

THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND

Focused action, increasing impact – transitioning to Phase III (2018-2022)

ANNUAL REPORT 2018





DELIVERING A WORLD WHERE
EVERY PREGNANCY IS WANTED,
EVERY CHILDBIRTH IS SAFE,
AND EVERY YOUNG PERSON'S
POTENTIAL IS FULFILLED

Cover photo:

© Evelyn Matsamura Kiapi, UNFPA Uganda, June 2018.
Winner of the 2019 MHTF photo contest.

Faith Baribumpe 30, a midwife serving in Panyandoli Health Centre IV in the Kiryandongo Refugee Settlement in western Uganda admires a baby she delivered the night before. The mother, 22-year-old year Eunice Abalo, a refugee from South Sudan, says she delivered safely with the help of the midwife. In 2018, with UNFPA support, 17 midwives deployed in refugee settlements in Uganda assisted 22,254 pregnant women in giving birth.



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ACRONYMS

EmONC	Emergency obstetric and newborn care
FGM	Female genital mutilation
FIGO	International Federation of Gynecology and Obstetrics
GIS	Geographic information system
H6 (formerly H4+)	UNAIDS, UNFPA, UNICEF, UN Women, World Bank Group, WHO
ICM	International Confederation of Midwives
ICPD	International conference on population and development
ISOFS	International Society of Obstetric Fistula Surgeons
MPDSR	Maternal and perinatal death surveillance and response
MHTF	Maternal and newborn health thematic fund
MNH	Maternal and newborn health
NGO	Non-governmental organization
RMC	Respectful maternity care
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMNAH	Sexual, reproductive, maternal, newborn and adolescent health
UN Women	United Nations Entity for Gender Equality & the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFCU	United Nations Federal Credit Union
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

This report on the work of the United Nations Population Fund (UNFPA) Maternal and Newborn Health Thematic Fund (MHTF) benefitted from various contributions at all levels – country, regional and global – to ensure continuous improvement in the health and well-being of women and girls around the globe.

UNFPA acknowledges with gratitude the support of its staff at headquarters, in 39 countries and in 6 regional offices in prioritizing maternal and newborn health as part of a broader focus on sexual and reproductive health and rights (SRHR).

The key international supporters of the MHTF in 2018 remained Sweden, Luxembourg, Germany, and Poland.

Our sincere thanks go to our United Nations colleagues around the globe, including from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children’s Fund (UNICEF), United Nations Entity for Gender Equality & the Empowerment of Women (UN Women), the World Bank Group and the World Health Organization (WHO). We are grateful for their collaboration and coordination on sexual, reproductive, maternal, newborn and adolescent health (SRMNAH). Together, we continue to demonstrate our leadership, commitment and strong partnership through platforms such as the H6 partnership.

A special note of thanks goes to other individual donors and UN trust funds. The contributions of our civil society partners at global, regional and country levels is critical in supporting the broader achievement of universal access to SRHR. These partners include the International Confederation of Midwives (ICM), the International Federation of Gynecology and Obstetrics (FIGO), the International Society of Obstetric Fistula Surgeons (ISOFS), Operation Fistula, Columbia University’s Averting Maternal Death and Disability Program, Johns Hopkins University and its Program for International Education in Gynecology and Obstetrics (Jhpiego), the Woodrow Wilson Center and additional champions and technical experts listed in Annex 1 as part of the Campaign to End Fistula.

Special mention needs to be made of our nurturing partnerships with the private sector. We thank GE Health, Johnson & Johnson, Laerdal Global Health, the UN Federal Credit Union (UNFCU) Foundation, Zonta International and particularly Friends of UNFPA.

Together we are working to ensure that women and girls not only survive, but thrive and transform their lives and societies as a whole.

FOREWORD

Since 2008, the UNFPA Maternal and Newborn Health Thematic Fund (MHTF) has been supporting countries with the highest rates of maternal and newborn mortality and morbidity. This support helps strengthen health systems and improve access to quality care. The MHTF's gender-sensitive, human rights-based approach aims to contribute to the 2030 Agenda for Sustainable Development by ending preventable maternal and newborn deaths.

With a strong focus on promoting equity in access, and improving accountability and the quality of care across the board, the MHTF continued making big strides in 2018. It provided catalytic support through national programmes on sexual, reproductive, maternal, newborn and adolescent health (SRMNAH), and through multi-stakeholder global and regional initiatives.

Over the past decade, the MHTF has helped countries strengthen their midwifery workforces. Nearly 29,000 midwives were trained in 2018 alone. More countries supported by the MHTF have enhanced their networks for providing quality maternal and newborn health care, including emergency obstetric and newborn care (EmONC) services. Access to surgical treatment for obstetric fistula has also increased, with nearly 11,000 fistula repairs supported in 2018. In addition, more maternal deaths were notified, increasing the prospect of successfully addressing the root causes of maternal mortality.

The evidence-based interventions the MHTF promotes are being applied across 150 countries supported by UNFPA around the world. As a result of long-term investments and advocacy by the MHTF, in 2018 the UN General Assembly adopted a resolution calling for an end to fistula within a decade. The most affected regions are now drawing up roadmaps to do so. Similarly, through MHTF advocacy and its vast network of partners, more governments recognize that investments in quality midwifery care are essential to improve sexual, reproductive, maternal, newborn and adolescent health.

None of the progress and results highlighted in this report would be possible without the collaboration of key partners, including civil society organizations, academic institutions, fellow UN agencies and others, as well as the critical support of our donors.

With a new 2018-2022 Business Plan for the Maternal and Newborn Health Thematic Fund, UNFPA has reaffirmed its commitment to facilitating and accelerating global efforts to improve the quality of life of women and girls, especially the most disadvantaged. Together, we can and will deliver a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.



Dr. Natalia Kanem
Executive Director, UNFPA

A handwritten signature in black ink, appearing to read 'Natalia Kanem'. The signature is fluid and cursive.

EXECUTIVE SUMMARY

The Maternal and Newborn Health Thematic Fund (MHTF) was established in 2008 to further UNFPA's contribution to achieving Millennium Development Goal 5 on improving maternal health and reducing death and disability. Since its inception, the Fund has offered tailored, catalytic support to countries to reach their sexual, reproductive, maternal and newborn health goals.

In 2018, the MHTF moved into Phase III (2018-2022) of its Business Plan based on three cross-cutting principles: equity in access, quality of care and accountability, in line with the three pillars of *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* of the UN Secretary-General¹, to which the MHTF's work contributes. The existing focus on strengthening country leadership; improving the quantity and quality of information on maternal, newborn, sexual and reproductive health; and increasing access to services for women and girls was maintained. In Phase III, the four MHTF intervention areas – midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), and obstetric fistula and other morbidities – will be further integrated and linked with other sexual and reproductive health programmes, including post-partum and post-abortion family planning, comprehensive sexuality education, and prevention and treatment of HIV and sexually transmitted infections (STIs). Reproductive morbidities will also be addressed in a more focused manner, emphasizing access to cervical cancer screening and treatment, safe abortion (where legal) and post-abortion care.

This report highlights key results achieved in 2018. It is structured around the three cross-cutting principles and the four intervention areas mentioned above.

Increasing and bolstering human resources for health is important for securing equitable access to quality care, so in 2018, over 28,000 **midwives** were supported in pre-service education and in-service training, 384 schools in 34 different countries were provided with

equipment for skills labs and training for tutors, and well over 1,000 midwifery tutors upgraded their clinical and teaching skills. Furthermore, 29 countries integrated respectful maternity care (RMC) into their pre-service education, and 30 countries are addressing this through programmes supporting midwives who are working in health facilities.

Several countries have identified pre-service midwifery candidates from rural and indigenous communities to deploy to their respective districts upon graduation as midwives. Midwives have also been instrumental in various countries impacted by humanitarian crises. Education, training, mentorship and coaching midwives were provided in nearly all MHTF countries. As of 2018, 80 per cent of supported countries' midwifery curricula include adolescent sexual and reproductive health (SRH), HIV prevention and safe abortion where legal. Midwifery associations in 28 countries had strategic plan.

UNFPA developed its Global Midwifery Strategy in 2018, adding workforce and health system development, and the midwife's central role in sexual and reproductive health and rights (SRHR) to the existing three pillars of education, regulation and association. These elements together form a holistic roadmap to strengthen the capacity and quality of midwives and midwifery services worldwide.

As of 2018, 10 countries supported by the MHTF have established a national network of EmONC facilities; five regularly document their **EmONC** indicators. Using a new approach developed by the MHTF² that leverages geographic information system (GIS) and the software AccessMod³, which helps identify geographical restrictions in access to services, five countries reviewed their national EmONC network to improve access to quality maternal and newborn health services, including EmONC services. These countries have also defined specific indicators to manage EmONC development. They capture, among other elements, the population covered by EmONC services within two hours of travel

1 <https://www.who.int/life-course/partners/global-strategy/ewec-globalstrategyreport-200915.pdf>

2 Improving Emergency Obstetric and Newborn Care (EmONC) - Implementation manual for developing a national network of referral maternity facilities. UNFPA Guidance document, 2019

3 <https://www.accessmod.org>



©UN Photo, Nektarios Markogiannis, South Sudan 2019.

time, gaps in the availability and quality of services and the proportion of satisfactory referral links with higher-level facilities.

Several countries focused on strengthening accountability for quality of care. **MPDSR** assessments significantly increased notifications of deaths and death reviews in most supported countries. Eight countries set up MPDSR committees to oversee maternal death reviews, analyse their quality and advise on changes to reduce mortality. Countries also involved senior midwives in providing technical support and mentorship for maternal death review meetings in health facilities, thus improving the quality of the reviews and implementation of their recommendations.

In 2018, the UN General Assembly adopted a resolution calling for ending **obstetric fistula** within a decade. It aligns with achieving the Sustainable Development Goals (SDGs) by 2030 and leaving no one behind. The MHTF supported repair surgeries for 10,758 women with fistula during the year, adding to a total of 105,000 surgeries supported by UNFPA and the MHTF since the launch of the Campaign to End Fistula in 2003. By the end of 2018,

27 of 33 (82 per cent) countries supported to address fistula had routine and continuously available fistula treatment services in strategically selected hospitals. To further promote country ownership and leadership, 30 countries were assisted in strengthening their national fistula task teams to enhance coordination, implementation and monitoring of interventions aimed at elimination. By the end of 2018, 21 MHTF-supported countries had national strategies to end fistula; 6 additional countries were in the process of developing them.

Overall, and despite declining resources, the MHTF has demonstrated value for money, effective coordination and efficient management. Its catalytic effect has encouraged several countries to mobilize additional national and international funding for improving maternal and newborn health. But the most vulnerable women, newborns and adolescents still need to be reached to realize the promise of the SDGs.

In Phase III, the MHTF will build on past experiences, implement lessons learned, and mobilize additional key players and resources to make ending preventable maternal mortality and morbidity a tangible reality.

PART

1



Two mothers entering the community health centre in Kono District, Sierra Leone
©UNFPA Sierra Leone, Salim Kamara, 2018.
Photo submitted to the 2019 MHTF photo contest.

KEY RESULTS

The Maternal and Newborn Health Thematic Fund (MHTF) is UNFPA's flagship programme on improving outcomes for women and their newborns in countries with the worst maternal and newborn health indicators and the highest needs. The programme entered an exciting new Phase III in 2018 with the launch of its new Business Plan 2018-2022. Aligned with the 2030 Agenda for Sustainable Development, the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), and UNFPA's Strategic Plan 2018-2021, Phase III of the MHTF aims to contribute towards eliminating preventable maternal and newborn mortality and morbidity.

Building on evidence and lessons from its two earlier phases, the MHTF will continue to follow a holistic and integrated health system approach with strategic interventions in its four areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR) and obstetric fistula and other morbidities. The MHTF is an integral part of UNFPA's broad intervention on sexual and reproductive health and rights, including on adolescent sexual and reproductive health; access to safe abortion (where legal) and post-abortion care; and cervical cancer treatment and prevention.

2018 was a transitional year for the MHTF, marking the end of Phase II and the beginning of Phase III as well as a new Results and Indicators Framework. The performance of all 39 MHTF-supported countries was reviewed, with agreement that starting in 2019, the MHTF would assist a total of 32 countries.

As the year 2018 is a transition year between Phase II and Phase III, no Results Indicator Framework (RIF) is presented in this report. The achievements and RIF of Phase II are described in the MHTF 2017 annual report and the new RIF for Phase III will be described in next years' report. The year of 2018 will serve as a baseline for the Phase III RIF. Key results for the four intervention areas are summarized on the following pages.

1.1 MIDWIFERY KEY RESULTS

In 2018, UNFPA continued to strengthen the quality of midwifery care through improvements in midwifery education and training. In 28 MHTF-supported countries, 667 midwifery schools were accredited by a regulatory body. MHTF funds further helped strengthen 384 midwifery schools in 34 countries by providing them with books and training materials, and equipping their skills labs with training models.

With UNFPA's facilitation, almost 9,500 midwives graduated from pre-service education, and another 19,000 were supported through in-service training, bringing the total number of midwives educated and trained in 2018 alone to 28,500. Overall, upwards of 1,000 tutors received support in upgrading clinical and teaching skills, bringing the total number of midwifery tutors trained to date to over 10,000. Over 80 per cent of the MHTF-supported countries included broader sexual and reproductive health (SRH) issues like adolescent SRH, safe abortion (where legal) and HIV in their midwifery curriculum. Eighteen MHTF countries also reported having integrated female genital mutilation (FGM) in the national midwifery curriculum. The quality of midwifery education was further strengthened through integrating respectful maternity care in the pre-service curriculum of 29 countries, while 30 countries also reported strengthening respectful maternity care through in-service training.

By the end of 2018, in a vast majority of MHTF-supported countries (over 95 per cent), pre-service education programmes had been linked with training centres in basic EmONC facilities, thus strengthening the clinical skills of midwives. About 25 MHTF-supported countries were using blended e-learning to strengthen skills in key obstetric emergencies either through pre-service education (in roughly 35 per cent of countries) or through in-service training. Countries like Bhutan, India and Tanzania, which are not covered by the MHTF, were supported in launching national e-learning. Skills in managing basic obstetric emergencies were strengthened through e-learning for midwifery tutors across the entire state of Rajasthan in India and in Bhutan.

Twenty-three out of 32 (72 per cent) of countries had a costed human resources plan for midwifery. Eleven

countries implemented a mentorship programme for midwives, while eight additional countries are establishing one. Midwifery associations in 28 countries had a strategic plan that is being implemented. A vast majority of associations (over 85 per cent) are actively engaged in in-service training.

By 2018, midwifery was being regulated by a midwifery council/board or another regulatory body in 25 countries, and about 6 countries were establishing such councils. Twenty-eight MHTF-supported countries reported that midwives are authorized to practice based on International Confederation of Midwives (ICM) standards.

Despite this progress, the deployment of midwives continues to remain an issue, with about 50 per cent of supported countries reporting that less than 20 per cent of new graduates were deployed within one year. Only 20 per cent of MHTF-supported countries (Bangladesh, Côte d'Ivoire, Ethiopia, Rwanda, Sierra Leone, South Sudan and Zambia) reported that over 80 per cent of new graduates were deployed within one year.

1.2 EMERGENCY OBSTETRIC AND NEWBORN CARE KEY RESULTS

As women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth, investing in improved access to and quality of care, especially EmONC, is essential. Despite a global increase in the coverage of skilled birth attendance, associated declines in maternal and newborn mortality and morbidity have been modest, and for stillbirths, virtually non-existent. One reason is the lack of access to quality EmONC. Countries need effective plans and monitoring systems to strengthen their national network of facilities to ensure access to quality basic and comprehensive EmONC services.

