

THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND

Advancing Towards Universal Health Coverage

ANNUAL REPORT

2019





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

Cover photo:

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November 2019. Winner of the 2020 MHTF photo contest.

Ms. Ayome Pitchou, 27, at her antenatal care visit with her midwife in Souanké, in the Sangha Region of the far north-western region of the Republic of the Congo. This facility is part of the national EmONC network developed through collaboration between UNFPA and the Ministry of Health.



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ACRONYMS

EmONC	Emergency obstetric and newborn care
GIS	Geographic information system
H6	WHO, UNFPA, UNICEF, UNAIDS, UN Women & World Bank Group
ICM	International Confederation of Midwives
ICPD	International conference on population and development
Jhpiego	Johns Hopkins University Program for International Education in Gynecology and Obstetrics
LGBTI+	Lesbian, gay, bisexual, transgender, intersex and other sexuality, sex and gender people
MPDSR	Maternal death surveillance and response
MHTF	Maternal and newborn health thematic fund
MNH	Maternal and newborn health
MPDSR	Maternal and perinatal death surveillance and response
NGO	Non-governmental organization
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMNH	Sexual, reproductive, maternal and newborn health
SRMNAH	Sexual, reproductive, maternal, newborn and adolescent health
SRMNCAH	Sexual, reproductive, maternal, newborn, child and adolescent health
UN Women	United Nations Entity for Gender Equality and 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 Organisation

ACKNOWLEDGEMENTS

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Thanks to the generous support from Sweden, Germany, Luxembourg and Poland, the MHTF was able to support 32 countries with the highest rates of maternal and newborn mortality and morbidity, in improving equitable access to quality sexual, reproductive, maternal and newborn health (SRMNH) services. We are also grateful for individual and private-sector contributions made through Friends of UNFPA and by Laerdal Global Health.

The bold, integrated and successful initiatives noted in this report would not have been possible without the collaboration of our public and private sector partners at global, regional and national levels. Among many others, they include the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, the International Society of Obstetric Fistula Surgeons, Operation Fistula, Columbia University's Averting Maternal Death and Disability Program, Johns Hopkins University and its Program for International Education in Gynecology and Obstetrics and the Woodrow Wilson Center. A listing of our Campaign to End Fistula partners is included in Annex 1; we gratefully acknowledge their contributions.

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

UNFPA acknowledges with gratitude the support of its dedicated technical and programme staff at headquarter level, across 32 MHTF-supported countries, and our advisers in five regional offices. They are instrumental in supporting countries to improve maternal and newborn health as part of a broader focus on sexual and reproductive health and rights.

Working together, we continue to make a difference and positively impact the lives of women and girls everywhere. Our collective efforts are bearing fruit as we move towards ending preventable maternal mortality by 2030.

President of Kenya Uhuru Kenyatta stated in his inaugural address at the 2019 Nairobi ICPD25 Summit: *"Empowering women essentially empowers all our families. It empowers our societies. It empowers our nations. It empowers our world."*

FOREWORD

The UNFPA Maternal and Newborn Health Thematic Fund (MHTF) supports global efforts to end preventable maternal and newborn deaths and deliver on the 2030 Agenda for Sustainable Development. The MHTF remains focused on strengthening health systems, improving quality of care, and providing equitable access to integrated sexual and reproductive health services.

Making motherhood safer is at the core of UNFPA's mandate. More than 800 women die every day from preventable causes related to pregnancy and childbirth. For every woman who dies, an estimated 20 or 30 encounter injuries, infections or disabilities. Most of these deaths and injuries are preventable.

Last year, the MHTF focused on 32 high-priority countries across five regions. Nearly 29,000 midwives received education and training while 2,700 midwifery tutors upgraded their skills. Investments were made to strengthen more than 400 midwifery schools, as well as bolster maternal and perinatal death surveillance and response systems. The MHTF also established health facility networks in four countries and supported more than 8,000 fistula repair surgeries, helping restore the dignity of some of the most marginalized women and girls.

With health systems stretched and priorities shifting due to the COVID-19 pandemic, UNFPA is doing all it can to ensure that sexual, reproductive, maternal and newborn health remains a priority. This means working to ensure that health workers, including midwives, are protected so that every woman can access high-quality care during pregnancy and childbirth.

UNFPA appreciates the collaborative efforts of all our partners, including governments, civil society organizations, academic institutions and other development agencies. Together, let us continue to build inclusive health systems, and let us do everything in our power to assure that every woman and newborn receives the 'care with caring' that they need and deserve.



Natalia Kanem

**Dr. Natalia Kanem
Executive Director,
United Nations Population
Fund (UNFPA)**

EXECUTIVE SUMMARY

Established in 2008, the [Maternal and Newborn Health Thematic Fund](#) (MHTF) continued to function as UNFPA's flagship programme on maternal and newborn health, accelerating progress towards achieving the 2030 Agenda for Sustainable Development and UNFPA's transformative result on ending preventable maternal mortality. In 2019, the MHTF marked the first year of implementation of Phase III of the MHTF Business Plan (2018-2022), as 2018 was a transition year. The MHTF built on its strength to offer a unique platform for delivering on the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), using an integrated, holistic, rights-based, person-centred, life course approach to the delivery of comprehensive sexual, reproductive, maternal and newborn health services.

The MHTF is a contributor to realizing universal health coverage through its focus on an available, accessible and acceptable health workforce – midwives – who can provide quality services through a functional, accessible and well-distributed emergency obstetric and newborn care (EmONC) network comprising health system facilities. The MHTF has taken steps in the past year towards realizing the vision of universal health coverage by: (1) providing maternal and newborn health care and creating demand for services; (2) improving the quality of care by focusing on quality midwifery care, EmONC, and maternal and perinatal death surveillance and response (MPDSR); and (3) by preventing and treating fistula across the globe to also make sure that the poorest of the poor can fulfil their basic human right to a healthy life. With an overall focus on enhanced national ownership, health system strengthening, improving quality of care, accountability, and equitable access to comprehensive sexual and reproductive health (SRH) services, the MHTF in 2019 supported 32 countries (see Annex 4) with among the highest rates of maternal and newborn mortality and morbidity across five regions (the Arab States, Asia and the Pacific, East and Southern Africa, Latin America and the Caribbean, and West and Central Africa).

Using strategically designed, high-impact, catalytic programmes with multi-stakeholder engagement, and numerous global and national partners, the MHTF continued to roll out and operationalize the six pillars¹ of UNFPA's Global Midwifery Strategy (2018-2030); build, strengthen and monitor EmONC networks; strengthen MPDSR systems; and support the implementation of the 2018 Secretary-General's resolution² on intensification of efforts to end fistula within a decade (by 2030). These key areas were further integrated with other SRH programmes, including post-partum and post-abortion family planning, prevention and treatment of HIV and sexually transmitted infections, cervical cancer screenings and treatment, comprehensive abortion care (to the full extent of the law) including post abortion care.

In 2019, the MHTF helped educate and train over 28,800 midwives, among whom over 9,000 graduated from higher education programmes, including with a bachelor's, master's or doctoral degree. Over 400 midwifery schools received training equipment, simulation models and books, and 2,700 midwifery tutors benefited from upgrades in teaching and clinical skills. The leadership and advocacy capacities of midwifery associations continued to be strengthened as they were fully engaged in the celebration of the International Day of the Midwife and in various policy dialogues. Roughly one third of MHTF countries are now able to deploy over 75 per cent of newly graduated midwives within one year.

Using a human rights-based, gender-responsive approach, the MHTF helped restore the dignity of some of the most marginalized women and girls who suffer from fistula, a debilitating childbirth injury, by supporting over 8,000 fistula repair surgeries through the [Campaign to End Fistula](#). Twenty-two MHTF-supported countries have now costed national strategic plans for ending fistula within a decade. By 2019, 14 (44 per cent) MHTF-supported countries had integrated fistula-related indicators in the national health management information system, fostering better data tracking. Nearly 2,000 fistula survivors benefited from social reintegration programmes supported by the MHTF.

1 The six pillars of UNFPA's Global Midwifery Strategy are: a) education; b) regulation; c) association; d) workforce policies; e) enabling environment for midwives and f) midwifery being integral to SRMNAH

2 [A/RES/73/147](#)

Establishment and strengthening of 24/7 functional, well-distributed EmONC facility networks with adequate numbers of fully trained midwives remained a key priority. In four new countries (Benin, Chad, Côte d'Ivoire and Sudan), bringing the overall total to 11 countries, collaboration with ministries of health and other stakeholders backed use of the AccessMod GIS tool developed by WHO and the Geneva University. To improve accountability and the quality of care, MPDSR programmes were further strengthened across all MHTF-assisted countries. Sixteen do have a national monitoring tool for tracking MPDSR processes and results at the national and subnational levels.

The MHTF continued to be innovative and trend-setting by pioneering major initiatives and strategies that influenced policy. Several interventions are well mainstreamed in UNFPA's overall Strategic Plan, and plans are underway to use the MHTF Business Plan as the basis for drafting UNFPA's corporate Strategy on Maternal Health. The MHTF has supported the overall costing and operationalization of UNFPA's transformative result to end preventable maternal mortality. Furthermore, MHTF-initiated programmes continued to inform those supported by the H6 partnership, the Partnership on Maternal Newborn and Child Health (PMNCH), the Sahel Women's Empowerment and Demographic Dividend Project (SWEDD) and Muskoka. Significant funding from Canada, Sweden, the United Kingdom, Johnson & Johnson and Phillips, among others, supported the scale up of midwifery programmes, EmONC and fistula initiatives in Bangladesh, Haiti, Liberia, Pakistan, the Republic of the Congo and South Sudan.

The MHTF has had a transformative, health-preserving and life-saving impact even in humanitarian and fragile settings. In Bangladesh, Chad, the Democratic Republic of the Congo, Haiti, Liberia, Mozambique, Nigeria, Sudan and other countries, midwives trained under the MHTF applied their skills, commitment and energy to improve the lives of vulnerable women and girls affected by natural disaster and humanitarian crisis. In addition to promoting safe delivery, family planning and postnatal care, and reducing the number of stillbirths, they also addressed other SRH needs including gender-based violence, comprehensive abortion care, and breast and cervical cancer screenings, among others.

Over the past decade, the MHTF has demonstrated that its strategies and holistic programmes have a visible impact on improving health systems and alleviating maternal and newborn deaths and disabilities. To sustain its impact and scale up its evidence-based and results-oriented programmes in existing and additional countries, the MHTF depends on continued, enhanced, multi-year funding support from all its donors and private sector partners.



PART

1



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Photo submitted to the 2020 MHTF photo
contest by Jenipher Mijere

KEY RESULTS

Universal health coverage is achieved when all people in all communities have access to the high-quality health services they need and can use those services without financial hardship. Progress towards universal health coverage requires keeping women's health and mothers and newborns at the centre, as the maternal and newborn health (MNH) continuum represents a critical window of opportunity for effective lifesaving interventions as well as prevention and health promotion, with effects throughout the course of life.

As in previous years, the Maternal and Newborn Health Thematic Fund (MHTF) contributed to universal health coverage by continuing to strengthen health systems in providing sexual, reproductive, maternal and newborn health (SRMNH) services. In 2019, it supported 32 countries (see Annex 4) to eliminate preventable maternal and newborn mortality and morbidity across the continuum of care, contributing to progress on the 2030 Agenda for Sustainable Development.

Using a human rights-based, people-centred, gender-focused approach, the MHTF continued to implement catalytic, transformative and integrated initiatives in four key thematic areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), and obstetric fistula and other morbidities. Strategic interventions were broadened to include access to comprehensive abortion care (to the full extent of the law) including post abortion care, adolescent sexual and reproductive health (SRH), and cervical cancer treatment and prevention. These initiatives were further integrated into quality EmONC service delivery and within midwifery training curriculums.

The global midwifery programme continued to roll out the new UNFPA Global Midwifery Strategy, with a particular focus on improving the quality of midwifery care and practice, strengthening an enabling environment for midwives, fostering interprofessional collaboration and advocating globally for enhanced investments in midwifery. Using geographic information system (GIS) technology, the MHTF supported the development of national EmONC facility networks in four additional countries, providing critical support in mapping the physical accessibility of facilities, evaluating the quality of services, and strengthening referral links to ensure access to quality basic and comprehensive EmONC services.

