 2017

- The Global Financing Facility (GFF) on the support provided to the development of concept notes integrating reproductive health interventions, maternal, newborn and adolescent health, and the development of health financing strategies and the investment framework of the Global Funding Mechanism of Women, Newborns, Children and Adolescents Health.

- As part of the development of the African Union Road map on Harnessing the Demographic Dividend through. Investments in Youth, the Muskoka mechanism, and in particular its SRHYP component, was able to highlight the originality of its mechanism presented and its good practices shared.

¹. Joint evaluation, commissioned by the Directorate General of Globalization, Development and Partnerships, of the interventions of the MAEDI and AFD in Maternal and Child Health to implement the commitments made by France to Muskoka.

². This decision was at the heart of the technical sessions of two Technical Committee meetings in June 2015 (Mali) and November 2015 (Senegal).
At the end of the five-year program of the French Muskoka Fund, a sixth year was implemented, following the renewal of support from the Ministry of Foreign Affairs and International Development, with in addition, the stated commitment to continue working beyond 2017.

The perspective is clear: keep the woman, mother, newborn and adolescent at the center of the health development target. This target is precisely defined, with the Sustainable Development Goals (SDGs), for which the development partners are all committed, with a common road map for the Global Strategy for Women, Children and Adolescent 2016 - 2030. Over the past five years, significant progress has been made in the countries targeted by the FFM, with improved indicators of women’s, children and adolescents’ health, including coverage indicators, such as the rate of deliveries assisted by skilled personnel. But the mothers, newborns and children’s health remains worrisome, with low or even poor status indicators, as evidenced, for example, by maternal mortality ratios. In light of this finding, the quality of care has become a priority. The improvement of the quality of care delivered in each health facility will reduce avoidable deaths. It is in this sense that the work continues.

Alongside its network of International Technical Experts (ITE) and regional health advisors, MAEDIL has developed, with FFM, an original tool for the implementation and monitoring of high-impact activities. The traceability of its actions meets the requirements for accountability for commitments made to women, children and adolescents’ health.

This partnership mechanism, similar to the H6 Global Coordinating Mechanism funded by Sweden and Canada, has demonstrated its visibility and operational effectiveness in the countries. It is now intended to set up joint actions with other partners. It develops its collaboration with the AFD in the countries. In the same way, coordination mechanisms will have to be set up, together with the Ministries of Health, between the FFM and the Global Fund to Fight AIDS, Malaria and Tuberculosis for a better impact of actions for women, children and adolescents.

A particular emphasis will be kept on sexual and reproductive health and adolescent health, with, in a cross-cutting manner, a strengthening of the health system, including support for human resources.

The continuation of the joint work for mothers, newborns, children and adolescents over the next few years is based on the solid foundation of the experience accumulated by the FFM. It will be important to assess the situation in order to better reflect all the results. Lessons learned, successes, improvement of supply and demand for care will be the best «evidence-based» advocacy for the continuing joint efforts of the Muskoka initiative.
**THE ITINERANT MIDLWIFE OF THE CASAMANCE ROADS**

Text and pictures of Mattéo Maillard for Monde Afrique - Excerpt

They are 17 for 171,000 inhabitants. Every month these specialist circle around the 7,000 km² of the region to treat the women, children, «old people». Every body.

Every month, Ngor, a midwife, visits at least once the fourteen villages that compose her «area of responsibility», as she calls it. She takes care of pregnant women and provides basic care for nearly 8,500 inhabitants. They are spread this dense and abundant nature which makes Casamance a paradox. The breadbasket of Senegal but also one of its poorer regions. Approximately 75 % of its inhabitants leave under the poverty line, according to the World Bank. The access to care is limited. One third of women deliver without medical assistance and infant mortality affects 55 births out of 1,000, compared with 4 per 1,000 in France.

Seven kilometers separates the health posts of Marakissa from the village of Dionie where we are going now. Many women tried this abrupt route the other way around, on foot or on motorcycles, to deliver in better conditions at the health post. Some couldn’t reach their goal. They gave birth on the ochre ground of the road. Which cost the life of the most unfortunate, or that of their newborn.

“Walking long distances while pregnant can be very serious”, says Ngor. They can bleed out and die. On contact with the ground, the child is at risk of infection or asphyxiation. It will be impossible to revive them if there is a problem.

On the front porch, Madame Daffé. The matron who runs the health hut in the absence of the midwife, opens the door to us. The room is dirty, the equipment spartan. A bed, a scale, a can with a tap, a bucket, a table, some chairs and that’s all. Ngor closes the red shutters in order to give the patients privacy and to spare them the heat. She chases away the curious kids who gather laughing at the window. Inside, it’s dark. There has been no water or electricity for a long time. So, the midwives practice the delivery with a headlamp, in a darkness of a cellar.

This requires unwavering attention. An absolute mastery of its tools and movements. «Question of habit,» says Ngor with humility. She takes out her equipment. She surrounds her neck with a stethoscope and opens on the table the registers containing the patient’s name, personal information, medical history, vaccinations received, number of children and consultations attended. «Here we are everything: the doctor, the gynecologist, the pediatrician, everything! She exclaimed with a little pride. Today I’m lucky since my chief, Njama Loly, supports me in my task. I’m usually alone.»

Ngor often says he is exhausted by the scale of the task. Her first wish? Be assisted by skilled personnel. "But we would also need electricity, fridges. Today they are using gas, it is dangerous.

They break down when the gas bottles are finished so we have to urgently transfer the vaccines*. Njama adds: "And also a more suitable ambulance! In the district, there are only five posts with working ambulances. The most enclaved areas do not have any and it is impossible to evacuate those seriously ill.

In the district of Sédhiou where Ngor and Njama practice, they are 22 midwives employed by the State, 17 of whom are itinerant. That is not enough to cover a population of 171,000 inhabitants in a territory of about 7,000 km², crossed by innumerable forests, rivers, rice fields, savannas and swamps that they run through relentlessly. People view them as their guardian angels. Here they are called itinerant midwives.
The majority of maternal, neonatal and child deaths are avoidable.

Thanks to the efforts from the Governments, and from their partners, 50 million of lives have been saved in the world since 2000.

We can save way more by 2030 if progress accelerate as scheduled by the Sustainable Development Goals.