Since 2012, the MHTF has supported 10 countries (Benin, Burkina Faso, Burundi, Guinea, Haiti, Madagascar, Niger, Senegal, Timor Leste, Togo) to define their national network of EmONC health facilities. Among them, Burundi in 2017 and Benin, Guinea, Madagascar - under finalization in 2019, Senegal, and Togo used the GIS/AccessMod, based on a new methodology developed

Table 1. Coverage indicators of the national EmONC network in Benin, Guinea, Senegal, and Togo

Countries	Designated national EmONC facility network		Functioning EmONC facility network ¹		Number of midwives needed in the EmONC network for services 24h/7d	Proportion of satisfactory referral links between Basic and Comprehensive EmONC health facilities
	Number of facilities	Population coverage (as illustrated by the maps in Figure 1)	Number of facilities	Population coverage		
Benin (preliminary data)	111	84%**	25	65%**	121	40%
Guinea (EMONC network validated by the MoH)	105	81%*	14	34%*	170	21%
Senegal (EMONC network validated by the MoH)	142	92%*	NA	NA	84	50%
Togo (EMONC network under validation by the MoH)	69	80%**	25	71%**	65	27%

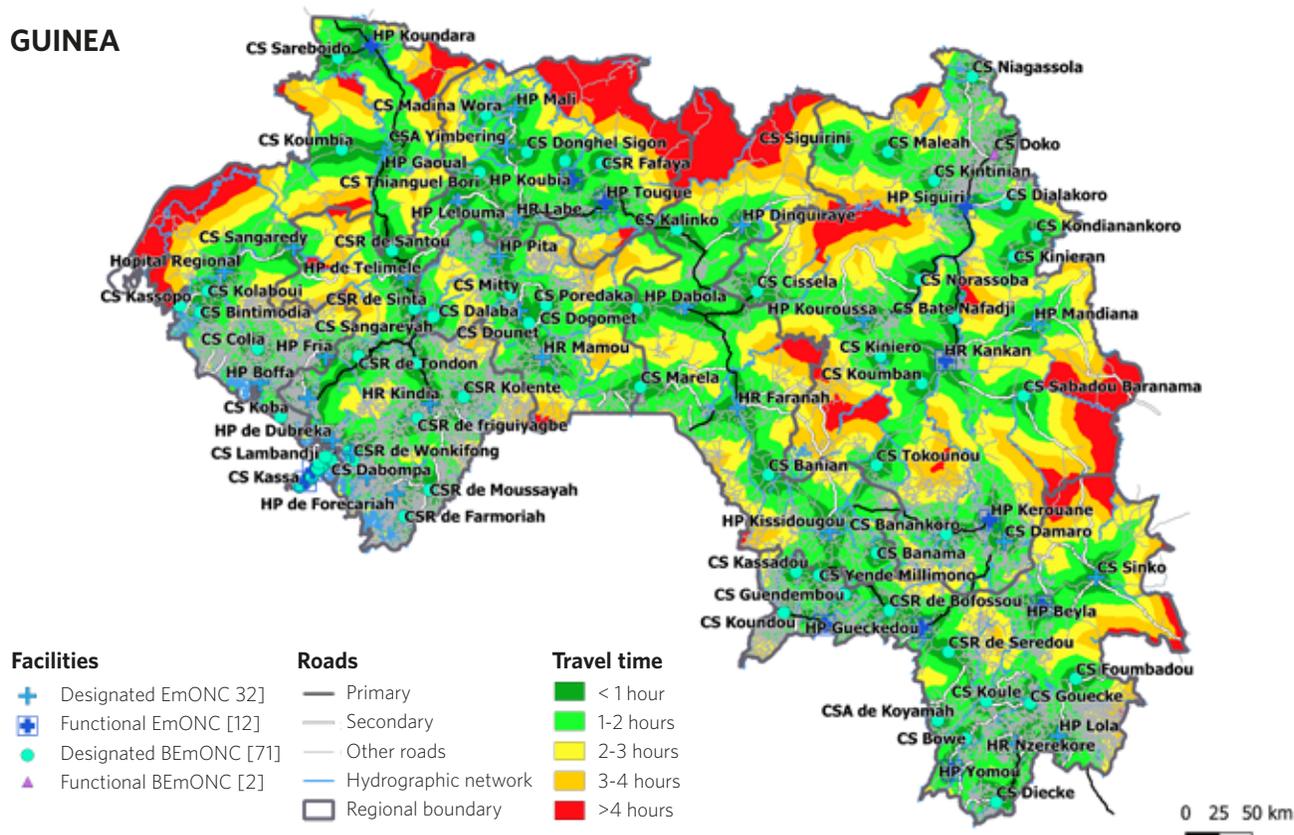
* Within two-hours of travel time.

** Within one-hour of travel time.

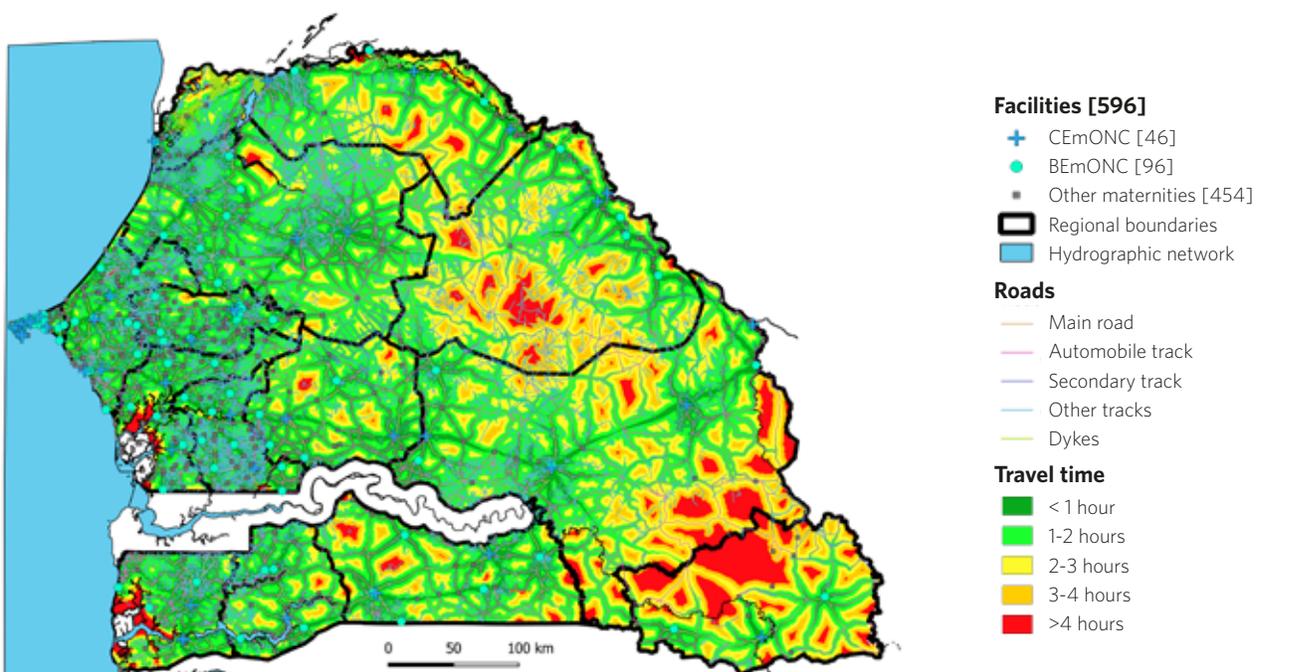
¹ A functioning EmONC facility is a maternity unit where skilled birth attendants provides obstetric and neonatal care 24/7 with no deficit in signal functions, which reflect the capacity to manage obstetric and neonatal complications.

Figure 1. Accessibility maps of national networks of EmONC facilities in Guinea, Senegal, and Togo

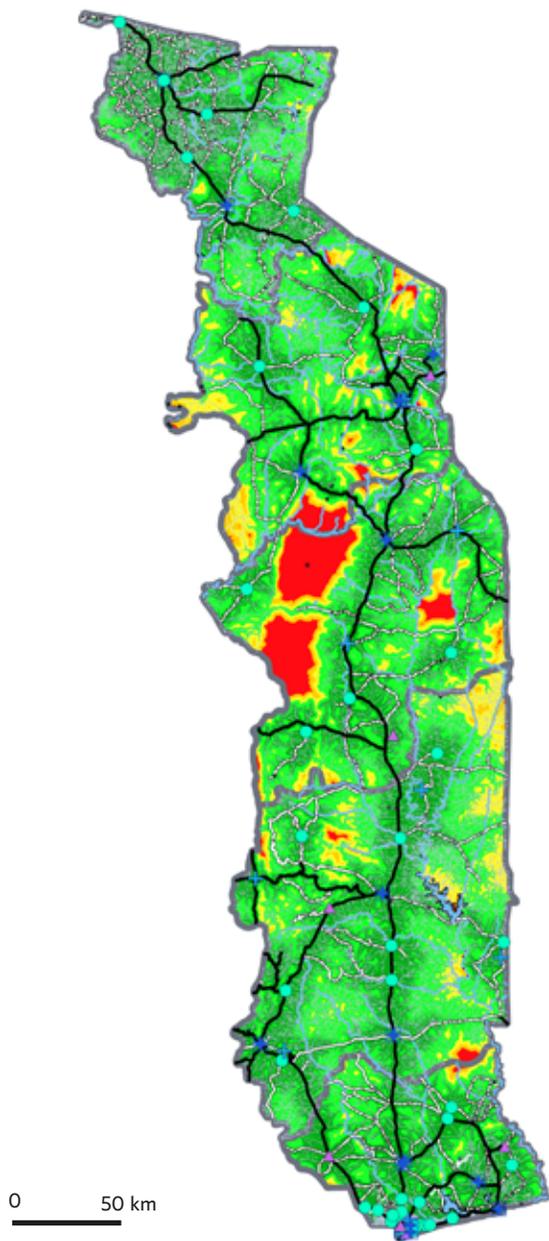
GUINEA



SENEGAL



TOGO



Facilities

- + Designated CEmONC [9]
- + Functional CEmONC [17]
- + Designated BEmONC [38]
- + Functional BEmONC [7]

Roads

- National roads
- Other roads
- Tracks/paths

Hydrography

- Rivers
- Lakes
- Regional boundaries

Travel time

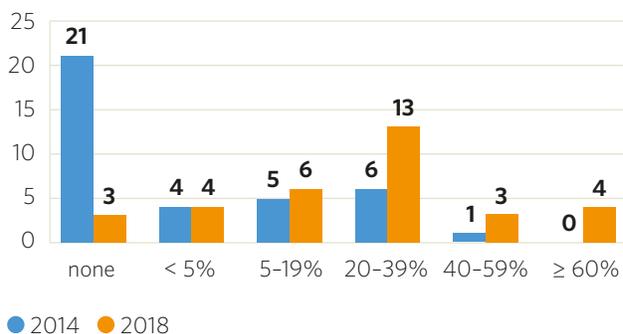
- < 1 hour
- 1-2 hours
- 2-3 hours
- 3-4 hours
- >4 hours

by the MHTF global team⁴, to identify their national network of referral facilities and estimate the proportion of the population covered. Estimating coverage within two hours of travel time of the closest referral health facility is a new and efficient way to establish baselines and targets for improving access to EmONC services (Table 1 and Figure 1). It also highlights huge gaps in countries in funding the development of EmONC at national scale so that every woman and newborn in need can access such care at the right moment.

This methodology proved to be easily contextualized to the specificities of different countries. It showed the importance of road conditions and access to public transportation for addressing maternal and newborn mortality and morbidity, and highlighted financial barriers to access obstetric and neonatal services and referral mechanisms. More countries requested such support for planning their national networks of referral EmONC health facilities in 2019.

Once the national network is defined, key SRMNH indicators are monitored to inform quality improvements. In 2018, Burkina Faso, Burundi, Haiti, Niger and Timor Leste regularly monitored these indicators in the national EmONC network.

Figure 2. The maternal death notification rate in MHTF-supported countries



⁴ Improving Emergency Obstetric and Newborn Care (EmONC) - Implementation manual for developing a national network of referral maternity facilities. UNFPA Guidance document, 2019.



A Rohingya mother brings her new baby to the UNFPA clinic in Kutapalong Refugee Camp in Bangladesh for her first check-up. Mother and baby are both in excellent health. ©UNFPA Bangladesh, Carly Learson, 2018. Photo submitted to the 2019 MHTF photo contest.

1.3 MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE KEY RESULTS

MHTF-supported countries improved their capacity to notify maternal deaths in their health information system in 2018. To monitor the implementation of the MPDSR, the MHTF created two indicators: the maternal death notification rate and the maternal death review rate. These indicators respectively divide the number of maternal deaths notified to the central Ministry of Health and the number of maternal deaths reviewed in a given year by the number of estimated maternal deaths in the same year (using the MMR estimates⁵) the number of maternal deaths notified to the central Ministry of Health in a given year by the number of estimated maternal deaths in the same year. In 2018, 50 per cent of MHTF-supported countries used this indicator to monitor trends in notification, highlighting their willingness to achieve accountable results. As illustrated in Figure 2, a significant increase in maternal death notifications occurred in most

countries. Five (Bangladesh, Benin, Ethiopia, Timor-Leste and Zambia) claimed a maternal death notification rate of around 50 per cent or more. Compared to 2014, the number of countries with no data significantly decreased, showing that most countries have implemented an MPDSR programme and produce data on notification (and also on maternal death reviews).

The number of maternal deaths reviewed to identify causes and drive improvements also increased in 2018. Reviews in 12 countries covered more than 20 per cent of the estimated number of maternal deaths. Three countries reviewed at least 50 per cent of the estimated maternal deaths (Bangladesh, Ethiopia and Timor-Leste).

One of the MHTF's major activities to strengthen MPDSR programmes is to support countries to improve the quality of maternal death reviews. This remains very challenging, but it is decisive in developing a qualitative programme where review conclusions and

5 Trends in maternal mortality: 1990 to 2015; Estimates by WHO, UNICEF, UNFPA World Bank Group and the United Nations Population Division; 2015.

recommendations are relevant and used to improve access to and quality of maternal health services. To improve review quality, the MHTF promotes the use of mentors to ensure a no-blame approach along with a comprehensive understanding of the root causes of each maternal death and what needs to be improved. Twenty-four MHTF-supported countries (72 per cent) are using mentors to improve the quality of maternal death reviews. Both the upcoming UNFPA's EmONC development guidance⁶ and the mentorship guidance under development by UNFPA's Regional Office for West and Central Africa and the MHTF Headquarter team promote this approach.

The MHTF recommends that national MPDSR committees create a national expert group in charge of analysing samples of maternal death reviews to estimate their reliability and relevance in identifying the cause of death and analysing the determinants of those deaths. Eight countries have already created such a group (Bangladesh, Lao People's Democratic Republic, Mozambique, the Republic of the Congo, Rwanda, Somalia and Timor-Leste). These expert groups will provide an interesting programme qualitative indicator: the proportion of maternal deaths reviewed that meet a quality standard defined by the Ministry of Health.

1.4 OBSTETRIC FISTULA KEY RESULTS

In 2018, the MHTF contributed to increased political commitment, government leadership and financial support to prevent and treat fistula in the context of improving maternal and newborn health outcomes, and upholding the human rights of women and girls with fistula and those at risk of getting it. The Fund specifically intervened on strengthening national programmes to end fistula and supporting high-level global, regional and country advocacy using evidence-based research and strategic platforms, including the commemoration of the International Day to End Obstetric Fistula on 23 May. These efforts significantly support the UNFPA-led global Campaign to End Fistula and complement prevention, treatment and social reintegration measures by campaign partners.

The year saw the issuance of the 2018 UN Secretary-General's Report on Intensifying Efforts to End Fistula⁷ within a Generation as well as a UN General Assembly resolution on ending obstetric fistula⁸. Building on the recommendations of the report, the resolution, adopted by all UN Member States, called for intensifying efforts and increasing investments to end fistula within a decade, aligned with the 2030 Agenda for Sustainable Development and the Sustainable Development Goals.

Through MHTF support, the biannual meeting of the International Obstetric Fistula Working Group (IOFWG) took place in Nepal, bringing together experts and thought leaders in the field of women's wellness, fistula care, management and programming, and global public health. The meeting kicked off preliminary consultations on the development of a global roadmap to end fistula. It is expected to be completed by 2020 and led by UNFPA and the global Campaign to End Fistula.

In 2018, UNFPA supported 10,758 fistula repairs through the MHTF and the Campaign. The "success rate at discharge" was monitored in 22 MHTF-supported countries. Twenty-seven out of 33 (82 per cent) of supported countries report routine and continuously available fistula treatment services in strategically selected hospitals, with the MHTF contributing to this achievement in 75 per cent of these countries. The majority (25 out of 33) of MHTF-supported countries, however, indicate an unmet need for treatment, as not all women and girls with fistula are able to access needed services. Equitable access remains a challenge, as 29 MHTF-supported countries estimated that the existing number of trained and active fistula surgeons cannot meet expected need for fistula treatment and repair, resulting in many women and girls continuing to suffer needlessly.

By the end of 2018, 21 MHTF-supported countries had put in place national strategies to end fistula, and 12 had measures to monitor implementation and track progress of planned interventions to end the condition. Seven countries (Bangladesh, Kenya, Malawi, the Republic of the Congo, Rwanda, South Sudan and Zambia) are developing new monitoring measures, while 30 had established functioning national task teams for fistula.

6 Improving Emergency Obstetric and Newborn Care (EmONC) - Implementation manual for developing a national network of referral maternity facilities. UNFPA Guidance document, 2019.

7 A/73/285

8 A/RES/73/147



Senior midwife taking blood pressure of patient during an antenatal care visit.
©UNFPA Kenya, Phillip Odhiambo, 2018. Photo submitted to the 2019 MHTF photo contest.