The MHTF backed MPDSR systems in tracking maternal and perinatal deaths in real time, while enhancing strategies for better notification of maternal and perinatal deaths. It assisted in cultivating understanding of the underlying factors contributing to these deaths, and guiding actions to prevent future deaths. The global Campaign to End Fistula, with MHTF support, strengthened and increased global, regional and national partnerships, coordination mechanisms, and national leadership and ownership, which remain key to ending the condition.

The following sections outline the key results achieved in each of the major areas of the MHTF.

1.1 MIDWIFERY

There is evidence that midwives, educated to the standards of the International Confederation of Midwives (ICM), licensed, working in interprofessional teams, fully integrated into the health system and practising within an enabling environment will provide high-quality care that transforms MNH outcomes. The MHTF continued to invest in the midwife-led continuity of care model as midwives play a crucial role in the achievement of universal health coverage.

Quality improvements in midwifery care and practice

remained the focus of the global midwifery programme in 2019. In collaboration with a host of global partners like the ICM, the Johns Hopkins University Program for International Education in Gynecology and Obstetrics (Jhpiego), Laerdal Global Health, Johnson & Johnson, the World Health Organization (WHO), ministries of health, midwifery associations and national regulatory bodies, the MHTF continued to invest in quality pre-service education for midwives. Efforts were made to build competencies of midwives already deployed in the field through in-service training and mentorship programmes, with a particular focus on strengthening the life-saving skills of midwives in key obstetric emergencies. These include post-partum haemorrhage, eclampsia/pre-eclampsia, post-abortion care, sepsis, prolonged obstructed labour and essential newborn care.

For example, in Timor-Leste, the MHTF supported clinical skills strengthening of 21 midwives from two student batches through hands-on EmONC training and supportive supervision. Innovative approaches such as “Helping Mothers Survive, Helping Babies Breathe”, and m-learning and e-learning continued to be scaled up globally. Master trainers were trained on “Helping Mothers Survive, Helping Babies Breathe” in **the Kingdom of Bhutan, Lao People’s Democratic Republic and Papua New Guinea** with support from UNFPA’s Asia and the Pacific Regional Office. Midwifery tutors from all midwifery schools in **Bangladesh** received a three-day e-training on seven key obstetric emergencies with technical assistance from UNFPA headquarters.

By the end of 2019, 492 midwifery schools in MHTF-supported countries had been accredited and were following a curriculum aligned to ICM standards, and 592 midwifery schools had access to at least one accredited basic or comprehensive EmONC facility for pre-service training, which together with mentorship programmes greatly contributed to improved clinical skills and decision-making.

Overall, in 2019, the MHTF supported the pre-service education of about 18,800 midwives and provided continuous professional development (in-service training) to another 10,000 midwives. These trainings, depending on the country and skills gaps, covered mentorship, fistula identification and management, EmONC, the Minimum Initial Service Package, respectful maternity care, haemorrhage, post-abortion care, cervical cancer screening and MPDSR trainings, among other areas. Over 9,500 new midwives graduated in 2019, of whom 8,800 (93 per cent) were supported through MHTF programmes. Another 9,300 midwives graduated from higher education midwifery programmes with a bachelor’s, master’s or doctoral degree. Over a dozen MHTF-supported countries introduced a nationally accredited, fully costed, 12 to 18-month bridging programme to higher education programmes such as those to earn a bachelor’s of science degree, providing midwives with a career pathway that did not exist before.

The MHTF supported the strengthening of more than 400 midwifery schools with training models, computers, books and equipment, and approximately 2,700 midwifery tutors benefited from MHTF-assisted trainings in clinical and teaching skills. Since the creation of the MHTF in 2008, 150,000 midwives have been trained to international standards, capable of performing 26 million safe births each year; 750 midwifery schools have

been fully equipped with training models, equipment and books; and the clinical and teaching skills of over 12,000 midwifery tutors have been upgraded.

The MHTF is developing evidence-based tools and guidance in collaboration with the ICM for global use and local adaptation. These support curriculum design, learning and teaching methodologies, teacher competence, assessment processes, practical and applied learning opportunities, and quality assurance measurement.

The following resources were completed in 2019:

- a) A facilitator’s guide to deliver a one-day “respectful care” course was finalized, tested and disseminated at various workshops and regional events;
- b) A resource pack for faculty on core concepts of midwifery; and
- c) A Guideline on mentorship.

Launch and roll-out of UNFPAs Global Midwifery Programme Strategy (2018-2030)

The new Global Midwifery Strategy was officially launched at the 2019 Women Deliver conference. It was disseminated widely in Asia and the Pacific at a regional workshop; in Africa at the ICM **Namibia** Regional Conference; and in Latin America (not including the Caribbean) at a regional midwifery meeting in **Argentina**. In all of these events, midwives brainstormed around various pillars of the strategy and developed action plans based on identified challenges and respective regional priorities. The strategy was translated into French and Spanish in 2019.

There is now global buy-in to the strategy, including by partners such as the ICM and Jhpiego, who were engaged in its development. UNFPA country offices have found the implementation guidance provided with the strategy useful in establishing a harmonized, systematic approach.

In collaboration with the Burnet Institute, UNFPA’s regional office for Asia and the Pacific identified two key priorities based on the strategy for 2019. A regional review to address the acute shortage of competent faculty was conducted. Additionally, a mapping was carried out to assess the status of midwifery education accreditation in 13 countries with



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high burdens of maternal mortality to help improve the quality of midwifery education. The region has now developed modules for midwifery faculty development and completed a compilation of best practice models for accreditation of midwifery education.

Building on efforts to improve the quality of care, 80 per cent of MHTF-supported countries have integrated respectful maternity care, comprehensive abortion care (to the full extent of the law) including post abortion care, cervical cancer, fistula and HIV prevention as part of the pre-service curriculum and in-service training. Among countries supported by the MHTF, 72 per cent now have a costed plan for human resources for health that includes midwifery.

An impediment to quality midwifery care in the past has been the lack of an enabling environment for midwives to practise their profession. By 2019, 50 per cent of MHTF-supported countries reported having included an enabling work environment in the national work force policy. Over 40 per cent were using an electronic register to help track the deployment of midwives.

Overall, deployment rates of midwives within a year of graduation continued to show major improvements. **Bangladesh, Burkina Faso, Côte d'Ivoire, Sierra Leone, and Zambia** achieved 90 to 100 per cent deployment rates, and **Benin, Kenya, Senegal and Somalia** over 70 per cent, based on baselines ranging from 30 to 50 per cent. But several countries still need to strengthen deployment policies.

Enhanced Global Advocacy

The achievement of the above results would not have been possible without continued investments in global advocacy to ensure that national governments understand the value of investing in quality midwifery care to address maternal and newborn mortality and morbidity.

The International Day of the Midwife, as in previous years, was celebrated globally on 5 May. The 2019 theme was "Midwives: Defenders of Women's Rights". A global UNFPA advocacy package to mark the

celebration was developed and disseminated, and a social media campaign conducted. A professionally designed advocacy toolkit was devised in collaboration with the ICM. All MHTF-supported countries planned major advocacy activities in collaboration with national midwifery associations to celebrate the achievements of midwives; engage and inform relevant stakeholders about the crucial contributions of midwives in promoting maternal, newborn and adolescent health; and motivate policymakers to implement conducive workforce policies and an enabling environment for midwives to practise their profession.

From colourful marches of midwives to debates with policy makers, free antenatal clinics, breast and cervical screening camps, HIV testing and awards for outstanding midwives, the event was a global success. In a statement, UNFPA Executive Director Dr. Natalia Kanem said, *"The health outcomes of Agenda 2030, which include ending preventable maternal and newborn mortality, access to an essential package of sexual and reproductive health services and universal health coverage, will not be attainable without scaled-up investments in quality midwifery care."*

A highlight of 2019 was the high-profile 4th Global Midwifery Symposium at Women Deliver in Vancouver, titled "Empowered Midwives, Transformed Communities". UNFPA organized this event jointly with the WHO and ICM, civil society and private-sector global partners. The symposium focused on the importance of a women-centred midwifery continuity-of-care model, the need for an enabling work environment for midwives, and enhanced interprofessional collaboration for the best sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) outcomes. Following the symposium, a global Call to Action was launched by UNFPA, the WHO, the ICM, UNICEF, Jhpiego, the Canadian Association of Midwives, Laerdal Global Health, the International Pediatric Association, the International Council of Nurses, and the International Federation of Gynecology and Obstetrics (see Annex 3).

Significant advocacy for enhanced investments in midwifery occurred at the Nairobi Summit on ICPD@25, marking the 25th anniversary of the 1995 International Conference on Population and Development (ICPD). Collaboration with the Wilson Center led to several public and private roundtable events, including with major SRMNH partners on "Taking Forward the ICPD Agenda and Delivering on an Essential Package of

SRMNH services", which highlighted the role of midwives. Other events were the "Intergenerational Dialogue on Moving the ICPD Agenda Forward" and "25 Years Since Cairo: Making ICPD@25 Relevant to Young People". Four blogs covering several MNH and health workforce events at the Nairobi Summit and the Global Midwifery Symposium received exceptional ratings and viewership.³

The development of the 2021 *State of the World's Midwifery Report* commenced in 2019. The contractual modalities were finalized, the framework of the report defined, and the process and methodology of data collection identified together with two core partners: the WHO and the ICM. A major global midwifery mapping exercise was conducted by the ICM in collaboration with UNFPA and will feed into the report. UNFPA, the ICM and the WHO launched a new publication at the World Health Assembly, "Strengthening quality midwifery education for Universal Health Coverage 2030: Framework for action". This highlights that quality midwifery care can help avert over 80 per cent of maternal and newborn deaths and stillbirths, if midwives are well educated, and appropriately deployed and supported. Beyond preventing maternal and newborn deaths, quality midwifery care improves over 50 other health-related outcomes, including in SRH, immunization, breastfeeding, tobacco cessation in pregnancy, malaria, TB, HIV, obesity in pregnancy, early childhood development and post-partum depression.

Continuing to build on the compendium of good practices in midwifery, two new good practices were documented: a young midwifery leader programme in Latin America and a mentorship programme in **Bangladesh**. The MHTF has documented 15 good midwifery practices to date that are shared through South-South exchanges and learning.

Despite overall progress in strengthening midwifery globally, efforts continued to be adversely impacted by weak national commitment, quality constraints, a poor enabling environment and shortage of human/financial resources due to competing priorities. Midwifery pre-service education and tutor competencies, particularly clinical (EmONC) competencies, need to be further strengthened, and combined with strong mentorship and supportive supervision programmes.

3 See, for example: www.newsecuritybeat.org/2019/12/icpd25-midwives-key-part-health-workforce-dream-team/ last accessed June 15 2020

1.2 EMERGENCY OBSTETRIC AND NEWBORN CARE

2019 highlights in EmONC

The MHTF in 2019 continued to support the establishment of physically accessible EmONC facility networks and the provision of quality care. Twelve countries improved the proportion of EmONC facilities with “no gaps” in midwives according to the national standard. **Burkina Faso** now has “no gaps” in over 80 per cent of facilities. Twelve countries have EmONC facilities with quality improvement processes in place. In **Benin** and **Guinea**, over 50 per cent of the population are now able to reach EmONC facilities within two hours of travel time. In 2019, **Benin** and **Burundi** had at least 40 per cent functioning referral links between basic and comprehensive EmONC health facilities within the national network.

Setting up national networks of EmONC health facilities in Benin, Chad, Côte d'Ivoire and Sudan

In 2019, four more countries decided to review their EmONC development strategy. Health ministries in **Benin, Côte d'Ivoire, Chad** and **Sudan** requested for MHTF technical expertise and financial support to develop their national networks of EmONC health facilities. With the support of UNFPAs country offices, various health ministry stakeholders, and with the GIS expertise of Geneva University, experts from each region of each country designed networks of designated EmONC health facilities. Following the usual process implemented in previous years in **Burundi, Guinea, Madagascar, Senegal** and **Togo**, and using the AccessMod GIS tool, participants in each subnational region built networks taking into account the population covered within two hours of travel time.