PART

2

A new mother after a few hours of birth in Mahama Health Center Kirehe District/MAHAMA CAMP.
©UNFPA Rwanda, Aimable Twiringiyimana, 2018. Photo submitted to the 2019 MHTF photo contest.



OPTIMIZING EQUITY IN ACCESS, QUALITY OF CARE, ACCOUNTABILITY

The goal of the MHTF is to support countries with the highest burdens of maternal and newborn mortality and morbidity to improve access to quality sexual, reproductive, maternal and newborn health services for women, newborns and adolescents. This includes bolstering health system performance and accountability.

Equity in access to sexual, reproductive, maternal and newborn health care means ensuring that every woman, newborn and adolescent girl has the same opportunity to receive needed information and care, of the quality required, regardless of income, socioeconomic or health status, geographic location, cultural background, or willingness and capacity to ask and pay for services. Vulnerable groups such as adolescent mothers, poor women, women and girls with disabilities (including fistula), indigenous peoples, newborns and isolated communities often have pressing health needs even as they experience challenges in accessing health care. This is particularly true for specific services such as post-abortion care, post-partum family planning and social reintegration after fistula repair. The MHTF supports local partners in addressing the role of communities in identifying their own priorities and contributing to solutions as well as monitoring interventions.

True equity depends fundamentally on high-**quality of care** and sound accountability across health systems. Towards that end, UNFPA joined the WHO and UNICEF in 2017 to found the Quality of Care Network for Maternal, Newborn, and Child Health (<http://www.qualityofcarenetwork.org/>). Nine countries supported by the MHTF are already part of the network and more are joining it. The WHO defines quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred”.⁹ Quality of care requires appropriate use of effective clinical and non-clinical interventions, strengthened health infrastructure, optimum skills and a positive attitude of health providers. Both quality of care and equity are ensured and maintained through accountability.

Accountability for health programmes can be demonstrated through advocacy, national ownership, open publication of data and implementation of innovative approaches to tackle the most challenging barriers. Accountability helps ensure that health workers operating in remote and hard-to-reach areas have equal access to updated knowledge, skills and support so they can provide quality services. The MHTF contributes to accountability by strengthening governance and coordination mechanisms; generating, sharing and enabling the use of data; and empowering health system stakeholders and beneficiaries, including in situations requiring a humanitarian response. Accountability is further promoted by mandatory notification of maternal and newborn deaths in order to fully analyse the causes and take remedial actions. For a solid accountability mechanism to be in place it is important that also rightsholders views and demands are captured as part of the full cycle of accountability. Such mechanisms are in place in some of the MHTF countries but far from all. The next phase of MHTF program will explore ways of further strengthening the accountability systems also to this end.

Since equity in access, quality of care and accountability are closely intertwined, the MHTF supports innovative measures and catalytic interventions that integrate the three so that high-burden countries accelerate action and scale up evidence-based innovations for improving maternal and newborn health.

The next section provides examples of the MHTF support to countries in improving equity in access, quality of care and accountability through integrated interventions. These are strengthening midwifery, EmONC and MPDSR, and addressing obstetric fistula and other morbidities. Since these intervention areas reinforce each other, countries need to invest concurrently in all four areas to equip their health systems to end preventable maternal and newborn mortality and morbidity. The MHTF's strategic interventions are further described in Section 2.3.

9 WHO, 2016, “Standards for Improving quality of maternal and newborn care in health facilities”.

2.1 COUNTRY HIGHLIGHTS

2.1.1 Expanding the reach and quality of the midwifery workforce and EmONC services

Ensuring that every woman and newborn receives skilled care in respectful and supportive environments requires ensuring fully stocked health facilities (including for the provision of EmONC services), and strengthening midwifery pre-service curricula, mentorship, respectful maternity care, functional referral and transportation systems, and more. Mentorship programmes are service-level interventions with the primary goal of equipping midwives and other health-care providers with the clinical knowledge, skills and attitudes to competently provide quality maternal and newborn health care. Programmes are designed to strengthen learning for pre-service students in the clinical environment.

In **Bangladesh**, mentorship was provided at 86 clinical education and deployment sites focused on midwife-led care and evidence-based practices for routine and emergency care. Mentors supported both pre-service and in-service midwives to provide care according to WHO evidence-based routine care guidelines. In addition, pre-service midwifery students are now being sent to subdistrict hospitals to learn within the model of midwife-led care, as opposed to referral facilities, where they were competing with nurse students and junior doctors for clinical tasks. This has resulted in an increased number of deliveries conducted by pre-service midwives as well as more exposure to autonomous midwifery practices. It will allow students to gain confidence in handling obstetric emergencies, and preventing or diagnosing obstetric fistula.

In **Ethiopia**, a midwifery gap assessment was conducted in 2017 in 42 per cent of the country's midwifery training institutions. It evaluated progress made in midwifery education since 2008, when the MHTF and other partners began to assist the Government with midwifery training through the provision of teaching and learning material, training for midwifery tutors, coaching and mentoring, exchange visit programmes, and more. The findings of the assessment showed that the learning-teaching environment has improved in universities with most tutors having bachelor of science and master's degrees. The tutor-student ratio improved to 1:19, and the number of female tutors increased by 29.4 per cent, with 25.5 per cent of the female tutors trained at the master's level. The assessment also reported that midwifery is a stand-alone department in 52 per cent of training institutions; 90.5 per cent of these institutions

have midwives heading the midwifery department. All of these advances indicate great progress in the enhancement of midwifery education in the country.

As part of its continuous commitment to improve the competencies of the midwifery workforce, the federal Ministry of Health in Ethiopia recently developed national mentorship guidelines for reproductive, maternal and newborn health care aimed at standardizing mentorship programmes and improving the quality of care. Health offices in four *woredas* (districts) in two regions were selected to implement the programme at four primary health-care hospitals and 12 health centres. A baseline assessment that evaluated mentees' knowledge gaps helped tailor training accordingly. Preliminary results show noticeable improvements, such as better organized emergency drug shelves, and the reorganization of delivery rooms to increase privacy. At in-service training sites, integration of the Mobile Learning System has helped increase access to continuing professional development, which became mandatory for health professionals' relicensing in July 2019.

The success of the Mobile Learning System in training tutors in remote provinces in Ethiopia as well as **Tanzania** in 2016 and 2017 prompted **Rwanda** to launch a similar initiative in its most remote and poorest district, Rutsiro. As a result, the Government has proposed a nationwide scale-up over the next several years. Other innovative programmes like Helping Mothers Survive and Helping Babies Breathe also continue to expand in collaboration with Laerdal Global Health and Jhpiego (the Program for International Education in Gynecology and Obstetrics affiliated with Johns Hopkins University). UNFPA has joined the ICM-led and Laerdal-funded 50,000 Happy Birthdays project in **Ethiopia, Malawi, Rwanda, Tanzania and Zambia**.

In **Burkina Faso**, 463 service providers were trained on contraceptive methods and family planning, with a focus on human rights and product logistics. Forty were trained specifically on logistics management, while 167 providers gained skills related to the reproductive health of adolescents and young people. As part of efforts to accelerate the realization of sexual health and reproductive rights, 427 pairs of educators were trained on community-based distribution of contraceptives.

In 2018, with MHTF support, **Ghana** began a partnership with the Incision Academy (<https://www.incision.care/>), which offers a wide range of online surgical courses for surgeons and other medical personnel. The Incision Academy developed videos for midwives on basic



Rhode-Cyndia, a midwife trained by the UNFPA supported midwifery program reassures a pregnant woman.
©UNFPA Haiti, Louis Flaubert Junior Jean-Michel, 2019

EmONC skills, such as repair of episiotomies, and aims to have a complete reference site for maternal health. To this end, the Nursing and Midwifery Council of Ghana is being engaged to provide continuous professional development points to support requirements for license renewal for nurses, midwives and doctors. UNFPA will continue collaborating with the Incision Academy to improve the surgical skills of both obstetric fistula surgeons and midwives. UNFPA also collaborates with the Maternity Foundation (<https://www.maternity.dk/>) in training midwives to use their Safe Delivery App, which helps improve the quality of clinical services. It has strengthened the knowledge base and skills of over 200 midwives.

Financial and technical support helped the Nurses and Midwives Council of **Malawi** (the national regulatory

body) to review the midwifery skills assessment tools of 15 midwifery colleges in line with ICM global teaching and learning standards. The assessment tools were validated and ready for use by 2019. Applied as part of midwifery licensure examinations, they will help in properly assessing midwives and ensuring they demonstrate the right skills for providing quality care.

Over 1,000 midwifery tutors upgraded clinical and teaching skills through a variety of methods, including multimedia e-learning, supplemented by hands-on training in skills labs and basic EmONC centres. For instance, in **Pakistan**, 25 midwifery trainers from all provinces, midwifery association members, members of the nursing council and policy makers completed e-learning modules. The modules are now being used in the humanitarian response in conflict-affected



©UNAMID photo/Albert Gonzalez Farran, Sudan.

regions of Pakistan to train midwives where few or no facilities are available. MHTF collaboration with the State Institute of Health and Family Welfare in Jaipur, **India** allowed midwifery tutors from 24 districts of the state of Rajasthan to complete nine e-learning courses. A similar training was conducted for 14 tutors in **Bhutan** at the request of the Ministry of Health and the Faculty of Nursing and Public Health.

In **Lao People's Democratic Republic**, the development and retention of the midwifery workforce in rural areas is a national priority. The MHTF advocated to offer women from indigenous groups to be trained as midwives per the ICM standards and to support their deployment back to their communities. Out of a total of 1,716 midwives trained in 2018, 336 came from indigenous backgrounds and are now providing their respective communities with comprehensive sexual, reproductive, maternal and newborn health services. This innovative approach has increased equity in access to health care, leading the Government to decide to maintain the programme.

In 2018, with MHTF support, **Guinea, Madagascar, Sudan, Senegal** and **Togo** successfully defined their

respective national networks of EmONC health facilities using GIS/AccessMod. They prepared for EmONC programme implementation and monitoring at a national scale. **Madagascar** started a similar approach, while in the **Republic of the Congo**, the MHTF support was used to develop a strategic partnership between UNFPA and Philips to help two rural districts improve access to maternal health and neonatal care for the Bantou and indigenous populations. This project will be further refined and extended at national scale during Phase III of the MHTF.

A rising number of institutional births has generated an increased focus on the quality of care for women and their newborns in many MHTF-supported countries. In 2018, **Burkina Faso, Burundi, Niger** and **Togo** started systematically documenting the case fatality rate from direct obstetric complications in EmONC facilities, gaps in midwives, stock-outs of life-saving commodities, the number of maternal deaths notified and the numbers reviewed. They also focused on mentorship for both pre-service and in-service midwives as well as capacity-building for teachers.

2.1.2 Ensuring access to integrated sexual and reproductive health services among adolescent girls and young women

In **Kenya**, over 1,200 adolescent girls and young women under 24 years old in Kilifi County accessed skilled antenatal, safe delivery, family planning and post-partum care, including HIV counseling and testing. Similarly, in **South Sudan**, 360 people were formed to support first-time young mothers. The groups discussed topics such as hygiene, breastfeeding and the importance of delivering with a skilled provider.

In all MHTF supported countries, the MHTF contributes to increase access of adolescent girls and young women to SRMH information and services and to ensure that the ones who are pregnant access quality reproductive, maternal and newborn health services, including safe abortion (where legal), post-abortion care, and post-partum and post-abortion contraception.

2.1.3 Improving access to and the quality of SRMNAH services in humanitarian settings

In 2018, several political and refugee crises as well as natural disasters affected MHTF supported countries, including **Afghanistan, Bangladesh, Mauritania, the Central African Republic, Mali, Somalia, South Sudan and Yemen**. MHTF programmes had to be subsequently tailored to address humanitarian needs. For example, in Mauritania, a steady supply of SRH and family planning resources were provided to target populations in the refugee camp in Mberra. In total, 186 pregnant and lactating women benefited from comprehensive SRMNAH services.

Midwives trained and supported through the MHTF continued to provide outstanding support in several countries affected by **humanitarian crises**, such as **Bangladesh** (Rohingya crisis), the **Democratic Republic of the Congo, Haiti, Mauritania, Nigeria and South Sudan**, among many others. In Nigeria, a humanitarian crisis has been ongoing for more than five years.

ACCESSING COMPREHENSIVE SEXUAL AND REPRODUCTIVE HEALTH CARE IN COX'S BAZAR REFUGEE CAMP

In Bangladesh, over 127 midwives trained in clinical management of rape and family planning counseling were deployed to 23 UNFPA-supported facilities in the Rohingya refugee camps in Cox's Bazar.

Jahanara and Dolu have just been to see a midwife for the first time at the UNFPA clinic in the refugee camp they live in near Cox's Bazar. Jahanara is having her first baby, and Dolu her third. In Myanmar, they had no access to medical care; Dolu gave birth to her first two children at home.

In Bangladesh, midwives are a flagship good practice. Their work and advocacy have led to a prioritization of comprehensive sexual and reproductive health care in humanitarian and national development settings. To this end, Bangladesh hosted a 28-day SRH competency-based training with increased focus on the health response to gender-based violence, family planning, post-partum health and more.



© UNFPA Bangladesh, Carly Learson, 2018. Photo and story submitted to the 2019 MHTF photo contest.

Furthermore, UNFPA supported the Directorate General of Nursing and Midwifery to revise the pre-service midwifery diploma curriculum to include comprehensive SRH.

An increasing number of MHTF-supported countries are focusing on research to improve the quality of care during labour and childbirth. UNFPA supported the University of Malawi-Kamuzu College of Nursing and Midwifery to conduct operational research on birthing positions, for example. It showed promising results in reducing pain, encouraging a more physiologically uncomplicated labour and reducing perineal tears in primigravida and young women. For the study, one district facility was equipped with necessary materials such as standing and squatting stools, furniture and other supplies.



© UN Photo/Evan Schneider, Malawi.

In August 2018, through strategic engagement of the midwifery regulatory body, selected staff from the body and two tutors from all 10 nursing and midwifery training institutions located in the four north-eastern states affected by the crisis (Adamawa, Borno, Gombe and Yobe) received training on the Minimum Initial Services Package. This strengthens capacities to provide and coordinate SRMNAH care and services to prevent and respond to gender-based violence during humanitarian emergencies.

2.1.4 Ensuring respectful and people-centered maternity care

Respectful Maternity Care (RMC) is essential to quality maternal and newborn care. It is being systematically addressed in MHTF-supported countries; 29 countries have integrated it in pre-service education and 30 in in-service training programmes. **South Sudan**, for example, organized four workshops to train 57 health-care workers, including midwives, on how to provide friendly and respectful care for first-time young mothers. In the areas where they were trained, 754 first-time young mothers benefited from various SRH services and information. **Nigeria** developed training modules on reproductive health, including one on RMC, used to train 10,228 midwives as part of mandatory continuing professional development. In the **Caribbean** region, UNFPA has rolled out a pilot initiative on RMC in collaboration with The Caribbean Regional Midwives Association.

As part of a midwifery mentorship programme, training on various lifesaving skills, including RMC, was provided in **Ethiopia**. It also incorporated RMC principles into celebrations of the International Day of the Midwife (May 5), which featured a skit on confidentiality and midwifery professional ethics. RMC is now emphasized in midwifery curricula and training in the **Democratic Republic of the Congo, Mozambique, South Africa, Zambia and Zimbabwe**.

In 2018 in the **Republic of the Congo**, the “Charte de l’Accouchement” (Childbirth Charter) was officially launched by the Minister of Health and Population. Now integrated in the pre-service education of midwives, it covers the rights of midwives, mothers-to be and communities, including theory and practical work.

2.1.5 Leveraging the power of data for sexual, reproductive, maternal and newborn health

In 2018, the Ministry of Health of **Benin**, with technical and financial support from UNFPA and the MHTF, released findings of an evaluation of the follow-up to surgical fistula repairs three months after discharge. The report¹⁰ identified the epidemiological profile of women with obstetric fistula and the success rate of their surgical repairs, and provided recommendations for improving the management of fistula cases. See page 7.

10 “L’évaluation des résultats des réparations chirurgicales trois mois après la prise en charge”, Ministère de la santé, République du Bénin, UNFPA, 2018.

BENIN'S MINISTRY OF HEALTH STRENGTHENS FISTULA REPAIR FOLLOW-UP

Tracking women after fistula repairs and social reintegration helps capture progress and the impact of national fistula programmes. In Benin, the national programme focuses on prevention and treatment of fistula, reintegration of women with repaired fistulas, advocacy, and resource mobilization to end the condition.