Table 1.1 shows the results of these workshops in each country, including the number of health facilities and the population covered by all maternities, by the network of EmONC health facilities defined, and, within this network, by functional EmONC health facilities. The latter provide services 24/7 and perform the seven EmONC signal functions for basic care and nine for comprehensive care.⁴

Table 1.1 Key national results of designing national EmONC networks

		Benin	Chad	Côte d'Ivoire	Sudan
All maternities	# facilities	387	545	657	631
	Population coverage (percentage)	97%*	71%**	96%*	96%**
Designated EmONC health facilities	# facilities	112	109	219	146
	Population coverage (percentage)	94%*	61%**	94,5%*	90%**
Functional EmONC health facilities	# facilities	25	29	4	127
	Population coverage (percentage)	75%*	20%**	11%*	80%**
Gap in midwives (national level)		122	71	217	313
Proportion of satisfactory referral links		40%	56%	10%	52%

Notes: * indicates within one-hour travel time for Benin and Côte d'Ivoire.

** indicates within two hours travel time for Chad and Sudan.

4 WHO, UNFPA, UNICEF and Mailman School of Public Health, Averting Maternal Death and Disability (2009). *Monitoring emergency obstetric care: A handbook.*



©UNFPA Madagascar, Harinivo Rahlimalala, 2019. Photo submitted to the 2020 MHTF photo contest.

Table 1.1 reveals that a significantly reduced number of designated EmONC facilities could cover a good share of the population. There is a major difference between the number of maternity units and the number of functional EmONC facilities. Most of the latter are comprehensive facilities; a few and often none are basic facilities. These findings validate the recommendation that efforts must be made to reduce the number of EmONC health facilities to ensure that these are functional and provide quality care. **Benin** demonstrates this principle, as it has the largest coverage in functional EmONC despite a low number of functional EmONC health facilities. In each country, the need for midwives to fill the national minimum standard in EmONC facilities is still significant.

The quality of referral links still needs improvement. A satisfactory referral link is defined as the capacity for a basic EmONC facility to refer to a comprehensive EmONC facility within two hours of travel time and without major financial or other barriers. The subnational stakeholders analysed each referral link of the designated network, which in each of the four countries highlighted the underestimated (and poorly documented) financial barriers to access.

In all four countries, technical reports presented and analysed the geographic accessibility maps. These reports have been validated by respective health

ministries, except in **Sudan**, where the process is ongoing. The validated reports serve as the basis for the official national EmONC facility network, and are used for advocacy, planning and reporting. The maps are helpful for stakeholders to understand national and subnational specificities, and address gaps in access to EmONC.

In the four countries, each region or state had three maps detailing geographic accessibility. The first map displayed the EmONC network and the density of the population. The second map showed geographic accessibility of the network of EmONC facilities, meaning the travel time to the closest EmONC health facility using the most common local mode of transport. The third map showed the catchment area of each EmONC facility in the network. The population density map and the geographic accessibility maps are consolidated into national maps. As an example, Figures 1.1, 1.2 and 1.3 provide the accessibility maps of **Côte d'Ivoire**, **Sudan** and **Chad**, respectively. Green areas denote populations within two hours of travel time to the closest designated EmONC health facility, while people in orange areas are located between three and four hours away, and in red areas more than four hours away.

As shown in Figure 1.1, much of the population of **Côte d'Ivoire** has good access to EmONC health facilities across the country, with limited orange and red areas.

Figure 1.1 Geographic accessibility map - EmONC facility national network of Côte d'Ivoire

CÔTE D'IVOIRE

Facilities

- ✚ Designated CEmONC [65]
- ⊕ Functional CEmONC [4]
- Designated BEmONC [150]
- Functional BEmONC [0]

Travel time to nearest EmONC

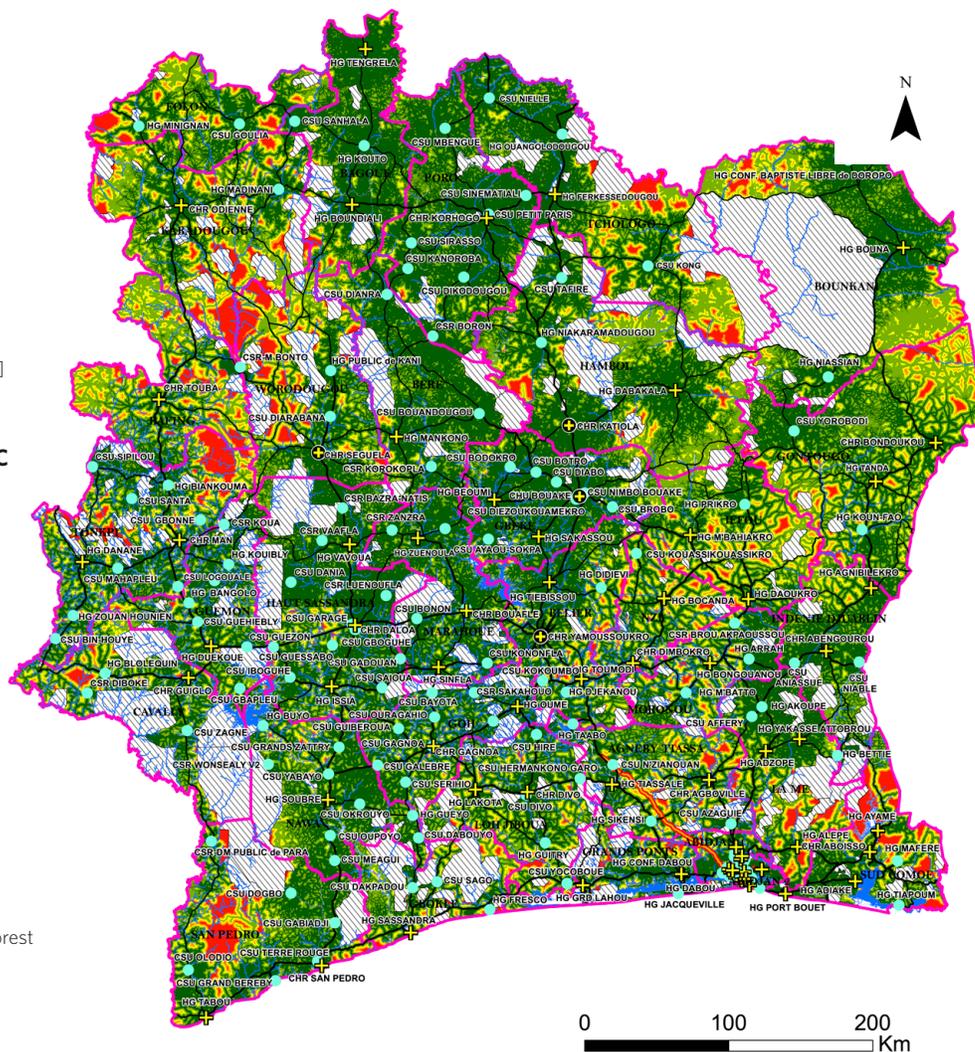
- < 1 hour
- 1-2 hours
- 2-3 hours
- 3-4 hours
- > 4 hours

Roads Network

- Motorway
- National paved road
- National unpaved road

Hydrography

- River
- Lake
- Park, reserve or classified forest
- Health region



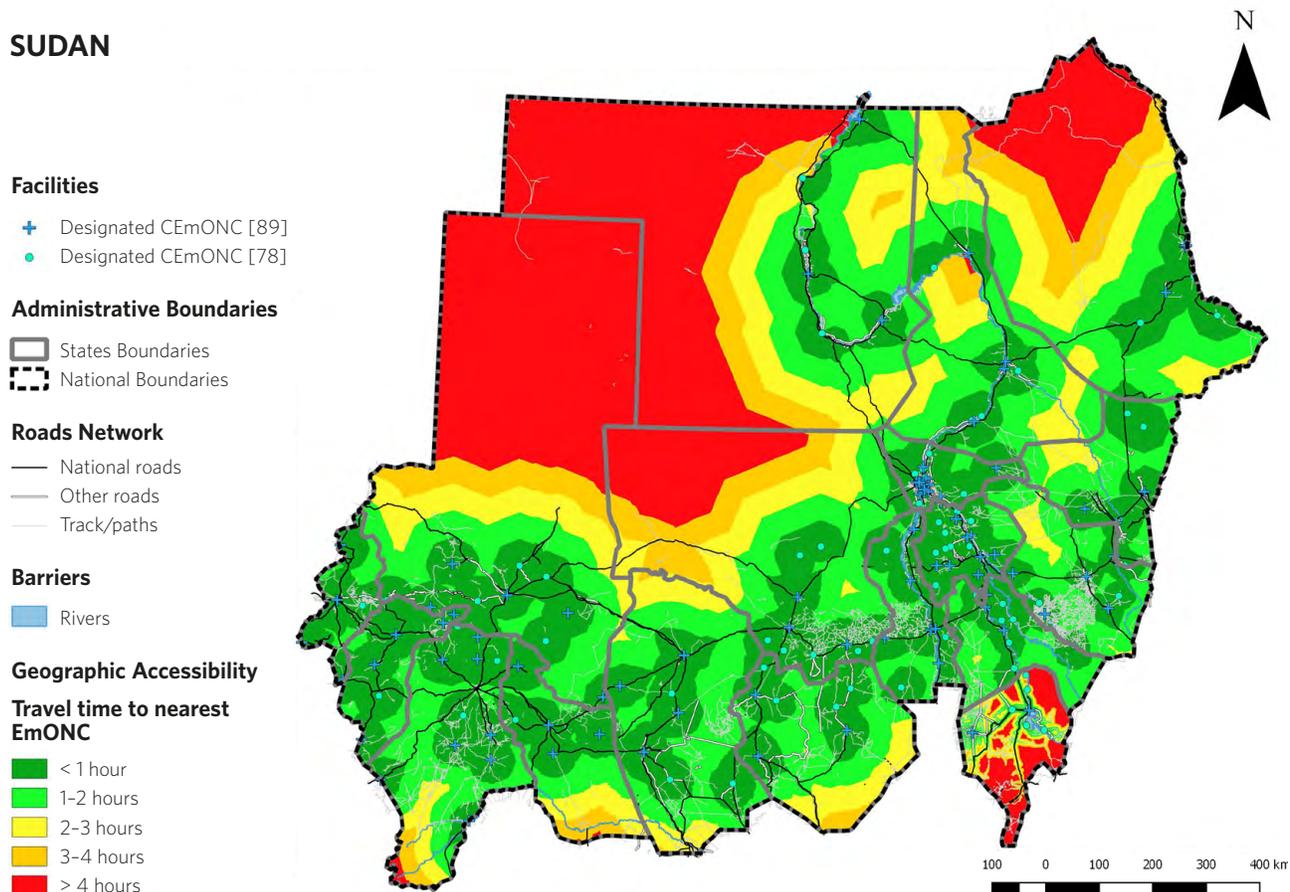
The main issue is not coverage, but quality of care and financial barriers. The country has a good road network that significantly contributes to keeping much of the population within an hour of travel time to an EmONC facility. The main issues in Côte d'Ivoire are the quality of care and financial barriers.

These findings have been discussed with senior ministry of health officials, and will feed into MNH planning at the subnational and national levels.

Despite important red areas in **Sudan** (Figure 1.2), overall geographic accessibility to EmONC health facilities is good with most of the population able to

access the closest facility within two hours. This is mostly due to very low population concentration in the red zone, which is mainly desert. An exception is the State of Blue Nile, where only 48 per cent of the population has access within two hours due to poor road networks and insecurity. Most functioning EmONC health facilities face major shortfalls in quality of care, however. Closer monitoring will help the Ministry of Health to address these issues, including unnecessary surgical interventions such as caesarean sections. Through UNFPAs support, the ministry will also strengthen its midwifery workforce and ensure more basic EmONC health facilities function and offer quality of care.

Figure 1.2 Geographic accessibility map - EmONC facility national network of Sudan



Chad has a geographical context similar to **Sudan**. Its large desert areas with very low population density combine with regions with high population density. **Chad** has poor road conditions, however, which affect access to EmONC (Figure 1.3). The Ministry of Health selected a limited number of EmONC health facilities for its first national EmONC network as very few EmONC facilities are currently functional.