Led by the Government, in collaboration with UNFPA and non-governmental organizations (NGOs), the national Campaign to End Fistula remains strong. In 2018, four fistula treatment centres, half of the total, included fistula indicators in the Demographic and Health Information Survey with support from UNFPA, as part of measures to strengthen fistula prevention in the subsequent pregnancies of fistula survivors. A total of 148 women with fistula were repaired in 2018.

Inadequate expertise and coverage of quality fistula repairs, however, coupled with the high cost of care, which many fistula sufferers cannot afford, remain a challenge. The success of surgical repair is typically assessed two weeks after surgery in Benin, after which patient follow-up has not been consistent.

In 2018, the Ministry of Health, with technical and financial support from UNFPA and the MHTF, evaluated the results of surgical fistula repairs three months after discharge. The report ("L'évaluation des résultats des réparations chirurgicales trois mois après la prise en charge") identified the epidemiological profile of women with obstetric fistula and the success rate of their surgical repairs, and provided recommendations for improving the management of fistula cases.

Data on 95 beneficiaries of fistula repairs performed in 2017 were collected from eight health facilities. The patients ranged from 18 to 60 years old. Topographic diagnoses were dominated by vesico-vaginal fistulas (63.2 per cent). In 87 of the women (91.6 per cent) obstetric complications were the cause of fistula. Other types were post-hysterectomy (iatrogenic fistula) or due to malformation. Women between

ages 25 and 34 years accounted for 34 per cent of the cases treated.

The evaluation showed that 99 per cent of repairs showed no change from the time of discharge. One case, which had been declared a failure at the time of discharge, was found to be closed and dry after three months. Key recommendations included:

- Institutionalization of the quarterly follow-up of women operated on for up to one year;
- Systematic integration of fistula data into the second round of the Demographic and Health Information Survey; and
- Strengthening of health systems for the prevention and treatment of fistula, including through capacity-building for staff, availability of adequate medical supplies and equipment, and improved management and record-keeping of patient data.



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The availability of quality fistula data contributes to evidence-based development and advocacy to end the condition. By 2018, 16 MHTF-supported countries (**Bangladesh, Benin, Burkina Faso, Burundi, Côte d'Ivoire, the Democratic Republic of the Congo, Ghana, Kenya, Liberia, Nigeria, the Republic of the Congo, Rwanda, Senegal, Sierra Leone, South Sudan and Uganda**) had integrated fistula-related indicators into the national health management information system, indicating a move towards more standardized reporting of diagnosed and treated obstetric fistula cases, and the tracking of fistula data from facility levels to the national level.

In the **Republic of the Congo**, to improve the availability, timeliness and quality of health data on mothers and children, the use of Google sheets coupled with data-sharing workshops have been integrated into the National Health Information System for departmental directorates of health. By September 2018, 117 maternal deaths and 765 neonatal deaths were reported.

2.2 REGIONAL AND GLOBAL HIGHLIGHTS

Through the 2018 biannual International Obstetric Fistula Working Group (IOWFG) meeting and the International Society of Obstetric Fistula Surgeons (ISOFS) conference in Nepal, the MHTF contributed to the quality of care by providing a platform for enhancing knowledge and skills to prevent and treat fistula, and assure the social reintegration of fistula survivors. Two fistula survivors and advocates from Ghana and Uganda participated in the IOWFG meeting. As part of the ISOFS conference, a workshop helped surgeons enhance their skills for repairs. The 2018 Kathmandu Declaration on fistula

developed by the ISOFS, UNFPA and other partners recognized the persistence of obstetric fistula and increasing incidence of iatrogenic fistula, and called for improved quality of care and increased investment in fistula prevention and care. To improve care quality, 25 MHTF-supported countries have established mechanisms for follow-up on fistula repairs.

Building on the MHTF's work and expertise in midwifery, **UNFPA's regional office for Latin America and the Caribbean** has supported the Federation of Latin American Midwives to develop a survey to collect information about the role of midwives in SRHR programme management in Argentina, Chile and Uruguay. The purpose was to identify opportunities for training midwives to better exercise their roles as managers of sexual and reproductive health programmes at all organizational levels. The survey was aimed at midwives in management or administrative positions in health-care institutions and education programmes, or in government bodies such as ministries, councils or municipalities where midwives are involved in decision-making. The survey also targeted presidents of associations, federations and schools. Based on the results, a four-module training course was developed and conducted in six countries: Argentina, Brazil, Ecuador, Paraguay, Peru and Uruguay, reaching 78 midwives.

With MHTF support, **UNFPA's regional office in West and Central Africa** has initiated the development of a guidance for mentorship programmes and a specific training programme for mentors. The training will help improve the quality of maternal death reviews and generate in-depth and qualitative lessons learned for the health system.

In **Guinea**, 544 maternal deaths were notified, and 175 maternal deaths and 151 neonatal deaths were reviewed, including nine verbal autopsies, in the regions of Kankan, Labe and Mamou. Health system malfunctions identified by the review and the implementation of its recommendations will improve the management of obstetric emergencies in health facilities. Eclampsia, haemorrhage and infections were the main causes of death. The review noted that the first delay (time for decision to seek care) was the most deadly for patients. This allowed the adoption of response plans and their effective monitoring by the regional MPDSR committees.



©UN Photo/Martine Perret

Source: Based on UNFPA country reported data from 2018

Building on the work done with MHTF support in other countries, **UNFPA's Regional Office in Arab States** organized with WHO a meeting in Oman on Maternal Near-Miss (MNM) Reviews, which are proxy measures used to identify gaps in maternal health services and facilitate targeted actions. They allow to draw valuable lessons from the women whose lives were saved and enhance the robustness of the data collected, as maternal deaths are so rare. The meeting aimed to showcase a one-year cross-sectional study covering 23 health facilities in Oman that account for more than 90 percent of all deliveries in the country with the aim to assess the implementation of MNM reviews and response.

Recommendations from the meeting included the need to:

1. Integrate near-miss approach in the RH management to continuously improve quality of care
2. Target intervention for promoting informed choices of contraception
3. Integrate comprehensive sexuality education in rural areas.

Institutionalizing MPDSR is one of the priorities of the African Union (AU) commission action plan towards ending preventable maternal, newborn, and child mortality in Africa. Maternal Death Surveillance and Response is also one of the key areas for the implementation of the Commission on Information and Accountability (CoIA) framework for the UN Secretary-General's Global Strategy for Women's and Children's Health. CoIA aims to encourage countries to be more accountable for women's and children's health. Therefore, real-time monitoring is needed if accountability at the country level is to be achieved and maternal deaths reduced. With MHTF support, **UNFPA's East and Southern Africa Regional Office** initiated in 2014 a process to track the integration of MPDSR in national health systems from identified countries. Following that initiative, in November 2018, an MPDSR workshop was organized by UNFPA, WHO, and UNICEF East and Southern Africa (ESA) regional offices for 31 countries (18 countries in ESA region and 12 countries from the Western and Central African region). Progress in the past four years shows that critical components of the MPDSR system are in place in all ESA countries except for South Sudan. However,

despite this progress, functionality and effectiveness of the MPDSR systems vary between countries. The policies for maternal and perinatal death notification and review may be in place but face several challenges: low coverage of maternal death notification, inadequate review and reporting, lack of involvement from civil society and communities, and competing priorities in an already overtaxed health care system, among others. The targets are demanding but not impossible to achieve to ensure universal access to sexual, reproductive, maternal, newborn, child and adolescent health care for women, children, and adolescents during the era of the Sustainable Development Goals.

In observance of both Mother's Day and the International Day of the Midwife, UNFPA celebrated the beauty and strength of mothers and midwives through the First Moments Campaign, which consisted of a photo feature and an accompanying web story about Georgetta, a midwife in Liberia. Over 3 million people were reached through effective social media and web features around the International Day of the Midwife, propelling new awareness of the critical roles of midwives in SRMNAH.

The world today is witnessing a global rise in the overuse of unnecessary medical interventions and pre-emptive procedures during pregnancy and childbirth, such as episiotomies, ultrasound, Caesarean sections, antibiotics and labour augmentations.¹¹ To raise awareness of this growing concern, the MHTF team at global level organized a global symposium, **"Going Overboard with Interventions", at the International Federation of Gynecology and Obstetrics (FIGO) World Congress in 2018**, attended by over 10,000 medical practitioners and policymakers. The purpose was not only to better understand the causes and extent of overused interventions during pregnancy and delivery, but also to discuss potential solutions. The midwifery model of care (which focuses on supporting and maintaining normal physiological birth, and where midwives decide when referral or medical interventions are needed) as well as measures fostering professional collaboration between midwives and other health-care professionals were highlighted as two important ways forward.

11 The Lancet Maternal Health Series, 2016: www.thelancet.com/series/maternal-health-2016.

At the Global level, the MHTF team is contributing to the following technical groups to advance the MNH agenda and to further support countries to address preventable maternal mortality and morbidity, including:

- Mother and Newborn Information for Tracking Outcomes and Results (MONITOR)
- Network for Improving Quality of Care for Maternal, Newborn and Child Health (<http://www.qualityofcarenetwork.org/>)
- Improving Maternal Health Measurement Capacity and Use (IMHM - <https://www.hsph.harvard.edu/women-and-health-initiative/projects/improving-maternal-health-measurement-capacity-and-use/>)
- The Every Newborn - Birth Indicators Research Tracking in Hospitals (EN-BIRTH) study (<https://www.ncbi.nlm.nih.gov/pubmed/30863542>)
- EmONC global working group
- MPDSR technical working group
- Midwifery global advocacy group

- International Obstetric Fistula Working Group (UNFPA/MHTF convenes this group)
- WHO social, behavioral, and community engagement core group.

2.3 DRIVING THE TECHNICAL AGENDA FOR EQUITY IN ACCESS, QUALITY OF CARE AND ACCOUNTABILITY: MHTF APPROACHES IN THE FOUR INTERVENTION AREAS

2.3.1 Midwifery

Midwifery is one of the pillars of maternal health and one of the most cost-effective strategies to provide quality, comprehensive maternal and newborn care and other SRH services. Midwifery in its broad scope of practice illustrates the MHTF's integrated and catalytic approach, and remains a key intervention in ending preventable maternal and newborn mortality. In addition to antenatal, intrapartum and postnatal care, EmONC, and prevention and diagnosis of obstetric fistula and uterine prolapse, midwives provide family planning and post-abortion care services. They can help to prevent mother-to-child

UNITED NATIONS GENERAL ASSEMBLY ADOPTS NEW RESOLUTION TO END FISTULA WITHIN A DECADE

Based on the recommendations of the 2018 UN Secretary-General's Report on Intensifying Efforts to End Fistula within a Generation, the Third Committee (Social, Cultural and Humanitarian) of the UN General Assembly on 7 December 2018 unanimously adopted a Resolution (A/RES/73/147) calling on the global community to intensify efforts to end obstetric fistula.

The resolution recognizes that intensified global and national investment as well as national ownership and leadership, political commitment and scaled-up national capacity are urgently needed to accelerate progress towards the elimination of fistula. Countries, especially those with the highest maternal mortality and morbidity levels, need strategies to prevent new cases of fistula and treat all existing ones. The resolution further calls on UN Member States to take all measures to ensure the rights of women and girls

to the highest standard of mental and physical health, including sexual and reproductive health and reproductive rights.

Calling for UNFPA and the Campaign to End Fistula to lead the development of a global road map providing strategic direction to end fistula, the resolution further notes that a human rights-based approach to eliminating fistula should be underpinned by accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation.

UNFPA and the Campaign to End Fistula played a key role in advocating for the resolution, and worked closely with Member States to bring talks to a successful and agreeable conclusion.

PILLARS OF THE UNFPA GLOBAL MIDWIFERY STRATEGY 2018-2030 (developed with the MHTF support)

- Ensuring midwifery education and continuous training and support (e.g. through mentorship)
- Strengthening midwifery regulation and associations
- Improving deployment and retention of midwives, including through an enabling environment
- Recognizing midwifery as critical for the provision of integrated SRMNAH services



transmission of HIV, malaria in pregnancy and sexually transmitted infections.

2018 marked the finalization of the new UNFPA Global Midwifery Strategy (2018-2030), which is aligned to the SDGs and the UN Secretary-General's Strategy on Women's, Children's and Adolescents' Health. The new strategy combines three existing pillars on midwifery education, regulation and association with three new ones: the midwifery workforce, on the retention and deployment of midwives; an enabling environment for midwives to practice their profession; and recognition of midwifery as integral to SRMNAH. The MHTF also

supported the development of an implementation guidance that describes the holistic approach needed to implement all six pillars of the strategy.

The key focus in 2018 was in improving the quality of midwifery services. This encompassed stronger competency-based curricula better integrated with broader SRMNAH issues (including abortions where legal, cervical cancer screenings, uterine prolapse, gender-based violence and FGM) and better-equipped midwifery institutions, with more competent faculty and mentorship programmes for midwives to improve their clinical skills (including EmONC) and provide respectful maternity care.

MHTF SUPPORTING YOUNG MIDWIFERY LEADERS

The Young Midwifery Leaders programme supported by the MHTF has helped to create a network of young midwives with leadership skills to advance their profession in supported countries and beyond. With MHTF support to the UNFPA's Regional Office for Latin America and the Caribbean, the programme was instituted in Latin America in 2013 and the Caribbean in 2016, and in Mexico in 2017. It utilizes a mentorship model, where experienced midwife leaders transfer their knowledge and experience, and facilitate mentees' acquisition of leadership skills. Two phases comprise one-month mentor preparation, followed by 15 to 16 months where mentees complete a series of modules and

leadership activities that prepare them to understand the policy environment and health needs of women. They also learn about global and regional issues influencing adolescents' and women's health and reproductive rights.

Programme graduates go on to become leaders in their countries and help to address the challenges that prevent midwives and women from achieving their full potential. They have led the Midwifery Association in Paraguay, contributed to updating the midwifery curricula to include SRH and the prevention of domestic violence in Chile, and started new midwifery programmes in Argentina and the Mexican states of Guerrero and Hidalgo.

For example, in Bangladesh, 356 midwives, including 20 faculty members, took part in a 28-day SRH competency-based training with a special focus on menstrual regulation, post-abortion care, family planning (particularly post-partum) and gender-based violence. Such trainings allow midwives to improve comprehensive SRH in EmONC facilities. In Uganda, 584 midwives received training on gender-based violence and adolescent health care. In Burkina Faso, over 400 midwives learned about contraceptive methods, family planning logistics management and reproductive health for adolescents. More MHTF countries are focusing on strong mentorship programmes, including Bangladesh, Guinea Bissau, Ethiopia, Kenya, Mozambique, Rwanda, Uganda and Zambia. In the last, midwifery training institutions are well linked with EmONC facilities for clinical skills training, and UNFPA has properly equipped skills labs. Ethiopia has finalized national guidelines to standardize mentorship programmes.

The lack of midwifery tutors is a huge bottleneck in the education system and the provision of sufficient numbers of graduated midwives as well as their ability to provide quality of care. In 2018, the MHTF continued to strengthen the capacities of midwifery tutors in key

life-saving skills, using multimedia e-learning modules supplemented with hands-on learning in skills labs and basic EmONC facilities.

Other areas of focus remained strengthening midwifery workforce policies, building the skills and capacities of midwifery association to advocate for their profession, and strengthening regulatory frameworks.

Lessons learned

Governments continued in 2018 to struggle with the deployment and retention of midwives, and workforce policies remained weak. The need for midwives to conduct a number of independent deliveries during their practice period is essential, but remains a bottleneck that needs to be removed. Although more countries have invested in midwifery education and the number of available midwives is increasing, the quality of care remains uneven. Improvement is still needed in identifying complications and providing the right care and referral. Another issue is deployment. About 50 per cent of MHTF-supported countries reported that less than 20 per cent of new graduates were deployed within

MIDWIVES AT THE FOREFRONT OF IMPROVING ACCESS TO REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS IN THE DEMOCRATIC REPUBLIC OF THE CONGO

Midwives have played a major part in the humanitarian response in the Democratic Republic of the Congo, especially in provinces such as Kasai and Tanganyika, where they provide free reproductive health services and family planning to displaced people. In Kinshasa, Kalemie, Tshikapa and Boma, midwives have helped recruit more than 10,000 new users of modern contraceptive methods.

With the support of the MHTF, the Democratic Republic of the Congo has placed greater emphasis on training and educating midwives through e-learning modules. It has increased the training of midwifery teachers as well as gap assessments of midwifery institutions. Midwives trained with UNFPA and the MHTF support have been playing a growing role in providing quality SRMNAH care in humanitarian settings, ensuring equitable access for displaced women and their newborns.



© Junior Mayindu, UNFPA Democratic Republic of the Congo, June 2018. Photo submitted to the 2019 MHTF photo contest.