Monitoring the national network of EmONC health facilities in Benin, Burundi, Guinea and Togo

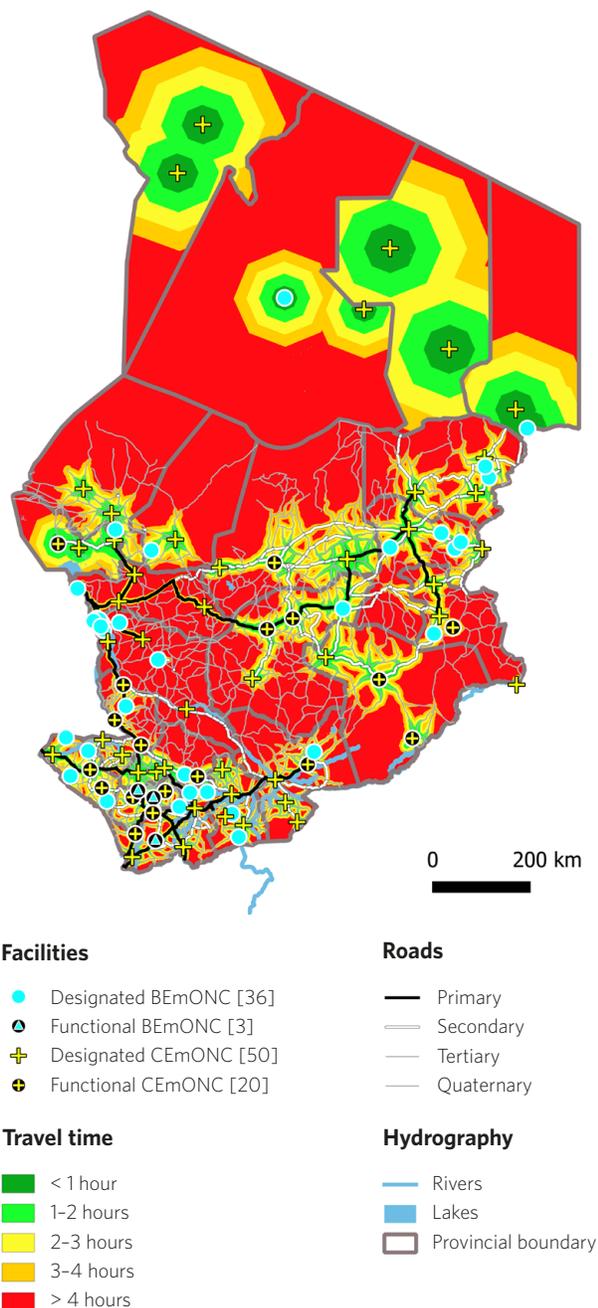
In 2019, four countries monitored key reproductive MNH indicators in their national network of EmONC health facilities, including EmONC indicators: **Benin, Burundi, Guinea and Togo**. The indicators are defined by national and subnational stakeholders, and validated by the ministry of health. Data on the indicators are collected on a quarterly basis in all designated EmONC

health facilities. Data collection is performed by “implementation support” teams, including members from regional and district health teams, that assist health facility staff to analyse data and identify specific responses to improve the availability and quality of EmONC services. Similarly, district, regional and national teams analyse consolidated EmONC data and define responses to address gaps at their levels. This bottom-up approach is a paradigm shift in most countries that has defined a national EmONC network. Only Togo, however, has currently reached the stage of analysing data and defining responses to improve the quality of care.

As shown in Table 1.2, while the share of the population able to access a nearby EmONC health facility is high in **Benin** and **Togo** (94 per cent within one hour of travel time in **Benin** and 80 per cent within one hour in **Togo**), the proportion of expected births taking place in EmONC health facilities is still very low in the two countries. This reflects issues linked to financial access and quality of care.

Figure 1.3 Geographic accessibility map – EmONC facility national network of Chad

CHAD



For example, the case fatality rate from direct obstetric complications managed in EmONC health facilities is 4 per cent in **Togo** compared to the maximum recommended norm of 1 per cent. Reviews of maternal deaths are critical to improve quality of care, yet only one third of maternal deaths in EmONC health facilities are reviewed in **Togo**. The review rate is higher in **Benin** and **Burundi**, but a careful analysis of the quality of the reviews is needed to make sure that the root causes of maternal deaths are well identified. The MHTF provides such analysis as well as support for implementing responses to address gaps.

The MHTF Supports the Philips Partnership in the Republic of the Congo

Under the coordination of the UNFPA's Strategic Partnership Branch, its Technical Division, the Ministry of Health and UNFPA's country office in the **Republic of the Congo** requested MHTF support to develop a public-private partnership with Philips aimed at devising a new model to finance a maternal health programme. Following the MHTF's recommendation, Phase 1 of the project will include two rural regions (Sangha and Lekoumou) in addition to Talengai, a popular district of Brazzaville. With MHTF funding, the country office has recruited a project coordinator with significant experience in developing networks of EmONC health facilities. As a first step, a subnational workshop was organized to use the MHTF's methodology in designing a regional EmONC network in the two regions.

In the **Republic of the Congo**, a new approach has been applied where referral links between the EmONC facility network and maternity units are determined at a decentralized health facility level. The planning process will take into account the specific needs of local indigenous populations, with their representatives already successfully engaged in the workshop.

Figure 1.4 shows a map of the Sangha region, which has low population density. Most people live alongside roads crossing tropical forests, which explains why the proportion of the population covered by the EmONC facility network is much better than otherwise expected (Table 1.3). There is still a challenge, however, in precisely estimating the number of indigenous peoples living a nomadic life in the Sangha and Lekoumou forests.

In Sangha, 62 per cent of the population is covered by functional comprehensive EmONC. This is an excellent result and a promising baseline. The Lekoumou region

Table 1.2 EmONC indicators in the designated EmONC network

Country	Benin	Togo	Burundi
EmONC monitoring period	2019 (first quarter)	2019 (first and second quarters)	2019 (first quarter)
Number of births in the EmONC network	34,352	32,875	42,558
Number of complications managed in the EmONC network	8,096	5,277	7,743
Proportion of expected births in the EmONC network	8%	10%	NA
EmONC availability (number of functional EmONC health facilities compared to the number of designated EmONC health facilities)	25%	21%	10%
C-section rate in EmONC health facilities	26%	24%	20%
Direct obstetric case fatality rate	NA*	4%	NA*
EmONC met need (in functional EmONC facilities)	7%	6%	NA
Number of maternal deaths notified in the EmONC network	168	134	53
Number of maternal deaths reviewed in EmONC network	99	44	51

Note: * the direct obstetric case fatality rate cannot be calculated for one quarter.

Figure 1.4 Sangha region EmONC facility network and population density map, including locations of indigenous peoples

SANGHA

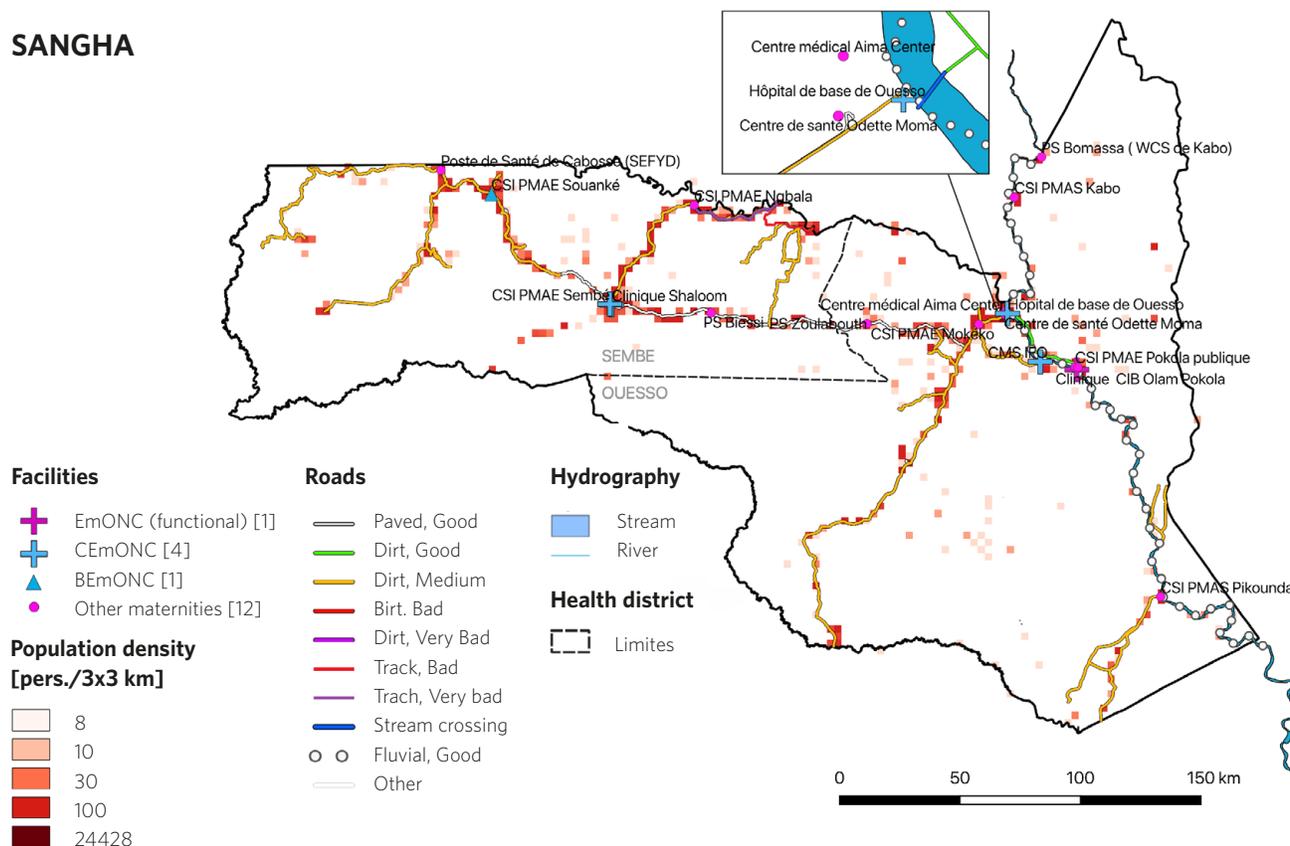


Table 1.3 Key results of the EmONC network mapping in two regions of the Republic of the Congo

Region		Lekoumou	Sangha
Population		139,112	123,744
All maternities	Number of facilities	21	16
	Population coverage (percentage) *	95%	93%
Designated EmONC facilities	Number of facilities	3	6
	Population coverage (percentage) *	82%	88%
Functional EmONC facilities	Number of facilities	0	1
	Population coverage (percentage) *	0%	62%
Gap in midwives (national level)		3	8
Proportion of satisfactory referral links		0%	0%
Maternity units at the lower level	Gap in midwives	24	12
	Proportion of satisfactory referral links	16%	36%

Note: * denotes within two hours travel time.

is a step behind and should see improvement following implementation of the project. Documentation of maternity units at the lower level illustrates additional efforts needed to upgrade them to provide satisfactory quality of care and efficient referral capacities. Maternities on the front line have closer contacts with indigenous peoples, and are a key component of the strategy to support these vulnerable populations in a respectful and culturally appropriate way. The Minister of Health has requested UNFPA to extend this approach on a national scale.

EmONC rapid needs assessment in Maniema Province of the Democratic Republic of the Congo

In 2019, the Ministry of Health in the **Democratic Republic of the Congo** drew on technical and financial support from the MHTF to assess the availability and quality of EmONC in Maniema Province. A total of 167 EmONC health facilities defined as such by the Ministry of Health and performing at least 20 deliveries per month (61 comprehensive and 105 basic EmONC health facilities) were surveyed in the 17 health zones of the province, home to an estimated population of 2.8 million inhabitants.

The survey included analysis of the provision of EmONC services and related infrastructure, human resources, equipment and supplies. EmONC availability was defined as 25 percent. Seven comprehensive EmONC health facilities are functional (providing the nine signal functions during the three months before the survey, with services available 24/7) compared to the 28 recommended by the international norm (five per 500,000 people). None of the basic EmONC health facilities are functional as per the defined criteria.

Around 32 per cent of the 167 health facilities lack a delivery room. About one third do not have a permanent source of running water and/or electricity. Transportation for referrals between health facilities is a major issue as only 7 per cent of the health facilities have a functional means of transportation. Human resources gaps across the province are particularly acute in terms of the scarcity of trained midwives. Continuous stock-outs of essential medicine are another difficulty.

Considering the province's poor availability of EmONC services, the Ministry of Health decided to revise the network of facilities by using the MHTF's approach. Efforts will focus on lowering the number of facilities, ensuring the strategic distribution of scarce human and financial resources to provide quality care 24/7 to a larger share of the population. The process will be

led by the Ministry and provincial stakeholders with the support of the MHTF. Lessons learned from the EmONC network in the Maniema Province are being used for advocacy with stakeholders to inform potential replications in other provinces of the **Democratic Republic of the Congo**.

1.3 MATERNAL AND PERINATAL DEATH SURVEILLANCE AND RESPONSE

MPDSR is a component of MNH programmes that provides a critical link between information and continuous improvements in lifesaving interventions. Instead of being set apart, MPDSR must be fully integrated in maternal and newborn health programmes and drive quality improvements along the MNH continuum.

It is designed to count every maternal, fetal and newborn death; analyse medical and non-medical causes; and examine what could have been avoided to inform the health system on improvements in care. As an important qualitative tool, MPDSR includes:

- Ongoing identification and notification of maternal deaths;
- Their review by local maternal death review committees and a short-loop response;
- Analysis at district and national levels to formulate recommendations and actions across multiple sectors; and
- Implementation of responses and monitoring of the entire action cycle.

The international community and countries face challenges in implementing and monitoring this programme at scale and with sufficient data quality. In March 2019, the MHTF hosted the annual MPDSR Technical Working Group meeting on programme monitoring at UNFPA headquarters. This group includes UNFPA, the WHO, the United Nations Children’s Fund (UNICEF), the Centers for Disease Control, the United States Agency for International Development, the Clinton Health Access Initiative, Jhpiego, the Liverpool School of Tropical Medicine, and the London School of Hygiene and Tropical Medicine. The main purpose of the meeting was to discuss programme implementation indicators. The MHTF attracted interest by presenting its implementation and monitoring framework which is based on indicators in 28 countries since 2015. While

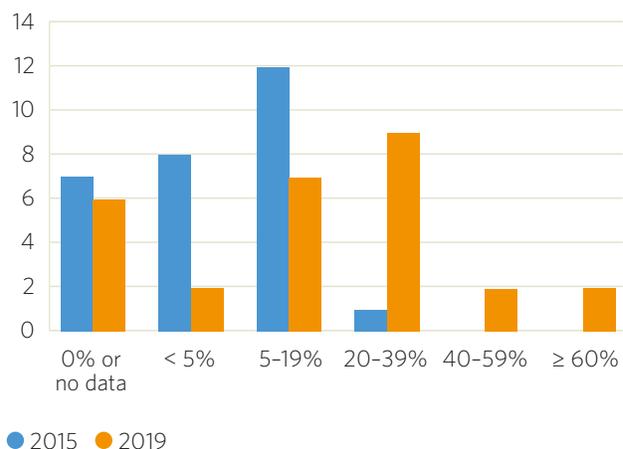
the MHTF has increasingly strengthened its capacity to monitor MPDSR programme implementation, much remains to be done:

- Only 13 per cent of MHTF-supported countries have the four recommended programme pillars in place (mandatory notification, a functioning national MPDSR committee, national guidelines and tools, and a costed budget);
- 48 per cent have implemented an MPDSR programme at a national scale.

A culture of blame, a lack of skilled staff, weak and stand-alone management, and underfunded responses to maternal review recommendations are well known obstacles to MPDSR programmes. These results also show, however, that programme implementation is not well supported, and that monitoring and evaluation remain weak. This reflects the broader situation of national MNH programmes in countries with high burdens of maternal and newborn mortality.

The annual technical working group meeting on MPDSR discussed the importance of tracking the maternal death notification rate and maternal death review rate indicators to monitor some of the expected results of MPDSR programmes. This helped reorient the workplan of the MPDSR Technical Working Group towards an enhanced focus on implementation. Since Phase II of the MHTF, the proportion of MHTF-supported countries using the maternal death notification rate to manage the national MPDSR programme has increased from 0 to 47 per cent.

Figure 1.5 The maternal death notification rate in 28 MHTF-supported countries, 2015 and 2019



Figures provided by the 28 MHTF-supported countries suggest that despite important weaknesses in implementation, some progress has been made (Figure 1.5). In 2015, the average notification rate was 16 per cent. In 2019, the average increased to 27 per cent. Yet most countries remain below the 40 per cent threshold for notification. With a few exceptions (**Bangladesh**, the **Democratic Republic of the Congo** and **Nigeria**), 60 per cent of the MHTF-supported countries are not able to report on maternal deaths in their communities.

A similar observation applies to maternal death reviews (Figure 1.6).

Figure 1.6 The maternal death review rate in 28 MHTF-supported countries, 2015 and 2019

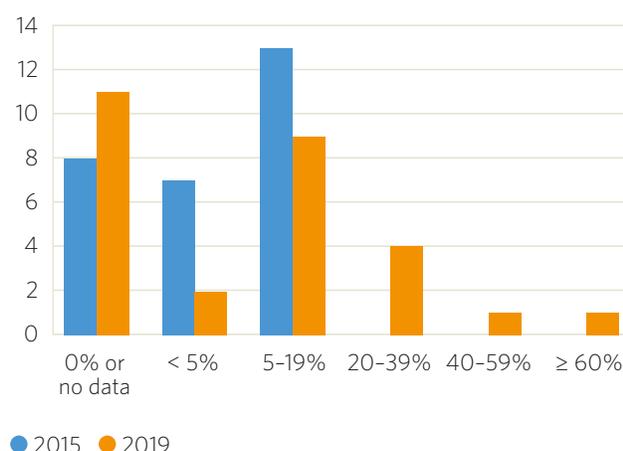


Figure 1.6 shows some progress. The average maternal review rate (proportion of expected maternal deaths reviewed) increased from 7 per cent in 2015 to 17 per cent in 2019. However, most countries remain below the 40 per cent threshold for review, and maternal deaths in communities are usually not taken into account.⁵

These indicators reveal capacity gaps in analysing maternal mortality trends in MPDSR reports. They also reflect weaknesses in community health programmes in terms of MPDSR and MNH. The MHTF will continue to track improvements in MPDSR analysis and reporting, and guide programme managers. Greater collaboration and better financial coordination are important components for

future MNH management support in countries with high burdens of maternal and newborn mortality.

1.4 OBSTETRIC FISTULA

Eradicating obstetric fistula is fundamental to upholding and realizing the promise and vision of the ICPD Programme of Action and achieving the Sustainable Development Goals (SDGs). In 2019, the MHTF focused on strengthening national capacities to prevent fistula and enhance the spectrum of care for women and girls who need it.

Global Policy Achievements

In 2019, the first year after United Nations resolution [A/RES/73/147](#) to end obstetric fistula within a decade, the MHTF catalysed interventions that bolstered country ownership, government leadership and financial support to prevent and treat fistula as part of improving MNH outcomes. It called increased attention to the health and human rights violation of obstetric fistula through high-level global, regional and country advocacy using evidence-based research and strategic platforms. These included the International Day to End Obstetric Fistula, the International Day of the Midwife, the United Nations Commission on the Status of Women and the World Health Assembly. A variety of efforts strengthened measures to realize and uphold the rights of women and girls with fistula and those at risk of getting it, and significantly supported the prevention, treatment, and social reintegration and advocacy efforts of the UNFPA-led global Campaign to End Fistula and its partners.

By the end of 2019, 69 per cent of MHTF-supported countries had developed national strategies to end fistula.⁶ Four more countries, **Liberia**, **Malawi**, **Rwanda** and **Sudan**, began developing national fistula strategies. Fourteen countries (44 per cent) had costed operational plans in place to facilitate efforts to end fistula, and 81 per cent had functioning government-led national task teams for fistula to bolster coordination and monitoring of the national response.

⁵ Due to COVID-19, maternal death notification and review figures for 2019 are not yet available in some countries. The “no data category” should decrease in 2021 without affecting the results analysis and conclusions.

⁶ Bangladesh, Benin, Burkina Faso, Burundi, Chad, Congo, Côte d’Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Guinea Bissau, Kenya, Madagascar, Mauritania, Niger, Nigeria, Senegal, Somalia, Togo, Uganda and Zambia.

ARAB STATES REGIONAL OFFICE COMMITS TO STRENGTHENING MPDSR PROGRAMMES

UNFPA's Arab States Regional Office prioritized strengthening MPDSR with MHTF support in 2019. To take stock, promote the cross-learning of experiences and knowledge to improve the quality of care, and enhance accountability, a regional maternal death surveillance and response (MPDSR) workshop was organized in July 2019 in Casablanca, **Morocco**. The workshop aimed at facilitating the development of H6 country platforms, enhancing maternal mortality tracking and addressing preventable causes to reach zero preventable maternal deaths. The workshop included representatives from ministries of health, academia, independent experts, University Mohammed VI of Health Sciences (UM6SS), the WHO and UNFPA from more than 14 countries.

Delegates discussed various elements of MPDSR: identification and notification, death reviews by local committees, monitoring and response, and inclusion of perinatal deaths (i.e., MPDSR). Additionally, the countries discussed their current MNH situations, MPDSR efforts, emerging issues like MPDSR in humanitarian settings and responding to near-miss challenges.

Some interesting experiences included: Jordan tracking maternal deaths in refugee camps and linking the data to national civil registration and vital statistics, Lebanon providing more than 80 per cent of services through the private sector, and **Morocco** achieving a significant reduction in maternal mortality in a short period. Other examples comprised **Oman's** effort to address near-miss issues and possibilities for further advancing maternal mortality prevention measures, and Sudan's partnership with the police to address delays in timely transport to facilities.

Some key challenges encompassed problems with reporting (misreporting, late or incomplete reporting), implementation problems in humanitarian settings, limited resources, high turnover of committee members, and slow and poor feedback from centralized review committees. Workshop participants formally recommended the establishment of feedback channels between the reviewing and implementing teams, and advocated for increased investments in MPDSR systems and cross checks.

The need for a comprehensive approach to improve existing MPDSR systems was identified as critical in the absence of strong and reliable civil registration systems. Many deaths go unrecorded and unreported because of weak systems. Making maternal and perinatal deaths a notifiable event is an essential starting point to ending preventable deaths. Global and regional efforts, such as the ICPD Nairobi Summit, provide momentum and opportunities to advocate for and engage with governments and different stakeholders to introduce and advance MPDSR.

Enhanced Advocacy to Build Commitment

The Campaign to End Fistula continued to advocate extensively for the elimination of fistula and put the spotlight on fistula as a human rights violation, and on eradication as key to achieving the SDGs.

Greater awareness of and commitments to ending fistula were realized through initiatives supported by the MHTF and the campaign, including the national commemoration of the International Day to End

Obstetric Fistula, significant messaging on social media, registration of clients under national health insurance schemes, training for obstetric fistula survivors as advocates, and sensitization and awareness creation on district and community radio stations. As a result of consistent advocacy, fistula is increasingly highlighted as a public health concern, a failure of health systems and a human rights violation.

The Lancet Global Health published a commentary⁷ to commemorate the 2019 International Day to End

7 Lauri Romanzi and others (2019), "Meeting the SDG challenge to end fistula & preventable childbirth-related morbidity & mortality," *The Lancet Global Health*, vol. 7, no. 7, E835-E836.



Zambia UNFPA Representative, Ms. Gift Malunga, interacting with 18 fistula patients who underwent fistula surgery in Mkushi, Central Province during the commemoration of the 2019 International Day to End Obstetric Fistula. © UNFPA Zambia, Precious Zandonda Chisanga, 2019. Photo submitted to the 2020 MHTF photo contest by Jenipher Mijere.