In the mobile clinic set up by UNFPA at the site for internally displaced people in Tanganyika province, a mother admires the baby she has just delivered thanks to a midwife trained by UNFPA. The camp supports more than 42,000 people; 15 per cent are pregnant women.

CELEBRATING THE INTERNATIONAL DAY OF THE MIDWIFE IN COUNTRIES

On 5 May 2018, as has become customary, all UNFPA country offices across the globe celebrated the **International Day of the Midwife**. The main theme in 2018 was “Midwives Leading the Way with Quality Care”. The purpose was to raise national awareness about the crucial role that midwives play in promoting maternal, newborn and adolescent health, and in reducing maternal and neonatal mortality and morbidity. The day also championed the achievements of midwives, and motivated policymakers to implement conducive workforce policies and enabling environments for midwives.

The MHTF developed a resource pack, including a social media pack, for all UNFPA country offices to guide efforts to advocate for midwifery around the day.

A variety of celebrations throughout MHTF-supported countries marked the International

Day of the Midwife in 2018. In **Burkina Faso**, 92 midwives and 152 midwifery students were trained on key interventions for the prevention of bleeding through the Helping Mothers Survive initiative, newborn resuscitation through Helping Babies Breathe, insertion and removal of IUDs, family planning services and cervical cancer screening. The celebrations in **Ghana** provided a critical moment for advocacy and brought attention to revisions of the budgeted strategic action plan for the Ghana Registered Midwives Association. In **Nepal**, a street rally mobilized over 250 nurses, midwifery students, and relevant experts and partners to reiterate the importance of the midwife. **Nigeria** marked the day by providing free reproductive health services to over 500 people in communities across the capital territory as well as Sokoto, Kaduna and Cross River states.

one year. Only 20 per cent of countries (Bangladesh, Côte d'Ivoire, Ethiopia, Rwanda, Sierra Leone, South Sudan and Zambia) reported that over 80 per cent of new graduates were deployed within one year.

Weak regulatory mechanisms, inadequate training in clinical skills at the pre-service level, and the lack of an enabling environment for midwives to practice their profession continued to impact the quality of midwifery care and practice.

While there is growing global commitment to quality midwifery as central to ending preventable maternal and newborn mortality and morbidity, finding the right strategies and coordinating global efforts are huge challenges.

There is a significant need for innovative and technology-driven approaches to improve the quality of both pre-service education and in-service training. Innovative training products, such as simulation-based trainings developed by Laerdal Global Health, and training and teaching videos, such as those developed by the Global Health Media Project, are worth investing in for quality improvements.

Improvements in regulatory mechanisms and an enabling environment for midwives need to be very seriously

addressed. For this, capacity-building and strong global, regional and national advocacy and partnerships are needed.

The tools and resources being developed in collaboration with the ICM – such as on respectful maternity care, quality curriculum, accreditation tools for schools, etc. – will need to be disseminated, and global capacity built on their usage.

Regional engagement and collaboration have seen steady improvements, including through UNFPA's regional offices. There have been steady gains through South-South learning. For example, after the UNFPA regional office for the Arab States produced a regional midwifery report in 2016, the UNFPA regional office for East and Southern Africa developed a similar report in 2017. In 2018, the office for the Pacific sub-region invested in a regional State of the World Midwifery report to analyse regional issues. These experiences have generated a wealth of information and understanding from which many lessons can be learned.

2.3.2 EMERGENCY OBSTETRIC AND NEWBORN CARE

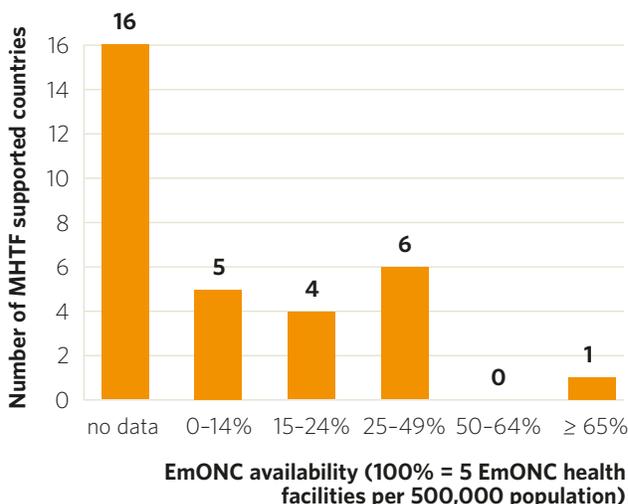
MHTF APPROACH FOR STRENGTHENING AVAILABILITY AND QUALITY OF EMONC SERVICES

- Identifying national network of referral (EmONC) health facilities to maximize the population covered within a defined travel time - using geographic accessibility (GIS/ AccessMod) and health facility characteristics
- Monitoring (through HMIS) key SRMNH indicators and availability of human resources, particularly midwives, in the EmONC health facilities
- Implementing quality improvement responses at all levels of the health system (“bottom-up” approach) with support teams and mentors.

An estimated fifteen percent of all pregnant women will develop a potentially life-threatening complication that calls for skilled care¹². Most of these are not predictable prior to labour, but almost all of them can be treated with appropriate management. This is why the MHTF supports EmONC facilities and deployment of midwives as critical strategies to reduce maternal and newborn mortality. Since Phase I of the MHTF, the Fund has supported countries to track EmONC indicators. Five countries are now able to regularly monitor these. Several other countries can report the “EmONC availability” indicator,¹³ using the EmONC Needs Assessment, its lighter version developed by UNFPA’s regional office for West and Central Africa¹⁴, the Service Provision Assessment¹⁵ or the Service Availability and Readiness Assessment.¹⁶ The MHTF shared available information on EmONC availability for the Countdown to 2030 report¹⁷, which uses the EmONC availability indicator to measure progress globally.

As illustrated by Figure 3, half of MHTF-supported countries are not yet able to document the EmONC

Figure 3. EmONC availability



availability indicator (or do not have reliable data for it). Timor-Leste is the only country supported by the MHTF that has reached 100 per cent EmONC availability.

In order to improve the situation, the MHTF-defined EmONC facility network approach aims to help countries establish 24/7 access to quality emergency care within two hours travel time. This approach uses GIS/ AccessMod software and a set of objective criteria related to the obstetric activity of health facilities, infrastructure and staff to identify national networks of referral (EmONC) health facilities. Two main criteria for selecting facilities are the number of deliveries and the potential catchment area of health facilities within two hours travel time.

This approach links population data with maternal and newborn health programme data. It also highlights the importance of road conditions and access to public transport as key factors in access to care, and can show how these conditions influence population coverage through modelled scenarios. Using the software AccessMod, the approaches allow to calculate the proportion of the population that would have access

12 Managing complications in pregnancy and childbirth: a guide for midwives and doctors – 2nd ed. Geneva: World Health Organization; 2017

13 Proportion of functioning health facilities with skilled birth attendants providing obstetric and neonatal services 24/7 and with no deficit in signal functions. The international recommendation is to have five EmONC facilities per 500,000 people. For more details, see WHO, 2009, *Monitoring emergency obstetric care – a handbook*.

14 Soins obstétricaux et néonataux d'urgence; Guide pour la réalisation des Enquêtes Rapides; UNFPA.

15 <https://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm>

16 https://www.who.int/healthinfo/systems/sara_introduction/en/

17 <http://countdown2030.org/pdf/Countdown-2030-complete-with-profiles.pdf>

to a maternity unit able to provide EmONC services within two hours of travel time (or less). This allows to measure population access to all maternity units, to the designated EmONC facilities (which can include functioning and non functioning facilities), and to functioning EmONC health facilities. This approach also includes a qualitative analysis of referral linkages between BEmONC and CEmONC health facilities. In countries using AccessMod, the MHTF supports the training of national GIS experts on the software¹⁸

In 2017, the MHTF assisted the Ministry of Health of Burundi in planning its EmONC national network using this approach, which provided outstanding results. Following this successful experience, in 2018, five additional countries requested the support of the MHTF

to identify their networks and define their baseline with the new population coverage indicators used in Burundi.

For example, in Guinea, health stakeholders in each region defined their network of EmONC facilities and, using AccessMod, derived the population covered by all the maternity units of a given region, the population covered by the designated EmONC facility and the population covered by functioning EmONC facilities. They also calculated gaps in the availability of midwives, considering that three to four midwives should be deployed in every EmONC facility in the network to ensure 24/7 access to obstetric services and improve quality of care, and the quality of the referral link between basic and comprehensive EmONC facilities.



Successful delivery in the mobile clinic of the Katanika displaced people camp, in Kalemie, province of Tanganyika (DRC), by Véronique, a UNFPA trained senior midwife.
©UNFPA DRC, Junior Mayindu, 2018. Photo submitted to the 2019 MHTF photo contest.

18 www.accessmod.org/

Figure 4. Map of the population density and EmONC network – Kankan Region, Guinea.

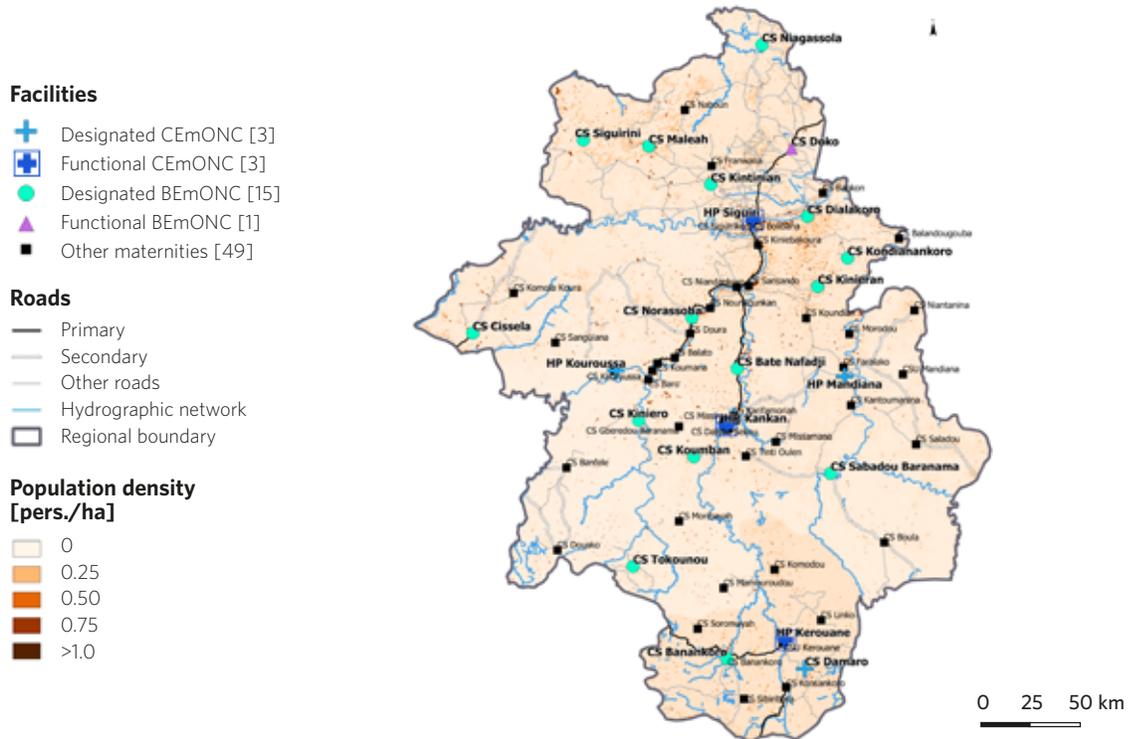


Figure 5. Map of the geographic accessibility to EmONC network - Kankan Region, Guinea.

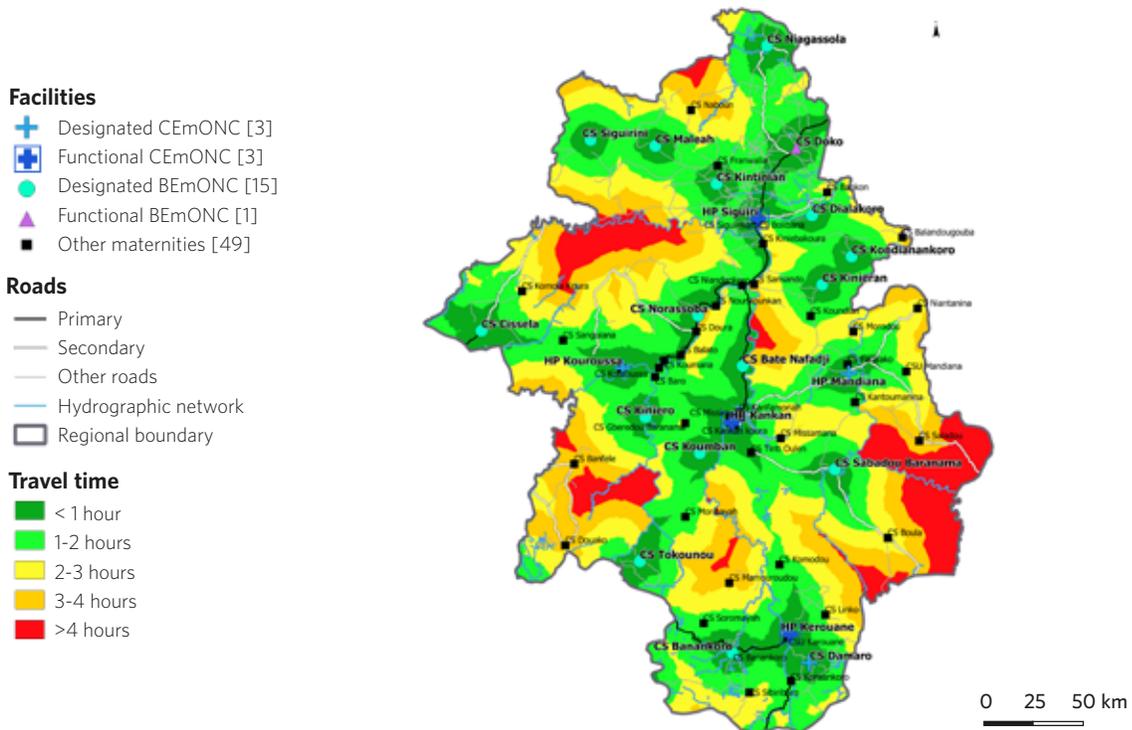


Figure 6. Map of the catchment areas of each EmONC health facility within 2 hours travel of time - Kankan Region, Guinea.

Facilities

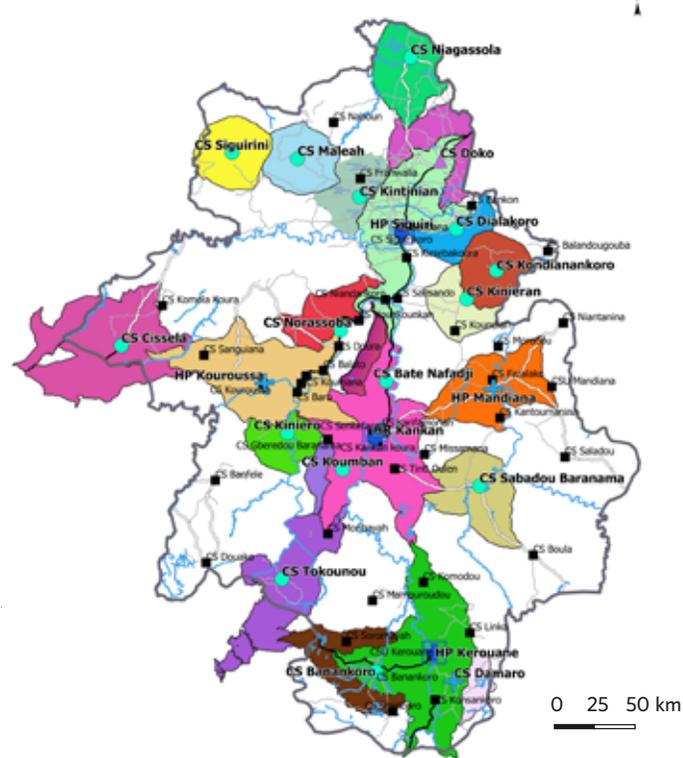
- + Designated CEmONC [3]
- + Functional CEmONC [3]
- Designated BEmONC [15]
- ▲ Functional BEmONC [1]
- Other maternities [49]

Roads

- Primary
- Secondary
- Other roads
- Hydrographic network
- Regional boundary

Catchment areas (120 min)

- | | |
|--|---|
| ■ CS Banankoro | ■ CS Niagassola |
| ■ CS Bate Nafadji | ■ CS Sabadou Baranama |
| ■ CS Cissela | ■ CS Siguirini |
| ■ CS Damaro | ■ CS Tokounou |
| ■ CS Dialakoro | ■ HP Kerouane |
| ■ CS Doko | ■ HP Kouroussa |
| ■ CS Kinieran | ■ HP Mandiana |
| ■ CS Kiniero | ■ HP Siguiri |
| ■ CS Kontinian | ■ HR Kankan |
| ■ CS Kondianankoro | |
| ■ CS Koumban | |
| ■ CS Norassoba | |
| ■ CS Maleah | |



Each regional group worked on EmONC network scenarios, using:

- A map matching population density and the designated network (facility distribution should fit with population density) – cf. Figure 4.
- A map measuring population access to the closest designated EmONC facility within one or two hours of travel time (in green), three or four hours of travel time (in yellow) or more (in red) – cf. Figure 5.
- A map showing the catchment (the area within two hours of travel time) of each EmONC facility of the EmONC network – cf. Figure 6.