Fistula. The commentary underscored the critical role of universal access to skilled care at birth, including EmONC and safe surgery, in ending preventable maternal and newborn mortality and morbidities, such as obstetric fistula and stillbirths. Drawing from recommendations from the Lancet Commission on High Quality Health Systems in the SDG Era and the Lancet Commission on Global Surgery, the commentary emphasized that ensuring all women and girls in need receive timely, high-quality, life-saving obstetric surgery (whether a caesarean section or fistula repair) is a fundamental human rights issue and a key strategy for achieving the SDGs.

Strong messaging and significant communications showing the human face of fistula; influential champions and fistula advocates speaking out; and enhanced collaboration and coordination with partners have helped keep obstetric fistula on the global health agenda. The MHTF contributed through the campaign, and by raising awareness and support in high-burden fistula countries around the world. Two fistula survivors who have become advocates, Kevin Nalubwama from **Uganda** and Razia Shamshad from **Pakistan**, participated in the Nairobi Summit, sharing their experiences and advocating for access to quality care and equitable health services.

Other Achievements

In 2019, the MHTF supported over 8,000 fistula repair surgeries. The “success rate at discharge” was 75 per cent in 24 MHTF-supported countries. Unmet need for treatment of fistula, however, remains high in many countries, with many women and girls still unable to access the needed services. This prolongs their suffering.

The Campaign to End Fistula rallied efforts to develop updated global guidelines to address obstetric fistula and other forms of female genital fistula in partnership with campaign partners such as Direct Relief, the Fistula Foundation, the International Society of Obstetric Fistula Surgeons, Engender Health and others. These new guidelines, which build on the 2006 WHO/UNFPA *Guiding Principles for Clinical Management and Programme Development for Obstetric Fistula*, reflect progress and challenges in obstetric fistula prevention, repair and rehabilitation over the last decade. They emphasize quality of care as a significant factor to improve MNH outcomes, and will be published and disseminated in 2020.

UNFPA, the WHO and Johns Hopkins University further reviewed and vetted the preliminary global and country estimates of fistula developed by Johns Hopkins. The estimates were modelled with data from over 50 countries

in the Campaign to End Fistula, including MHTF-supported countries. The estimates will inform planning, programming and policymaking to realistically eliminate fistula, with finalization and dissemination planned for 2020.

Regional Strategies to End Fistula

Sub-Saharan Africa and South Asia account for 86 per cent of maternal deaths globally.⁸ In East and Southern Africa, a roadmap was developed for making pregnancy safer and preventing disabilities such as fistula. The roadmap highlights strategic investments in human resources including midwifery skills, data and knowledge generation on maternal death and obstetric fistula, integration of obstetric fistula in sexual and reproductive health and rights (SRHR) programmes, capacity development for service providers and addressing barriers to emergency obstetric care. As part of a wider regional strategy to improve maternal health in Asia and the Pacific, 12 countries, including 4 MHTF-assisted countries (**Bangladesh, Lao People's Democratic Republic, Nepal** and **Timor-Leste**), developed roadmaps to reduce maternal mortality and morbidity, including fistula. A regional strategy on eliminating fistula in West and Central Africa (2018-2021) was also finalized, and is seen as key to harnessing the demographic dividend and empowering women.

MHTF SUPPORT FOR STRENGTHENING HEALTH SYSTEMS TO ADDRESS OBSTETRIC FISTULA

Supporting the transition from “campaign mode” to routine obstetric fistula repairs by strengthening expert capacities for quality treatment;

Improving data on obstetric fistula through routine monitoring (health management information system), disease surveillance systems and monitoring of the quality of treatment;

Evaluating social reintegration programmes for fistula survivors; and

Harnessing domestic resources for fistula response through partnerships.

Fistula prevention was supported through integrated, cost-effective interventions, including improving skilled attendance at birth (through support to pre- and in-service training of midwives), access to family planning and timely access to quality EmONC.

Twenty-five MHTF-supported countries have mainstreamed fistula prevention into the midwifery pre-service curriculum. Midwives are being sensitized and trained on fistula prevention and its early management. Whereas timely emergency obstetric and newborn care – specifically, caesarean surgery – is a primary way to prevent obstetric fistula when a woman experiences prolonged obstructed labour, the increasing incidence of iatrogenic fistulas caused by medical error threatens progress made in improving access to and use of surgery. With increased safety and quality measures, including ensuring quality surgical competence and training, both types of fistulas can be eliminated.

In 2019, seven MHTF-supported countries (**Ghana, Guinea, Nepal, Kenya, Nigeria, Somalia** and **Togo**) achieved targets to treat newly identified cases of fistula. These countries further monitored the “success rate of repair at discharge”. MHTF-supported countries in general continued to transition from the campaign (or camp) mode of repairs to more sustainable, facility-based, routine repairs. Health facilities were strengthened to manage fistula through capacity-building. This was provided to local and resident fistula surgeons and surgical teams by expert and skilled surgeons from within and/or outside a country, in strategically located hospitals. Additionally, medical supplies and equipment were provided to support quality care. The MHTF assisted the **Ghana** Health Services/Ministry of Health, in collaboration with the national fistula task team, to conduct an assessment of the success of fistula repairs. **Madagascar** assessed the level of skill among national fistula surgeons, with findings expected to inform a training plan to address gaps in competencies.

To end fistula by 2030, robust research and data are critical to track new cases, determine the status of existing and repaired cases, and monitor progress on surgical and social outcomes. Since data contribute to evidence-based advocacy, supporting data generation has been a key priority of the MHTF and the Campaign to End Fistula. Fourteen MHTF-supported countries have integrated fistula-related indicators into national health management information systems. But the

8 Source: *Trends in Maternal Mortality: 2000 to 2017*, with estimates by the WHO, UNICEF, UNFPA, the World Bank Group and the United Nations Population Division.

marginalization and ostracization of women and girls with fistula often renders them invisible and at risk of being left even further behind. These barriers continued to limit the collection of prevalence data, with negative impacts on the correct estimation of treatment needs. Advances in disease surveillance and technology provide opportunities to improve case identification, strengthen follow-up on fistula cases and monitor progress towards elimination.

Social reintegration programmes help break the cycle of economic and social vulnerability that puts women and girls at risk of getting fistula. Though essential in the continuum of fistula treatment, such programmes have lagged behind. In 2019, **Mozambique** and **Uganda** assessed social reintegration programmes to inform subsequent planning and implementation of holistic national fistula programmes. Through MHTF support, **Sudan** developed an evidence-based social reintegration programme that informed its national fistula strategy. A UNFCU Foundation-funded initiative continued to support women and girls with fistula, including those deemed incurable in southern and northern **Nigeria**, in partnership with a local non-governmental organization (NGO), Fistula Foundation Nigeria. Facilitated through technical support from the MHTF and the Campaign to End Fistula, the initiative helped strengthen referral linkages between communities and health facilities. Overall, nearly 2,000 women and girls benefited from social reintegration programmes in 2019.

In collaboration with governments, the MHTF activated advocacy and resource mobilization with the private sector, garnering significant resources for fistula. The Government of the **Democratic Republic of the Congo**

and UNFPA, in collaboration with the private sector, mobilized resources through gala events to support the development of skills for fistula surgery and treatment for over 1,000 women. The Kaduna Fifth Chukker Polo & Country Club in **Nigeria** committed resources for 10 years to support the Kaduna State Government to end fistula. In **Burkina Faso**, UNFPA brokered a partnership with private faith-based organizations for the routine care of obstetric fistulas at the Schiphra, Saint Camille and Pal VI health facilities. As part of North-South cooperation and with the support of UNFPA, expert surgeons from Belgium treated 50 complex cases of fistula and at the same time developed the capacities of the local surgical team at the CMA Schipira (**Centre médical avec antenne chirurgicale**; faith-based health facility) for treating and managing fistula.

Through strategic interventions and significant advocacy, access to fistula treatment has increased substantially since the launch of the global campaign in 2003, although ensuring equitable access to treatment remains a challenge. Provision of care is uneven, and when available, it is often of poor quality, and delivered without respect or dignity.

1.5 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTEGRATION

A world where every person has equitable and accountable access to good quality SRH, MNH and rights requires meeting the needs of the individual throughout the life course, regardless of whether that person is an unmarried adolescent, mother of three children, a transgender person or a person living with disabilities.

SUPPORTING REINTEGRATION AND REHABILITATION OF PATIENTS WITH FISTULA IN BANGLADESH

In 2019, UNFPA worked closely with the National Fistula Centre at Dhaka Medical College and other government and NGO partners to establish a model to refer all identified fistula cases to available rehabilitation and reintegration programmes.

With UNFPA support, the World Mission Prayer League Hospital implemented fistula rehabilitation activities in Rangpur Division. The interventions included identification, referral and management of fistula cases, psychosocial support for all fistula patients, and needs-based rehabilitation and reintegration support involving links to government ministries/departments such as the Department of Social Welfare and the Department of Women Affairs. In 2019, 109 fistula survivors received psychosocial and mental health support during the pre-operative, peri-operative and post-operative stages, including during follow-ups. Furthermore, 29 fistula survivors accessed reintegration support from the Department of Women Affairs.

The four MHTF intervention areas – midwifery, EmONC, MPDSR, and obstetric fistula and other morbidities – offer a unique platform for providing integrated SRH services, positioning the fund well to strengthen links among different components in a comprehensive approach to SRHR.

During 2019, linkages among the four MHTF intervention areas and with other elements of SRHR continued to be further strengthened, including between maternity care and contraceptive service provision, community mobilization and awareness campaigns, screening and referral for gender-based violence, cervical cancer screenings, and prevention and treatment of HIV and sexually transmitted infections. In **Guinea**, 82 per cent of women who sought post-abortion care reported receiving modern contraception as part of it, as did 77 per cent in **Burkina Faso**. Nine countries reported screening women for cervical cancer. They benefited from the extended use of cryotherapy, with **Ethiopia** reporting 100 per cent of eligible women getting treatment, **Kenya** 75 per cent and **Côte d'Ivoire** 72.9 per cent. Many other countries have maternal health integrated cervical cancer screenings, such as **Burkina Faso**, the **Democratic Republic of the Congo**, **Madagascar**, **Mozambique**, **Nigeria** and **Zambia**.

In **Sierra Leone**, UNFPA supported the Ministry of Health to implement post-partum family planning services in selected health facilities, significantly increasing voluntary uptake of modern contraception among women leaving the maternity ward. Facilities that have started this programme are expected to meet their goal of 50 per cent of women leaving the maternity ward with a modern contraceptive.

In **Niger**, UNFPA worked closely with community leaders through a partnership with l'Association des Chefs traditionnels du Niger to raise awareness in their communities of SRHR, in particular through local initiatives taken by cantonal heads to improve the health of women and children. To advance holistic service provision, MHTF interventions in Niger have helped improve skills among midwives for screening, treatment and referral processes, including EmONC skills and capacities to diagnose obstetric fistula.

In **Ethiopia**, a mentorship programme established by the MHTF has developed midwives' capabilities to diagnose fistula and refer patients to nearby fistula centres. Mentees reported an increase in their knowledge, basic lifesaving skills and ability to provide better quality care. As a result, there have been improvements in cleanliness,

antenatal care, family planning, childbirth and postnatal care rooms, adherence to infection prevention standards and the availability of newborn corners in delivery rooms.

In the **Democratic Republic of the Congo**, UNFPA worked to increase access to the reproductive rights of women and girls in communities affected by conflict. Over nine months, more than 70,000 rights-holders gained different SRHR services and information, based on their needs, including safe childbirth, management of sexually transmitted infections, assistance for survivors of gender-based violence and obstetric fistula interventions. UNFPA also helped midwives become better equipped in providing SRHR services and information in humanitarian settings.

To enable more holistic and person-centred care, countries implementing interventions under the MHTF have expanded links between SRHR and adolescent and youth programming. MHTF-assisted countries are increasing their emphasis on adolescent-responsive service provision, making sure that SRHR services meet the needs of adolescents and youth through capacity-building, awareness-raising, addressing social norms among health-care providers and community leaders, and connections with comprehensive sexuality education programmes in and out of school.

UNFPA in **Uganda** is implementing a "Live Your Dream" campaign that targets adolescents and youth, and addresses underlying factors that result in their exploitation and hamper them from reaching their full potential. Four main approaches include linking gender-based violence prevention, screening and treatment with contraceptive service provision and information; an emphasis on education, including comprehensive sexuality education; innovation and social change enacted by young people themselves, and a mentorship programme between adolescents and the elderly in local communities.