A consolidation of subnational data allowed the development of a national accessibility map (cf. Figure 1) and the calculation of population coverage indicators at a national scale (See Table 1): 446 maternity units cover 94 per cent of the population in Guinea. Subnational working groups of the Ministry of Health designated

105 facilities to upgrade to EmONC facilities. This designated EmONC network covers 81 per cent of the population, yet the functioning EmONC facility network only covers 34 per cent. As the designated EmONC facility network defined by the working groups is realistic and limited to 105 facilities, the operational target of the Ministry of Health for the next programme cycle (next four years) is therefore to increase the population covered by a functional EmONC network from 34 per cent to 81 per cent while also improving the quality of services.

The methodology allowed the Ministry to define an immediate need for 116 midwives in the EmONC facility network. Further, it found that only 21 per cent of referral links between basic and comprehensive EmONC were rated “satisfactory”. This information supports the capacity of the Ministry to plan, monitor and report on the development of the EmONC network, and beyond to the implementation of the maternal and newborn health programme. Madagascar, Senegal and Togo have also defined national networks of EmONC facilities using the MHTF approach, and are ready for national monitoring,



©UN/MINUSCA/Hervé Serefio, Central African Republic, 2018.

including the quarterly monitoring of the deployment of midwives in the EmONC facilities, as well as measures addressing gaps in the availability and quality of care.

A national EmONC network provides a unique platform for the integration of SRMNAH services, and for the delivery of quality and respectful care. It should be supported by domestic and international funding as a key strategy for ending preventable maternal and newborn mortality and morbidity.

Lessons learned

Supporting other countries to implement the MHTF-defined approach to EmONC development requires additional experts in UNFPA's regional offices to provide consistent technical support, covering aspects from identifying the national EmONC network to monitoring key SRH indicators in health facilities to setting up quality improvements, including with the support of mentors. The regional office of West and Central Africa has started organizing a regional group of experts to support

countries. Further developing the approach also requires national expertise in GIS and AccessMod that the MHTF continues to help build. It also calls for quality data on population (ideally, recent census data), health facilities and GIS layers (such as road networks and geographic barriers). Monitoring the national EmONC network depends on a strong health management information system and strengthened use of data by all stakeholders in the maternal and newborn health programme.

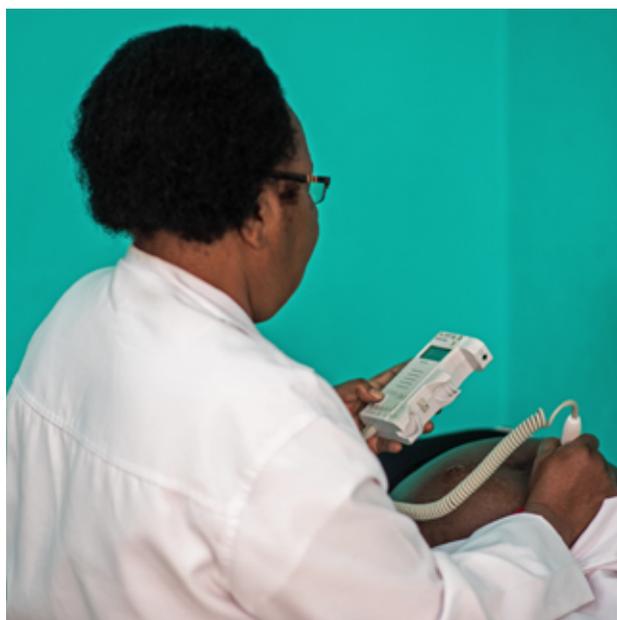
As many countries are ready to operationalize EmONC development at national scale, it is critical to coordinate available financial and technical capacities to move forward. Coordination and the efficient channeling of resources are still weak jeopardizing the MHTF's efforts to change maternal and newborn health conditions in countries with high burdens of mortality and morbidity. By leading the technical agenda on EmONC development, the MHTF contributes to aligning efforts on EmONC by different partners, including the Muskoka funds, the H6 partners and the Global Financing Facility (GFF).

2.3.3 Maternal and Perinatal Death Surveillance and Response

MHTF SUPPORT FOR IMPROVING THE IMPLEMENTATION OF MPDSR

- Strengthening the national monitoring of the maternal deaths notifications and reviews
- Improving the quality of the maternal deaths reviews and the identification and implementation of responses to address causes of maternal and perinatal mortality

The MHTF supports countries to improve their capacity to notify maternal deaths in the national health information system. In order to track notified maternal deaths, the MHTF created two indicators: the maternal death notification rate (number of maternal deaths notified to the central level of the Ministry of Health in a given year divided by the number of estimated maternal deaths in the same given year) and the maternal death review rate (number of maternal deaths reviewed in a given year divided by the number of estimated maternal deaths in the same given year).



Midwife monitoring fetal heart during antenatal care (ANC) visit. ©UNFPA Kenya, Phillip Odhiambo, 2018. Photo submitted to the 2019 MHTF photo contest.

Despite the fact that all MHTF-supported countries implement an MPDSR programme, and that the

notifications and reviews of maternal deaths have increased in many countries, only 12 countries (36 per cent) have assessed their MPDSR programme. Among them, one of the weaknesses identified has been the lack of quality in maternal death reviews.

One major MHTF aim in 2018 was therefore to strengthen the MPDSR process by supporting countries to improve the quality of maternal death reviews. This is an extremely important component because the conclusions and recommendations of death reviews inform and guide improvements in the quality of care to reduce preventable maternal deaths. To improve quality, the MHTF promotes the use of mentors with extensive clinical experience and the capacity to moderate the review process to ensure a comprehensive conclusion on where the health system failed, and where improvements are needed most. They should be able to build a trusting relationship with the staff of maternity units and facilitate internal analysis of what went wrong. Mentors are not supposed to review death cases at their own facility but at other health facilities where they have a “neutral” status. This fosters a “no-blame” approach during the review. Twenty-four MHTF-supported countries (72 per cent) now state they are using mentors to improve the quality of maternal death reviews.

The MHTF also recommends that MPDSR national committees create a national group of experts to analyse samples of maternal death reviews, and estimate their reliability and relevance in identifying the cause of death and analysing the determinants of respective cases. Experts should assess the quality of the reviews by direct observation, and also review the analysis made and provide feedback to the MPDSR national committee. The MHTF encourages the use of a new qualitative indicator of maternal death reviews: “the proportion of maternal death reviews of satisfactory quality (based on a defined standard)”.

With the MHTF support, UNFPA programme staff have participated in several maternal death reviews to observe how the meetings are organized as shown in the following case study.

CASE STUDY ON THE QUALITY OF THE REVIEW OF A MATERNAL DEATH

In September 2018, the midwife in charge of a basic EmONC facility called the regional hospital to refer Claire (name given to the patient for anonymity purpose), a 20 year old in her fourth pregnancy, for immediate treatment for post-partum haemorrhage. It took 30 minutes for the ambulance to reach the hospital (with a NaCL IV and 20 IU of Syntocinon/Oxytocin). Claire was examined by a student doctor who gave her Misoprostol for uterine atony (failure of the uterine smooth muscle to contract and constrict - uterine atony is responsible for the majority of post-partum haemorrhage cases). He called for an anesthetist but none was available. Claire died one hour later. Her baby (3,900 grams) survived.

In their report, the conclusions of the healthcare team on duty were the following: a) poor quality of antenatal care, b) late referral of a post-partum haemorrhage due to uterine atony, unsuccessful call for an anesthetist, c) Management of the post-partum haemorrhage with Misoprostol.

The review of this maternal death by the health facility team reported that she was followed at the regional hospital and that she attended seven antenatal care visits. They also mentioned that her obstetrician recommended that she delivers at the regional hospital because of a drepanocytose history, a likely big baby. However, she decided to deliver to the basic EmONC facility where the midwife induced the labour after five hours as the birth was slightly overdue. Following the vaginal delivery of the child (4kg and low Apgar scores - Appearance, Pulse, Grimace, Activity, Respiration - of 4 at 1 minute and 6 at 5 minutes on a scale of 10), she quickly showed low blood pressure and tachycardia. The review confirmed that the cause of death was a uterine atony.

At the end of 2018, the MPDSR regional committee reviewed four cases (out of 89 maternal deaths notified in the region). The regional director asked UNFPA to participate in the work of this Committee. UNFPA decided to behave as an expert group observing the functioning of this committee and used the following analysis grid:

Observations and issues identified	Proposed corrections	Comments
For the management of the case		
Non-adherence to the protocols (inducing labour in a basic EmONC facility) and no immediate adequate management.	To increase supervision.	Following the call, the regional hospital should be better prepared to manage such a case (obstetrician, operating room available).
Maternity unit of the regional hospital not ready to manage the case despite the call of the midwife.	Both the obstetrician and the anesthesiologist should have been available.	Quick diagnosis and quality of management are two important factors for survival in time of critical emergencies.
Weak diagnosis and inadequate management.	Need for an operational definition for categories of haemorrhage (protocol).	Inducing labour, very efficient contractions, oxytocin management do not indicate a uterine atony.
	After discussion with UNFPA, the head of the maternity unit agreed that the diagnosis was likely a uterine rupture.	Inducing labour (with no monitoring), short labour, low Apgar, 4-kilogramme baby, fast pulse, low blood pressure with no visible bleeding suggest uterine rupture.
Insufficient technical support from senior staff.	Both an obstetrician and anesthesiologist should be on call in the hospital.	Quick diagnosis for adequate management.
In the review process by the regional MPDSR committee		
The doctor who presented the case to the review committee had managed the case.	Someone less involved in the case should have presented the review to the committee.	High risk of bias because s/he may omit some information.
Nobody asked why the patient decided to deliver in the basic EmONC facility rather than in the regional hospital.	The maternal review file should be more comprehensive and discuss the social and financial sides.	UNFPA asked the question and found out that delivery in the regional hospital is much more expensive, and that midwives are promoting private services.
Maternal and perinatal death review methodology could be improved.	The steps of the review should be followed more closely. Discussion on financial and social determinants should be included.	Consider a more rigorous approach to make a diagnosis, consider social and financial issues, and analyse health system weaknesses.

During the review, the obstetrician leading the meeting blamed the midwife who induced the labour (who was not present at the review) and minimized the hospital's responsibility.

However, by the end of the review, the committee concluded that the cause of death was not a uterine atony but a uterine rupture. Further, the committee highlighted that the hospital was not well organized to manage the situation and that no investigation took place to understand the root causes of her death. Financial issues were a primary factor as Claire decided not to deliver at the regional hospital because of its cost.

On a more positive note, the review ended with a follow-up of the previous recommendations. A phone network set up to advise staff in basic EmONC facilities that had been cut off due to a lack of funding is now supported by the regional administration. This is a good improvement of the system based on the maternal death reviews by the regional committee.



© Anju Gurung, UNFPA Bangladesh, 2018. Photo submitted to the 2019 MHTF photo contest.

This case study shows that observation remains the best approach to assessing the quality of the maternal reviews. The MHTF Phase III Business Plan has highlighted the need to improve the quality of the MPDSR programme, and will support and monitor these interventions.

Lessons learned

To ensure that the four components (national guidelines and tools; functional national review committee; mandatory maternal death notification; MPDSR costed plan) of the MPDSR programme are established in every MHTF-supported country, closer follow-up of yearly workplans is necessary. In addition of monitoring these programme components, countries should monitor the effective implementation of the programme through indicators such as the maternal deaths notification rate, the maternal deaths review rate, and the proportion of maternal deaths reviewed with satisfactory quality.

As maternal and newborn health are indivisible, UNFPA, other UN agencies as well as main partners and stakeholders involved in maternal and newborn health consider necessary to associate MDSR with Perinatal, hence its consideration in Phase III.

2.3.4 Obstetric Fistula - systemic changes towards its end

MHTF SUPPORT FOR STRENGTHENING HEALTH SYSTEMS TO ADDRESS OBSTETRIC FISTULA

- Supporting the transition from ‘campaign mode’ to routine obstetric fistula repairs by improving capacities of treatment centers and surgical teams
- Improving data on obstetric fistula through global estimates and HMIS, including the monitoring of the quality of repairs
- Advocating and providing technical support for the inclusion of obstetric fistula in national health insurance schemes
- Evaluating social reintegration programmes for fistula survivors

Ending the health and human rights violation of obstetric fistula is essential to realizing the promise and vision of the Programme of Action of the International Conference on Population and Development (ICPD) and achieving the Sustainable Development Goals. Fifteen years after UNFPA, together with partners, launched the global Campaign to End Fistula in 2003, global, regional and national partnerships; coordination mechanisms; investments and initiatives to address maternal, newborn and child health; and country ownership and commitment remain key to preventing and treating fistula, and reintegrating survivors.

As previously highlighted, in 2018, the MHTF supported fistula prevention through integrated, cost-effective interventions to reduce maternal mortality and morbidity by improving skilled attendance at birth (through support to pre- and in-service training of midwives), access to family planning and timely access to EmONC.

The MHTF also assisted countries to develop robust health systems with expertise and health facilities to treat obstetric fistula and shorten treatment pathways. In 2018, the treatment capacities of 238 health facilities in 32 MHTF-supported countries were expanded through strengthening surgical repair/treatment and care teams, and providing medical supplies and surgical equipment. A total of 866 health-care providers, apart from fistula surgeons (including nurses, midwives, doctors and anaesthetists), received training in fistula prevention and management.

Given the extreme marginalization and “invisibility” of women and girls living with fistula, prevalence data are limited, and estimating the number of people affected as well as treatment needs can be challenging. Supporting efforts to generate updated, robust fistula data has been a key priority of the MHTF and the Campaign to End Fistula in recent years. This effort and investment bore fruit at the MHTF global planning meeting in Nairobi, Kenya in September 2018, where UNFPA and the Johns Hopkins University School of Public Health, a campaign partner, presented new preliminary estimates of the prevalence of fistula at the global level and for the over 50 countries supported by the campaign, including all MHTF-supported countries. Colleagues at country, regional and global levels then had the opportunity to participate in an interactive session to help vet the data and plan finalization.

This work has since advanced significantly, and is scheduled for publication and dissemination in 2019. The data will support countries to estimate their needs and facilitate

evidence-based planning, programming and policymaking to address gaps and realistically eliminate fistula.

Some of the most successful interventions supported by the MHTF raise awareness and commitments to ending fistula. They include the national commemoration of the International Day to End Obstetric Fistula (May 23), free registration of clients under national health insurance schemes, training obstetric fistula survivors as advocates, sensitization and awareness creation on district and community radio stations, and establishment of hotlines. Through consistent, concerted efforts, advocacy, and intervention on the part of UNFPA and partners in the Campaign to End Fistula, governments and other key stakeholders, access to fistula treatment has increased substantially. Among MHTF-supported countries, 27 now provide routine and continuously available fistula treatment services in strategically selected hospitals.

Despite this achievement, equitable access to fistula treatment remains a challenge, resulting in many women and girls continuing to suffer needlessly. Beyond medical and surgical treatment, a holistic approach that addresses the psychosocial and socioeconomic

needs of survivors is required to ensure full recovery and healing. Social reintegration for survivors, however, continues to lag behind, with services offered to only a fraction of patients. Follow-up is still a major gap in the continuum of care. In 2018, 2,177 women and girls in MHTF-supported countries received varied forms of social reintegration, including village banking (Zambia), microfinance (Benin and Côte d'Ivoire); vocational and income-generation skills training and small business management (Burkina Faso, Chad, Guinea Bissau, Kenya, Nigeria, Sierra Leone, Togo, Uganda), and training in SRHR and as safe motherhood ambassadors (Mozambique and Ethiopia, respectively).