Efforts have increased to develop a comprehensive approach to SRHR during 2019, as a direct result of the MHTF's new Business Plan. More mindful planning is necessary, however, taking links into account from the planning phase, reflecting links and integration indicators in monitoring and evaluation frameworks, and ensuring that interventions are designed to deliver holistic services across comprehensive SRHR packages.



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Abraham Gelaw, 2019.
Photo submitted to the
2020 MHTF photo contest.

PART

2



Deployed by UNFPA in the health section of Kalole, Province of South-Kivu, Eastern DRC, Estelle Bahatisage contributed to addressing humanitarian needs and to responding to Sexual and Reproductive Health interventions. Focus was given to UNFPA's 3 transformative results (to end preventable maternal death, to end unmet needs in family planning and to end gender-based violence and harmful practices). ©UNFPA Democratic Republic of the Congo, Junior Mayindu, 2019. Photo submitted to the 2020 MHTF photo contest.

ADDRESSING EQUITY IN ACCESS, QUALITY OF CARE AND ACCOUNTABILITY: A COMPREHENSIVE APPROACH

As in previous years, the MHTF continued to implement an integrated, comprehensive SRMNAH approach to strengthening MNH programmes, focused on three cross-cutting, core principles: **equity in access, quality of care and accountability.**

All three principles are fundamentally a matter of respecting, protecting and realizing human rights, including the right to health, of all individuals. Fulfilling the three principles and the right to health in all its forms and at all levels requires services, commodities and facilities to be available in sufficient quantity; physically and financially accessible; culturally and ethically acceptable; and responsive to gender and life-course requirements. It also means catering to the specific needs of diverse population groups, with respect for confidentiality and informed consent. Services should be scientifically and medically appropriate, and of good quality⁹.

Equity in access ensures that every individual in need is able to access SRMNH services, regardless of geographic location, socioeconomic status, ability to pay, education, ethnicity, race or gender, and should be empowered and informed to use needed health services. Accessibility further implies fulfilment of the principal of non-discrimination and the right to seek, receive and impart health-related information (United Nations Office of the United Nations High Commissioner for Human Rights¹⁰). Certain populations are more disadvantaged in accessing comprehensive SRH services, including people living in poverty, adolescents, indigenous people, migrants, refugees, single women, persons with disabilities (including women and girls with fistula), LGBTI+ populations, and/or persons living in remote, rural areas.

Quality of care underlies all aspects of SRMNH. It implies that commodities and facilities should be of good quality, and services must be delivered in a safe, effective, timely, efficient, integrated, equitable and people-centred manner, based on care standards and treatment guidelines, and taking into account people's experiences and perceptions of care, including affordability and acceptability.

Accountability: SRMNH is underpinned by human rights, and the financial, political and performance accountability required to maintain high standards of SRMNH care, with inclusiveness and transparency at all levels of the health system. Accountability calls for capturing and taking into account rights-holders' views and demands in planning and implementation of SRMNH programmes. Review processes, such as MPDSR, enabling legislation and regulatory bodies all contribute to accountability, continuously maintained quality of care, equity in access and overall responsibility for SRMNH.

Equity in access, quality of care and accountability are mutually reinforcing; it is crucial to address all three. For instance, if there is no equity in access, there can be no accountability, which in turn requires ensuring quality of care and equity in access, leaving no one behind. Similarly, unless quality services are offered, women will not use them even if there is equity in access.

The comprehensive, integrated approach of the MHTF helps countries achieve high-quality, impactful results while maintaining accountability and making constant improvement based on lessons learned. This section of the report highlights several country examples where these integrated approaches are showing positive results.

9 Source: Human rights and health, World Health Organization

10 Toolkit on the Right to Health, United Nations Human Rights Office of the High Commissioner

COUNTRY EXAMPLES OF IMPLEMENTATION IN SERVICE DELIVERY

Competent Midwives as the Centrepiece of Quality Improvements

The midwifery programme continued to focus on improving the quality of service delivery through ICM competency-based curricula. Over 90 per cent of MHTF-supported countries are now using and strengthening regulatory mechanisms, which helps ensure that midwives graduate with the necessary skills, knowledge, practices and professional behaviours.

In 2019, mentorship programmes for midwives continued to be strengthened and expanded across MHTF-supported countries within EmONC facilities and midwifery schools. Midwives became more confident in their clinical and life-saving skills, and in managing morbidities such as fistula. The Association of Midwives of **Burkina Faso** partnered with the national network of EmONC facilities to create and execute a mentorship programme, training 75 providers and serving as a benchmark for other countries in the region. Additionally, 856 midwifery students in eight schools were trained on EmONC and family planning. **Madagascar** trained 25 mentors on integrated basic EmONC mentorship skills.

Nigeria implemented a large-scale effort to expand the capabilities of nurses and midwives. As part of the Nursing and Midwifery Council's Mandatory Continuing Professional Development Programme, 11,627 nurses and midwives were trained in a variety of modules, including those on EmONC, female genital mutilation, psychosocial support, clinical management of rape, adolescent SRH services and contraceptives. The programme trained 2,118 midwives on respectful maternity care and obstetric fistula prevention. Additionally, a maternal nutrition module was developed, and 76 professionals, including 34 nurses and midwife tutors, were oriented on disseminating it. A total of 3,126 nurses and midwives successfully completed the module, which addresses healthy eating, iron and folic acid, and nutritional support for women of all ages.

MAINSTREAMING MPDSR IN THE PRE-SERVICE CURRICULUM IN ETHIOPIA

With support from the MHTF in 2019, Mekelle University in Ethiopia revised its master's-level midwifery curriculum to include MPDSR, and developed midwifery curricula at the undergraduate and doctoral levels. Participants from six universities took part in the exercise. Additionally, MPDSR was integrated in two postgraduate programmes at Gondar University, for a master's degree in public health under the reproductive health track and a master's degree in midwifery.

A five-day preceptor training course was instituted in **Ghana**, and 28 midwives from 11 midwifery schools became preceptors. **Somalia** held a two-day workshop to strengthen the capacity and supervision skills of EmONC facility supervisors. In **Côte d'Ivoire**, the MHTF supported the internships of midwives in EmONC; 300 supervisors were trained in 2019, and 2,500 undergraduate midwives are currently enrolled across six branches of the National Institute for the Training of Health Workers. **Benin** has introduced weekly clinical presentations and new training exercises for midwives, and internship sites have been updated.

UNFPA continued to foster and promote Laerdal's "Helping Mothers Survive, Helping Babies Breathe" initiative to drive high-quality health care by using the low-dose, high-frequency approach.¹¹ These training programmes, when used at the facility level and integrated in pre-service education, help midwives develop skills for normal births, essential newborn care, treating emergencies due to post-partum haemorrhage or eclampsia/pre-eclampsia, and newborn resuscitation. UNFPA continued to participate in the 50,000 Happy Birthdays Project led by the ICM in collaboration with Laerdal Global Health, Jhpiego, and midwifery associations in **Ethiopia, Malawi, Rwanda, the United Republic of Tanzania and Zambia**. Overall, 17 MHTF countries have a standardized in-service training programme for midwives for short-term competency-based courses (**Bangladesh, Burkina Faso, Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Guinea Bissau, Haiti, Kenya, Lao**

¹¹ The low-dose, high-frequency approach is designed to build capacity and promote the maximal retention of clinical knowledge, skills, and practices. It entails short, targeted, in-service simulation-based learning activities, which are spaced over time, and reinforced with structured, ongoing facility-based practice sessions.

People's Democratic Republic, Malawi, Mauritania, Rwanda, Senegal, Somalia and Zambia).

In addition to skills-building initiatives for health workers, 16 MHTF-supported countries have recently completed regulatory frameworks for midwives, covering the scope of practice, a code of conduct and accreditation (**Bangladesh, Burkina Faso, Côte d'Ivoire, Kenya, Liberia, Madagascar, Malawi, Nepal, Nigeria, the Republic of the Congo, Rwanda, Sierra Leone, Somalia, Sudan, Uganda and Zambia**).

Innovative Technology-Driven Approaches to Improve Quality of Care and Equity in Access

Innovative approaches to MNH rooted in technology continued to be scaled up to enhance the skills of midwives and improve quality of care. The Ministry of Health in **Ethiopia** expanded access to and strengthened e-learning for midwifery through the large-scale distribution of computers. It also directly linked the e-learning curriculum to the Licensure Exam Directorate hub, and conducted examinations for seven cadres. In **Nigeria**, greater digital access and e-learning are improving the quality of training, with

UNFPA supplying the Kaduna State School of Midwifery with several computers, a website, unlimited Internet services, electronic simulators, teaching materials and books. Fifteen staff members at the school were trained in computer-based teaching, and students had a 90 per cent success rate on the National Qualifying Examination. **Haiti** is currently establishing schools in its northern and southern regions and is incorporating e-learning training platforms and digital libraries for ease of access and increased quality. The Canadian Association of Midwives is working with UNFPA in **Haiti** to complete a comprehensive online library. In **Nepal**, community mobilizers have supported the reintegration of obstetric fistula survivors through regular communication with survivors on the phone and through home visits.

UNFPA's e-learning modules covering all key obstetric emergencies were rolled out in **Bangladesh** in 2019, in collaboration with the Directorate General of Nursing and Midwifery. A total of 39 midwifery faculties from all 38 nursing and midwifery institutes and colleges in Bangladesh completed nine modules and are now deploying these in midwifery schools nationwide. Participants were given childbirth videos on childbirth and essential newborn care, such as on managing

ASIA PACIFIC REGION SCALES UP "HELPING MOTHERS SURVIVE, HELPING BABIES BREATHE"

To strengthen the clinical competencies of midwives in key life-saving skills related to major causes of maternal and newborn mortality, as well as for conducting normal births, UNFPA's Asia and the Pacific Regional Office, with support from the MHTF, scaled up "Helping Mothers Survive, Helping Babies Breathe" training in **the Kingdom of Bhutan, Lao People's Democratic Republic and Papua New Guinea**, using a low-dose, high-frequency approach. The office partnered with the Burnet Institute, Jhpiego and Laerdal Global Health.

A total of 38 midwives with master's degrees were trained and mentored to train a subsequent round of master's-level trainers in the three countries. The teaching approach and content were extremely well received and will be incorporated into pre-service curricula. All three countries saw significant improvements in pre- and post-training knowledge, skills and confidence levels, which were tested using OSCE¹² assessments.

The participants developed action plans to roll out trainings in health facilities and schools. In 2020, UNFPA will support the Ministry of Health in **Lao People's Democratic Republic** in establishing a network of master's-level trainer midwives in each province. They will be responsible for rolling out the training and helping to establish practice corners in facilities where sessions can be conducted. The training will be integrated into the activities of the Lao Association of Midwives as part of their continuous professional development for midwives.

12 Objective Structured Clinical Examination is an assessment system for clinical skills.

the second and third stages of labour, and infection prevention, that were developed by the Global Health Media Project. Over 25 countries are now using the e-learning modules.

Ghana hosted a two-day hackathon on nursing and midwifery in collaboration with Jhpiego. Key ideas, such as e-learning mechanisms and apps for mentorship, were proposed to the Midwifery and Nursing Quadriad Committee. The hackathon incorporated the ideas of over 30 different stakeholders, including midwifery students and directors, preceptors, young people, and entrepreneurs.

In **Zambia**, through the Maternity Foundation and the Ministry of Health, 25 midwives and other health-care professionals were trained in using the Safe Delivery App throughout the country to enhance key life-saving skills. With MHTF support, **Rwanda** developed a web-based app for the Rwanda Council of Nurses and Midwives that monitors midwives and nurses, and provides a registry for licensing as well as access to resources for professional development. A mobile learning system launched in 2018 is now fully established in the Rutsiro district as part of continuous professional development for the midwifery programme.

LAO GIRL IN PURSUIT OF HER CALLING AS A MIDWIFE

“My mother delivered my brother on the road as a premature baby at the age of 17 years, and they both suffered severe complications. This is still an everyday reality in Phongsaly today, but I want to change this,” said Phailine, a 21-year-old woman from Phongsaly Province. She is in the final year of studying midwifery at the Vientiane Provincial Nursing School in Lao People’s Democratic Republic.