Intensive social reintegration of women and girls whose cases are deemed to be inoperable or incurable also remains a major gap. Since these women endure significant social challenges, an individualized approach, tailored to their specific needs, is required to facilitate reintegration. Promising programmatic models such as the UNFCU Foundation-funded initiative to support women and girls deemed inoperable and incurable in fragile regions in northern Nigeria (in partnership with a local NGO, Fistula Foundation Nigeria) are leveraging

RESTORED HOPE AND DIGNITY: THE STORY OF MANJU, A FISTULA SURVIVOR IN NEPAL

Manju Khadka (right) is all smiles as she sits in her relative's home after being discharged from BP Koirala Institute of Health Sciences, a hospital in eastern Nepal, following a successful fistula surgery. The 37-year-old is excited to be finally dry and no longer leaking urine. Manju was 25 when she developed fistula, caused by obstructed labour without timely access to a Caesarean section. She lived with the condition for 12 years, wondering if she would ever be healed. Fortunately, her sister-in-law (left) discovered that the hospital offers treatment for fistula patients. Realizing that there was hope for Manju to heal and regain her dignity, she travelled eight hours on a bus and walked six hours on foot to reach Manju's village so she could bring her to the hospital. In May 2018, Manju underwent a successful repair, and can now mingle and live in the community and with her family, without shame.

Manju is one of 49 women and girls repaired at BP Koirala in 2018. Nepal launched the Campaign to End Fistula in 2010, and since

then, UNFPA, with the support of the MHTF, has worked with the Government and other partners to end and prevent obstetric fistula. This includes strengthening the capacity of health institutions to improve maternal health outcomes by providing quality services for repairs and the rehabilitation of fistula survivors.



©UNFPA Nepal, Santosh Chhetri, 2018. Photo and story submitted to the 2019 MHTF photo contest.

MHTF SUPPORTING THE UNFPA-LED GLOBAL CAMPAIGN TO END FISTULA

Through its network of nearly 100 partners, the UNFPA-led global Campaign to End Fistula has generated significant awareness of obstetric fistula at the global, national and subnational levels. It has mobilized efforts to extend treatment, social rehabilitation and reintegration. Through consistent, concerted advocacy and intervention by UNFPA, governments, campaign partners and other key stakeholders, access to fistula treatment has increased substantially since the

launch of the campaign. Given sustained support for strengthening health systems, and developing country ownership and leadership, a gradual shift can be seen from repair campaigns to routine treatment services. These are increasingly anchored in national health strategies, plans and budgets, and fully integrated into health systems through strategically selected hospitals that provide continuous and holistic fistula care (e.g., in Côte d'Ivoire, Ethiopia, Madagascar and Uganda).

technical support and assistance from the MHTF and Campaign to End Fistula to address this critical shortfall.

In Phase III of the MHTF Business Plan, countries will be further supported to strengthen national programmes to end fistula, including by implementing evidence-based social reintegration programmes. Country ownership and leadership remain key to sustaining efforts to prevent and treat fistula.

Lessons learned

The persistence of fistula is a violation of the rights of women and girls living with the condition and an indicator of a failing health system. Though 2018 saw some progress on indicators for addressing obstetric fistula, urgent and significantly increased actions and investments are required to eradicate the problem. Key to this achievement will be the availability of in-country financial and human resources, including qualified midwives, as well as technical expertise and quality data to inform programmes. Technical and financial support from the international community remains important for fistula-affected countries to eliminate obstetric fistula within a decade.

STRENGTHENED COORDINATION AND PARTNERSHIPS HELP REDUCE OBSTETRIC FISTULA IN UGANDA

With the support of the MHTF and the Campaign to End Fistula, the National Fistula Technical Working Group in Uganda continues to play a key role in oversight, monitoring, coordination and stronger partnerships for the national fistula programme. In 2018, the working group was instrumental in the successful development and costing of a new national fistula strategy (2019-2024), which aligns to key national and international policies and strategies, including the Health Sector Development Plan, the Vision 2040 and the Sustainable Development Goals, with the aim to leave no one behind.

The working group has fostered continued awareness of the urgent imperative to end fistula at the national, district and community levels. Advocacy efforts, such as the commemoration of the International Day to End Obstetric Fistula, have advanced political, financial and community support. In 2018, 1,188 women with fistula were repaired with support from UNFPA and the MHTF, and 400 women and girls received social reintegration assistance.

The latest Demographic and Health Survey in 2016 reported a downward trend in fistula prevalence, underscoring the importance of the partnerships and support coordinated by the working group as well as broader progress in maternal and newborn health¹⁹. Key global and local partners supporting the Ugandan government who have been part of



©UNFPA Uganda, Evelyn Matsamura Kiapi, October 2018. Photo and story submitted to the 2019 MHTF photo contest.

Freda Lanyero, a midwife serving in Belameling HIV IV, Palorinya Refugee Settlement, Uganda, admires a baby she safely delivered. Midwives are key to the prevention of fistula. For every maternal death, 20 to 30 more new mothers experience morbidity such as fistula. With the placement of a midwife, no maternal deaths have been recorded in the last two years at the health centre where Freda works. The health centre delivers 60 to 70 babies a month. In 2018, with UNFPA support, 17 midwives recruited and deployed in the refugee settlements in Uganda assisted 22,254 pregnant women to give birth.

Uganda's achievements include UNFPA, the MHTF and the Campaign to End Fistula; USAID and the Fistula Foundation; the African Medical and Research Association; Terrewode; World Vision; Women at Work International; Medical Teams International and the Uganda Village Project.

19 Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015.

PART

3

©UN Photo,
Isaac Billy, South
Sudan, 2018.



MANAGEMENT AND RESOURCES

3.1 MANAGEMENT AND MONITORING OF THE MHTF

The MHTF comprises two multidonor funding streams: the Thematic Fund for Maternal Health (ZZT06) and the Thematic Fund for Obstetric Fistula (ZZT03).

As is the case with most multilateral organizations, donors are earmarking more and more of UNFPA's resources for a specific purpose or region.

While it is positive that such non-core resources continue to increase, earmarking creates challenges in ensuring that the many pockets of non-core funds are not deployed in isolation but work together towards the realization of UNFPA's Strategic Plan. Accordingly, MHTF funds are allocated to countries based on a specific set of criteria to ensure that they are used where they are most needed and aligned with other UNFPA resources and the Strategic Plan (Figure 7).

Figure 7. MHTF resource allocation criteria and weighting in 2018

MHTF resource allocation criteria and weighting	Weight, percentage
Maternal mortality ratio	20
Skilled birth attendance	20
EmONC availability	20
Expenditure rate	20
Maternal health programme monitoring (the extent to which information is available at various levels in the country)	20
Total	100

MHTF-supported countries receive a score for each category. Cumulatively, these form the basis for the annual resource envelope from the MHTF. To mitigate the impact of sudden changes in allocations, a cap limits budget reductions to 10 per cent from year to year.

In 2018, the MHTF continued to work in high maternal mortality countries in accordance with its programme agreement. Funds were allocated to activities in 39 countries and 4 regional offices (Arab States, East and Southern Africa, Latin America and the Caribbean, and West and Central Africa).

The two funding streams above mentioned have been programmatically integrated since 2009. Most funding for the Campaign to End Fistula is now provided directly from the Thematic Fund for Maternal Health, since this eases coordination and programme management. Only 3 per cent of overall funds for the MHTF and fistula programming was provided via the Thematic Fund for Obstetric Fistula.

In terms of monitoring, a new Results Indicator Framework has been developed for Phase III and will be implemented from 2019. The UNFPA team, based at headquarters in New York and supported by regional offices, monitors country office workplans and reporting throughout the year. In 2018, a survey collected additional quantitative and qualitative information on strategic interventions.

3.2 MANAGEMENT AND RESOURCES.

Contributions

As shown in Figure 8, the Thematic Fund for Maternal Health received US\$3.7 million and the Thematic Fund for Obstetric Fistula US\$0.4 million in 2018, a 40 per cent decrease from 2017, when the two funds received US\$6.9 million.

Figure 8. Donor contributions to the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula in 2018

Donors	Thematic Fund for Maternal Health (US\$)	Thematic Fund for Obstetric Fistula (US\$)	Collected revenue (US\$)*
Friends of UNFPA	14,550	3,429	17,979
Germany	1,620,813	0	1,620,813
Luxembourg	1,967,593	347,222	2,314,815
Poland	0	61,893	61,893
Interests and adjustments	119,998	8,506	128,504
Total	3,722,954	421,050	4,144,004

*Collected revenue comprises actual amounts transferred from donors to UNFPA in 2018.

Figure 9. Donor contributions to the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula in the fourth quarter of 2017 for use in 2018.

Donors	Thematic Fund for Maternal Health (US\$)	Thematic Fund for Fistula (US\$)	Total (US\$)
Friends of UNFPA	13,864	526	14,390
Germany	1,061,321	0	1,061,321
Poland	0	98,728	98,728
Swedish International Development Cooperation Agency	3,592,384	0	3,592,384
Interest and adjustments	136,219	7,983	144,201
Total	4,803,788	107,237	4,911,024

MOBILIZING DOMESTIC RESOURCES FOR FISTULA THROUGH A GALA AFFAIR IN THE DEMOCRATIC REPUBLIC OF THE CONGO

In 2018, the Democratic Republic of the Congo, with the support of the MHTF, organized an evening gala to mobilize resources for the national fistula programme. Unique in the country, the event brought together prominent government officials, ambassadors, politicians, parliamentarians, mining and oil companies, UN

heads of agencies, heads of international NGOs and civil society, academia and obstetric fistula survivors. Participants pledged support in cash and other ways to support the fight to end fistula in the country, mobilizing US\$120,000. This supported fistula repairs for 996 women and girls in 2018.

Operating budget

The operating budget for the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula in 2018 encompassed the end-of-year balance for 2017 plus income received during the first three-quarters of 2018. Income received during the fourth quarter is typically carried over to the following year, since it normally cannot be programmed and expended within such a short time frame. In accordance with the International Public Sector Accounting Standards, transactions are only recorded as expenses when the services or goods have actually been carried out or handed over to the implementing partner.

As Figure 9 shows, the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula received US\$4,911,826 in the fourth quarter of 2017 to be used in 2018. An additional US\$5,220,441 was carried over from the regular programme budget from 2017 to 2018. Further, US\$2,332,794 was received in donor contributions during the first three-quarters of 2018. This brought the total operating budget for the Thematic Fund for Maternal Health to US\$12,465,061 in 2018 (Figure 10).

Figure 10. Budget for the Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula, 2014 to 2018 (in US\$)



Expenses

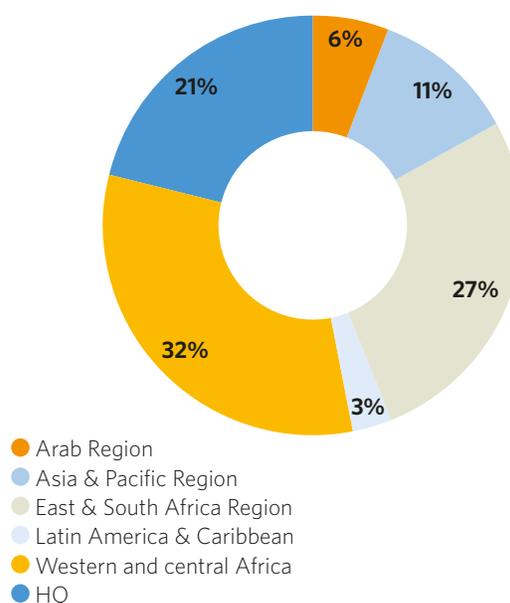
In 2018, expenditures for maternal health through the Thematic Fund for Maternal Health totaled US\$12.1 million (US\$12,067,835) compared to US\$13.3 million in 2017, US\$13.6 million in 2016, US\$13.4 million in 2015 and US\$16.8 million in 2014.

During 2018, spending by country and regional programmes accounted for 79 per cent of expenditures, whereas global activities accounted for 21 per cent. Included in the global activities are disbursements of US\$326,631 to international implementing partners. When accounting for the fact that international implementing partners use resources for country and regional level operations, the distribution was 82 per cent for countries and regions, and 18 per cent for global activities.

Out of total expenditures, 14 per cent or US\$1.7 million was disbursed via NGOs; 24 per cent or US\$2.9 million via a governmental partner; and 62 per cent or US\$7.7 million via UNFPA directly.

West and Central Africa accounted for most of the expenses for maternal health, with 32 per cent (US\$3.9 million) of the total. East and Southern Africa came second at 27 per cent (US\$3.2 million). Headquarters expenses constituted 21 per cent (US\$2.5 million).²⁰ Asia and the Pacific accounted for 11 per cent (US\$1.4 million), the Arab States for 6 per cent (US\$0.7 million), and Latin America and the Caribbean for 3 per cent (US\$0.4 million). See Figure 11.

Figure 11. Shares of expenditures for the Thematic Fund for maternal health and the Thematic Fund for Obstetric Fistula by region and globally in 2018



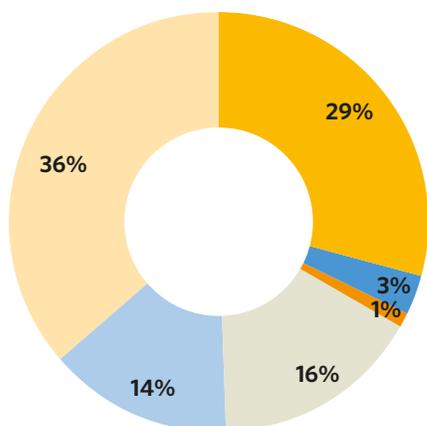
²⁰ Includes activities at headquarters and by implementing partners such as research institutions, NGOs, etc., the majority of which support activities at the country level.

In 2018, the US\$12.1 million in expenditures on maternal health represented a financial implementation rate of 97 per cent against the total operational budget of US\$12.5 million. The amount transferred to 39 country offices, 4 regional offices and headquarters units was US\$10.3 million.

Categories of expenditure

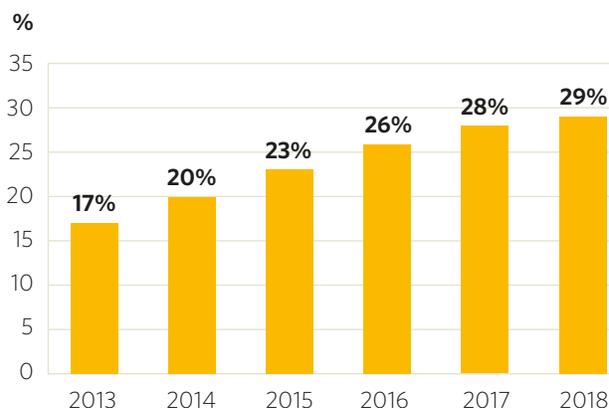
As highlighted in Figure 12, the total allocation to country, regional and global programmes in 2018 was US\$12.4 million, and the corresponding expenses were US\$12.1 million. The expenditure categories are presented below.

Figure 12. MHTF staff costs as a percentage of total expenses (in US\$)



- Staff and other personnel costs
\$3,504,648.64
- Supplies, commodities, materials
\$374,723.42
- Equipment, vehicles and furniture including depreciation
\$142,127.04
- Contractual services
\$1,957,361.01
- Travel
\$1,735,900.02
- Transfers and grants counterparts
\$23,129.52
- General operating and other direct costs
\$4,329,945.67

Figure 13. MHTF staff costs as a percentage of total expenses





Vardine Jean-Baptiste, midwife country counselor at UNFPA Haiti, sensitizes a group of girls about the risks of early pregnancy during a mobile clinic held in Jean-Rabel, less-favoured area of Haiti. ©UNFPA Haiti, Louis Flaubert Junior Jean-Michel, 2019.

PART

4



©UNFPA Sierra Leone, Angelique Reid, 2018. Photo submitted to the 2019 MHTF photo contest.

WAY FORWARD

2018 marked a transitional year from Phase II to Phase III of the MHTF. The **new MHTF Business Plan** draws upon the lessons learned from the first two phases, and provides a roadmap and strategic direction for the third phase from 2018 to 2022. A global MHTF meeting in Kenya in September helped build common understanding among MHTF participating UNFPA country offices of the strategies, priorities and monitoring framework of the new Business Plan (www.unfpa.org/publications/maternal-and-newborn-health-thematic-fund).

Going forward, the focus will remain on using a **holistic, integrated SRMNAH approach** to ensure human rights-based, gender-responsive, sustainable results, and a focus on equity in access, quality of care, and accountability, across the course of life. For instance, following the roadmap defined by UNFPA's new global midwifery strategy, a highly integrated midwifery programme will ensure that the midwifery curriculum is well designed according to global ICM and WHO standards. It will further the competencies of midwives to deliver the essential package of SRMNAH services: safe abortion (where legal) and post-abortion care; HIV/STI testing; prevention and early management of obstetric morbidities like fistula and uterine prolapse; cervical and other reproductive cancer screenings; prevention and response to gender-based violence; and FGM screening. Special attention will be paid to the retention and equitable deployment of midwives in EmONC facilities. Midwives will also be trained to support maternal death notification and response mechanisms.

Compared to 39 countries in the previous two phases, a total of 32 countries will receive focused support from the MHTF.

The MHTF will continue to leverage its catalytic impact through partnerships (H6, GFF, civil society and the private sector, the Campaign to End Fistula) and upstream policy advocacy at global and national levels. Dialogue with policy makers will aim at systematic health system strengthening as well as strong SRMNAH policies and programme implementation. Evidence-based approaches will be advanced through participation in various global networks such as the Quality of Care Network, Ending Preventable Maternal Mortality and Every Newborn Action Plan working groups. Technical and financial support from the MHTF will also go

towards the generation of research and data, such as the next State of the World's Midwifery Report in 2021; EmONC network development and monitoring and EmONC needs assessments; updated global and national estimates of obstetric fistula prevalence; new clinical and programme development guidelines for fistula; and maternal death surveillance and notification reports that will feed into policy advocacy as well as programme design and implementation. A global roadmap to end fistula will be designed as mandated by the 2018 General Assembly resolution to end fistula within a decade. UNFPA's new Global Midwifery Strategy (2018-2030) will be widely disseminated to global audience and stakeholders, and launched at the Women Deliver and the ICM regional conference in Namibia in 2019. And the implementation manual for developing national network of referral health facilities (EmONC) will be released.

Quality results are not possible without the **capacity development of staff and stakeholders**. The MHTF will continue to provide technical support and collaborate with partners to strengthen the capacities of UNFPA staff (e.g., country midwife advisors, and fistula and EmONC focal persons), national governments and other stakeholders to deliver **quality programmes. Innovative technology-driven approaches** – such as e-learning and m-learning, GIS mapping, and low-dose/high-frequency Helping Mothers Survive and Helping Babies Breathe programmes – will drive the MHTF support for equitable access to quality SRMNAH programmes.

Across all aspects of programme design and implementation, the MHTF will continue to uphold accountability through its focus on improving equitable access to quality maternal and newborn health care programmes that focus on respectful and women-centered care.

ANNEX



CAMPAIGN TO END FISTULA PARTNERS

1. Aden Hospital, Yemen
2. African Medical & Research Foundation (AMREF)
3. American College of Nurse-Midwives (ACNM)
4. Babbar Ruga Fistula Hospital
5. Bangladesh Medical Association (BMA)
6. Bill and Melinda Gates Institute for Population and Reproductive Health
7. Bugando Medical Centre, Tanzania
8. CARE
9. Centers for Disease Control and Prevention (CDC)
10. Centre Mère-Enfant, Chad
11. Centre National de Référence en Fistule Obstétricale (CNRFO), Niger
12. Centre National de Santé de la Reproduction et du Traitement des Fistules, Chad
13. Columbia University's Averting Maternal Death and Disability Program (AMDD)
14. Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)
15. CURE International Hospital of Kabul, Afghanistan
16. Direct Relief International
17. Dr. Abbo's National Fistula and Urogynaecology Center, Sudan
18. East Central and Southern Africa Association of Obstetrical and Gynaecological Societies (ECSAOGS)
19. EngenderHealth
20. Equilibres & Populations
21. Eritrea Women's Project
22. Family Care International
23. Fistula e.V.
24. Fistula Foundation
25. Fistula Foundation Nigeria
26. Freedom from Fistula Foundation
27. Friends of UNFPA
28. Geneva Foundation for Medical Education and Research (GFMER)
29. Girls' Globe
30. Governess Films
31. Gynocare Fistula Center, Kenya
32. Hamlin Fistula, Ethiopia
33. Healing Hands of Joy
34. Health and Development International
35. Health Poverty Action, Sierra Leone
36. Hope Again Fistula Support Organization (HAFSO), Uganda
37. Human Rights Watch
38. Institut de Formation et de Recherche en Urologie et Santé de la Famille (IFRU-SF), Senegal
39. International Confederation of Midwives (ICM)
40. International Continence Society (ICS)
41. International Federation of Gynecology and Obstetrics (FIGO)
42. International Forum of Research Donors (IFORD)
43. International Medical Response
44. International Nepal Fellowship (INF)
45. International Planned Parenthood Federation (IPPF)
46. International Society of Obstetric Fistula Surgeons (ISOFS)
47. International Urogynecology Association (IUGA)
48. International Women's Health Coalition
49. Islamic Development Bank
50. Johnson & Johnson
51. Johns Hopkins Bloomberg School of Public Health
52. Kupona Foundation
53. Lake Tanganyika Floating Health Clinic
54. Ligue d'Initiative et de Recherche Active Pour la Santé et l'Education de la Femme (LIRASEF), Cameroon
55. London School of Hygiene and Tropical Medicine
56. Maputo Central Hospital, Mozambique
57. Médecins du Monde
58. Médecins Sans Frontières (MSF)
59. Mercy Ships
60. Moi University, Kenya
61. Monze Hospital, Zambia
62. Mulago Hospital and School, Uganda
63. National Obstetric Fistula Centre of Abakiliki, Nigeria
64. Obstetrical and Gynaecological Society of Bangladesh (OGSB)
65. One by One
66. OperationFISTULA
67. Pakistan National Forum on Women's Health
68. Pan African Urological Surgeons Association (PAUSA)
69. Population Media Center
70. Psychology Beyond Borders
71. Regional Prevention of Maternal Mortality Network (RPMM)
72. Royal College Of Obstetricians & Gynaecologists (RCOG)
73. Sana'a Hospital, Yemen
74. Selian Fistula Project
75. Société Africaine des Gynécologues-Obstétriciens (SAGO)
76. Société Internationale d'Urologie
77. Solidarité Femmes Africaines (SOLFA)
78. The Association for the Rehabilitation and Re-Orientation of Women for Development (TERREWODE), Uganda
79. Uganda Childbirth Injury Fund
80. United Nations Population Fund (UNFPA)
81. United States Agency for International Development (USAID)
82. University of Aberdeen
83. University Teaching Hospital of Yaounde, Cameroon
84. Virgin Unite
85. White Ribbon Alliance
86. Women and Health Alliance International (WAHA)
87. Women's Health Organization International (WHOI)
88. Women's Hope International (WHI)
89. Women's Missionary Society of the African Methodist Episcopal Church (WMS-AMEC)
90. World Health Organization (WHO)
91. World Vision
92. Worldwide Fistula Fund
93. Zonta International

DETAILED BUDGET ALLOCATIONS

Approved allocations, expenditures and financial implementation rate for Maternal Health and Fistula 2015-2017 (incl 7% indirect cost)

Regional office/ country office/glob- al technical support	2017 (MHTF & Fistula)			2018 (MHTF & Fistula)			Change in Expenses 2018 vs 2017
	Approved allocation (US\$)	Expenses (US\$)	Implemen- tation rate (%)	Approved allocation (US\$)	Expenditure (US\$)	Implemen- tation rate (%)	
Sub-Saharan Africa							
East and Central Africa Regional Office/ Johannesburg	168 000	149 937	89%	136 960	127 498	93%	(22 439)
Western and Central Africa Regional Office/Dakar	100 000	103 991	104%	88 275	65 265	74%	(38 726)
Benin	296 810	284 814	96%	327 813	302 467	92%	17 652
Burkina Faso	270 880	273 186	101%	288 323	282 629	98%	9 443
Burundi	375 753	407 757	109%	397 835	397 437	100%	(10 320)
Cameroon	111 821	92 975	83%	85 600	57 246	67%	(35 729)
Central African Republic	100 000	28 517	29%	77 893	77 372	99%	48 855
Chad	568 174	351 235	62%	403 173	387 739	96%	36 504
Congo	192 006	207 717	108%	255 463	198 412	78%	(9 304)
Côte D'Ivoire	325 211	336 908	104%	353 005	388 896	110%	51 988
Democratic Republic of the Congo	615 348	633 513	103%	436 649	483 784	111%	(149 729)
Ethiopia	485 996	716 277	147%	495 620	457 819	92%	(258 458)
Ghana	282 479	255 190	90%	302 921	251 748	83%	(3 442)
Guinea-Conakry	168 960	237 481	141%	179 760	247 364	138%	9 883
Guinea-Bissau	100 000	118 039	118%	103 434	97 600	94%	(20 439)
Kenya	215 041	208 422	97%	278 200	267 129	96%	58 707
Liberia	243 777	196 432	81%	-	16 650		(179 781)
Madagascar	382 128	368 126	96%	403 491	356 203	88%	(11 923)
Malawi	171 189	151 038	88%	224 828	130 344	58%	(20 694)
Mali	100 000	101 167	101%	97 905	68 305	70%	(32 861)
Mauritania	130 650	130 450	100%	135 566	114 274	84%	(16 175)
Mozambique	160 946	131 134	81%	214 000	82 346	38%	(48 787)
Niger	292 924	281 825	96%	389 733	387 247	99%	105 421
Nigeria	271 292	303 850	112%	302 917	282 187	93%	(21 663)
Rwanda	193 471	206 206	107%	257 410	252 057	98%	45 851
Senegal	148 391	167 996	113%	204 313	179 349	88%	11 353
Sierra Leone	437 564	438 977	100%	388 115	340 174	88%	(98 803)
South Sudan	100 000	93 604	94%	102 720	53 823	52%	(39 781)
Togo	119 100	118 365	99%	158 360	149 991	95%	31 626
Uganda	328 550	316 716	96%	353 036	344 251	98%	27 535
Zambia	237 349	203 915	86%	275 065	268 907	98%	64 992
Sub-Saharan Africa total	7 693 809	7 615 759	99%	7 718 380	7 116 515	92%	(499 244)

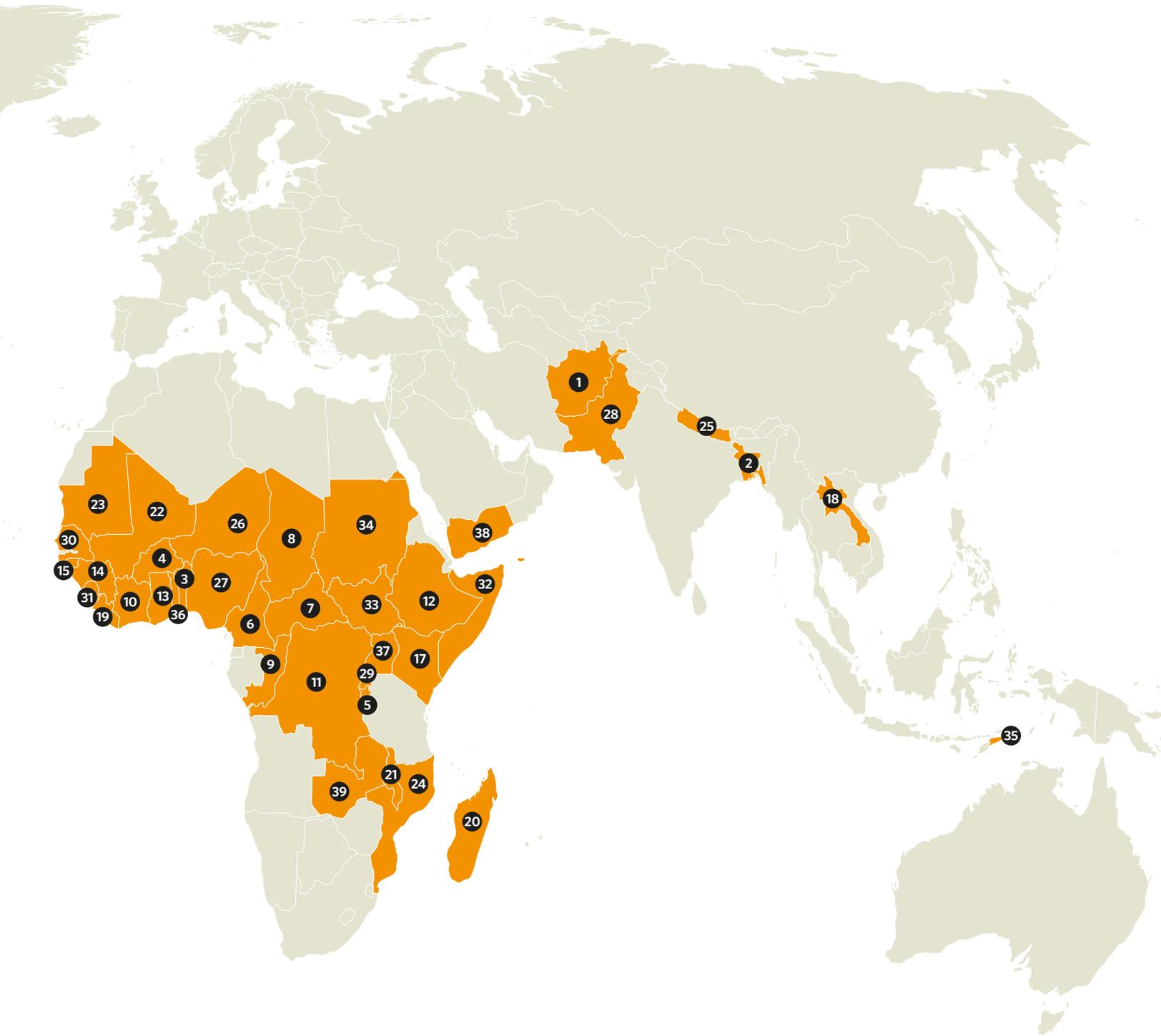
Regional office/ country office/global technical support	2017 (MHTF & Fistula)			2018 (MHTF & Fistula)			Change in Expenses 2018 vs 2017
	Approved allocation (US\$)	Expenses (US\$)	Implemen- tation rate (%)	Approved allocation (US\$)	Expenditure (US\$)	Implemen- tation rate (%)	
Arab States							
Arab States Reg. Office/Cairo	-	106 573	0	107 000	104 882	98%	(1 691)
Republic of Yemen	100 000	97 531	98%	107 000	77 496	72%	(20 035)
Somalia	258 049	258 049	100%	225 026	219 227	97%	(38 822)
Sudan	335 396	414 900	124%	395 838	262 368	66%	(152 532)
Arab States total	693 445	877 053	126%	727 864	663 974	91%	(213 079)
Asia and the Pacific							
Regional Office/ Bangkok	-	106 528	0	53 500	11 154	21%	(95 374)
Afghanistan	343 338	339 001	99%	346 194	344 022	99%	5 020
Bangladesh	125 372	125 368	100%	133 445	105 235	79%	(20 134)
Timor-Leste	119 100	116 024	97%	158 391	137 113	87%	21 088
Laos	321 864	319 471	99%	427 251	449 688	105%	130 218
Nepal	135 926	118 138	87%	180 848	124 835	69%	6 697
Pakistan	241 626	236 332	98%	257 185	216 567	84%	(19 765)
Asia and the Pacific total	1 287 226	1 360 862	106%	1 503 315	1 377 459	92%	16 598
Latin America and the Caribbean							
Latin America and the Caribbean Regional Office	80 000	87 396	109%	78 966	77 928	99%	(9 468)
Haiti	370 540	326 480	88%	328 668	317 829	97%	(8 651)
Latin America and the Caribbean total	450 540	413 875	92%	407 634	395 756	97%	(18 119)
Global technical support							
Global technical support, including implementing partners	3 236 468	2 507 729	77%	2 660 506	2 319 253	87%	(188 476)
Media and Communications Branch	268 724	269 008	100%		402		(268 606)
Non-Core Funds Management Unit	220 420	213 316	97%	184 786	183 321	99%	(29 995)
Global technical support total	3 725 612	2 990 053	80%	2 845 292	2 502 977	88%	(487 076)
GRAND TOTAL	13 850 631	13 257 603	96%	13 202 485	12 056 682	91%	(1 200 921)

NB: Includes data for ZZT03 and ZZT06

MHTF-SUPPORTED COUNTRIES



1. Afghanistan
2. Bangladesh
3. Benin
4. Burkina Faso
5. Burundi
6. Cameroon
7. Central African Republic
8. Chad
9. Congo
10. Côte d'Ivoire
11. Democratic Republic of the Congo
12. Ethiopia
13. Ghana
14. Guinea
15. Guinea-Bissau
16. Haiti
17. Kenya
18. Lao People's Democratic Republic
19. Liberia
20. Madagascar
21. Malawi
22. Mali
23. Mauritania
24. Mozambique
25. Nepal
26. Niger
27. Nigeria
28. Pakistan
29. Rwanda
30. Senegal
31. Sierra Leone
32. Somalia
33. South Sudan
34. Sudan
35. Timor-Leste
36. Togo
37. Uganda
38. Yemen
39. Zambia



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country territory, city or area or its authorities or the delimitation of its frontiers or boundaries. A dotted line approximately represents the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not been agreed upon by the parties



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and choices for all.**