A life-changing opportunity presented itself to Phailine when she was admitted to a higher diploma of midwifery programme, despite practical challenges like a language barrier. Phailine speaks a different language than Lao, which is the official language for teaching midwifery. But she is determined that “these difficulties cannot stop me from becoming a midwife to safeguard the health of women and babies”. She plans to return to her hometown to serve the local community after her graduation.

“When trained midwives are deployed in the hardest to reach communities, and are supported with necessary tools and equipment, they can tackle the unfinished business of ending preventable maternal deaths,” said Mariam Khan, UNFPA Representative in **Lao People’s Democratic Republic**. As stated in the Midwifery Improvement Plan (2016-2020), the most critical intervention for safe motherhood is to ensure the presence of a competent health professional with midwifery skills at every birth.

UNFPA supported the Ministry of Health to revive the midwifery cadre in 2009 following a few decades without specific midwifery education. Since 2015, UNFPA has been focused on improvements in midwifery education through the revision of the national midwifery curriculum, training of midwifery teachers and scholarships for midwives from minority ethnic groups. Nursing schools received support in expanding midwifery education to promising young people like Phailine.

As of 2019, 1,867 midwives serve in hospitals and health centres nationwide, and 512 are from ethnic minorities. The Lao Association of Midwives was re-established to strengthen the skills of clinical midwives and build a strong cadre.

Lao People’s Democratic Republic made significant progress in bringing down maternal mortality from 294 maternal deaths per 100,000 live births in 2010 to 197 in 2015. As of November 2019, maternal mortality has declined to 112. To reach the target of ending maternal death by 2030, the Government will continue to promote midwifery education as part of its health sector reform strategy, and aim at universal coverage of quality midwifery services, especially among the most vulnerable communities. The MHTF is strongly supporting this initiative.



©UNFPA Lao People's Democratic Republic, 2019.

Improved service delivery, accountability and monitoring through data tracking

Data collection has enabled the tracking of care providers and patients geographically, allowing MHTF countries to identify gaps in the care and monitoring of patients. Through MHTF support, **Bangladesh** and **Ethiopia** made strides towards integrating fistula into disease surveillance and emergency public health management information systems, respectively. UNFPA supported **Bangladesh** in conducting workshops to extend and strengthen its online, mobile phone-based SRHR surveillance system to include a fistula reporting mechanism. This will be managed by the Institute of Epidemiology, Disease Control and Research of the Ministry of Health and Family Welfare, supported by UNFPA. The Government of **Mozambique** in partnership with UNFPA and Operation Fistula (a Campaign to End Fistula partner) developed and launched InfoFistula, a real-time monitoring system that tracks interactions with fistula patients, generating data for the national

fistula response. **Zambia** began tracking fistula repair surgeries in select districts and provinces, including 187 fistula survivors in 2019. By 2019, 14 (44 per cent) MHTF-supported countries, **Bangladesh, Burkina Faso, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ghana, Guinea, Kenya, Niger, Nigeria, Rwanda, Senegal, Togo** and **Uganda**, had integrated fistula-related indicators into the national health management information system. This indicated a move towards more standardized reporting of diagnosed and treated obstetric fistula cases, and the tracking of fistula data from facilities to the national level.

Following the establishment of the National Midwives Association of Uganda last year, **Uganda** improved its tracking of midwives, enrolling 956 midwives and nurses into a GIS database covering 10 districts. Through collaboration with the Ministry of Health and Ministry of Education and Sports, this information guides the placement and training of midwives. In **Sierra Leone**, a comprehensive electronic database of midwives was

established, and 781 midwives, about 70 per cent of the expected number, were registered. Thirteen MHTF-assisted countries have reported use of a professional midwifery electronic register, with **Bangladesh, Burkina Faso, Kenya, Liberia** and **Somalia** reporting registration of over 75 per cent of midwives.

MHTF-supported countries continued to prioritize data collection for MPDSR, increasing accountability for improving the quality of care in EmONC facility networks. Sixteen countries¹³ reported having a national monitoring tool, and 12 reported using the tool to track implementation (including MPDSR framework components) and results at the national and subnational levels.

Although MPDSR has been prioritized in East and Southern African countries, the focus has been on facility-based maternal deaths. Community identification has been neglected. It is critical to strengthen this component to progress towards zero preventable maternal death. Effective coordination, collaboration, commitment, monitoring mechanisms and resource mobilization will be essential. Extensive advocacy is needed to accelerate the scale-up of community MPDSR.

Enhanced integration of MHTF and SRHR components

Enhanced integration of all aspects of SRHR (post-partum family planning, fistula, comprehensive abortion care, to the full extent of the law, including post abortion care, adolescent SRH and cervical cancer screenings, among others) remains a focus of the MHTF. The **Democratic Republic of the Congo** has been systematically involving various stakeholders in the promotion of family planning. Specifically, a project in Tanganyika targeted adolescents for comprehensive sexual education, family planning, empowerment through entrepreneurship for young mothers, and promotion of access to SRH resources.

Beyond family planning, MHTF countries have integrated several facets of SRH into health systems through training and curriculum reviews. In **Ethiopia**, the Gondar Fistula Center trained 43 midwives and other health-care professionals on post-abortion and cervical cancer care, while at the facility level, 3,335 women were screened for cervical cancer. The MHTF also supported the training of 850 health providers on MPDSR. **Malawi's** midwifery curriculum was reviewed and revised to cover obstetric fistula. In **Mauritania** two midwives were trained on

ACCELERATING COMMUNITY MPDSR IN EASTERN AND SOUTHERN AFRICA

Under the United Nations Secretary-General's Global Strategy for Women's and Children's Health (2010-2015), MPDSR was introduced in East and Southern Africa around 2013. It helped consolidate and coordinate various fragmented efforts in a few health facilities scattered across different countries. MPDSR was key to bringing together various activities implemented as hospital-based maternal death reviews and audits.

Despite implementation of MPDSR, the community death notification system for maternal deaths faces continued challenges. Towards optimizing and functionalizing the system, UNFPA's Eastern and Southern Africa regional office defined two approaches: a case study to document experiences and challenges, and South-to-South exchanges and learning on tools and mechanisms. The case study is described here, with the exchanges planned for 2020 and 2021.

A mixed-method case study captured experiences in **Ethiopia, Malawi, Uganda** and the **United Republic of Tanzania** in November 2019. It found that none of the countries had used their community death notification data for preparing an action plan or implementing a response plan. Most countries are struggling for nationwide coverage. A lack of human resources, the dropout of volunteers, inadequate orientation, a lack of community awareness and non-functional MPDSR committees are key barriers.

13 Bangladesh, Benin, Burkina Faso, Burundi, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Guinea, Guinea Bissau, Liberia, Madagascar, Malawi, Nigeria, Rwanda, Senegal and Zambia.

obstetric fistula post-operative care, and nine midwives on clinical rape management. Six comprehensive EmONC facilities in **Sudan** were fully equipped with high-quality family planning clinics, and health providers were trained to provide post-partum and post-abortion family planning services. Additionally, 50 health centres instituted cervical cancer screenings using the Visual inspection of the cervix with acetic acid (VIA) method, and five hospitals were prepared to provide cryotherapy treatment. Burkina Faso reviewed the obstetrics component of the midwifery curriculum at training schools, and identified and addressed gaps in basic EmONC education, including fistula management. **Côte d'Ivoire** helped train 15 surgeons in fistula repair, and 50 midwives in fistula screening, identification, referral, management and post-operative care.

THE DEMOCRATIC REPUBLIC OF THE CONGO SCALES UP FISTULA CARE

Still in a fragile phase of post-conflict reconstruction and peacebuilding, the **Democratic Republic of the Congo** is a least developed country with a very high maternal mortality ratio of 473 per 100,000 live births¹⁴. Over half its people live in rural areas, where health resources are sparse. Accessing a hospital can be close to impossible. Dirt roads may be completely flooded and impassable for months on end.

In these circumstances, the incidence of fistula is high. UNFPA supports an average of 1,000 fistula repairs a year. In 2019, with MHTF assistance, access to fistula treatment was scaled up through collaboration with two centres of excellence for fistula repairs, the Foundation/Panzi Hospital in Bukavu and St Joseph's Hospital in Kinshasa. Training and the establishment of six surgical teams to manage simple obstetric fistula cases facilitated routine fistula repair, and 14 hospitals strengthened capacities for fistula treatment.

A total of 1,220 women with fistula from 14 out of 26 provinces were repaired. Local resources mobilized through strategic partnerships and two gala nights (one

in Kinshasa and the other in Kolwezi) contributed to these achievements.

The MHTF continued to address the issue of mental health support and social stigma accompanying obstetric fistula. With its support and in partnership with government ministries and Campaign to End Fistula partners, 1,906 women and girls from nine countries (**Bangladesh, Côte d'Ivoire, the Democratic Republic of the Congo, Mauritania, Niger, Nigeria, Sierra Leone, Togo and Uganda**) benefited from various social reintegration programmes. MHTF support facilitated assessments, evaluation and monitoring of existing social reintegration programmes in **Benin, Sudan and Uganda**, contributing to an evidence base to inform and improve programmes in line with the needs of fistula survivors. The Terrewode Women's Community Hospital in Eastern **Uganda** was built with the capacity to treat and reintegrate 600 fistula patients annually. It is the first specialized fistula hospital in this region. **Madagascar** has established psychosocial support in post-operative follow-up care.

Interventions for increased integration can only function if accompanied by respectful maternity care. **Zambia's** Ministry of Health and Midwifery Association created and implemented a framework for respectful maternity care for midwives and other health-care professionals. The guidelines were supplemented by training manuals.

Access, quality and accountability: a matter of legislation and political will

A key way to improve SRMNAH outcomes is through suitable legislation, and enabling and empowering policies. The quality of midwifery care, for instance, is impacted by strong regulatory frameworks and accountability mechanisms to monitor services.

The assessment and implementation of EmONC networks at country level does require strong political will. UNFPA was able to create such political will by highlighting the significant impact of quality EmONC networks on maternal and newborn mortality reduction and maternal health in general. This implies, however, that the EmONC network approach can only be fully implemented in countries where Ministry of Health senior management requests UNFPA for

14 Trends in Maternal Mortality 2000 - 2017. Estimates by WHO, UNFPA, UNICEF, WB and the United Nations Population Division. 2019

THE KADUNA STATE GOVERNMENT AND UNFPA TAP INTO PUBLIC-PRIVATE PARTNERSHIPS FOR AN INTEGRATED RESPONSE TO FISTULA

Thousands of women and girls live with fistula in **Nigeria's** Kaduna State. In 2019, UNFPA signed a partnership agreement with the Kaduna Fifth Chukker Polo and Country Club to support the state government's efforts to end the suffering of these women and girls. Club members agreed to a multi-year action plan to mobilize resources, such as through a road walk and a high-level fundraising seminar, reinforced by mass media campaigns. The club made a 10-year pledge of 50 million naira with an annual release of 5 million naira. In tandem, the governor of Kaduna State created a 50 million-naira (US\$140,000) budget line for obstetric fistula with a commitment to strengthen the capacity of the Hajia Gambo Sawaba General Hospital in Zaria to provide quality management of cases.

Through the MHTF, UNFPA also collaborated with the Kaduna State Government to strengthen midwifery education to end preventable maternal mortality and morbidity. The Kaduna State School of Midwifery was upgraded to WHO/ICM standards, and earned full accreditation from the Nursing & Midwifery Council of Nigeria. Student uptake doubled to a minimum of 100 students per year, up from 50. The College is recognized as a centre of excellence for pre-service training and as a training centre for other nursing institutions in Nigeria, as well as a centre for the Mandatory Continuous Professional Development Programme.

support. As a result of UNFPAs advocacy efforts, four additional countries decided to join this approach: **Benin, Chad, Côte d'Ivoire, and Mozambique** in 2019.

With MHTF support, the Midwifery Association of the **Democratic Republic of the Congo** developed a revised midwifery regulation bill presented to a new parliamentary commission for health. Political advocacy for midwifery through provincial leaders, including in the offices of governors and departments of health, is helping ensure that midwives are placed in health facilities. Similarly, in **Sierra Leone**, a revised midwifery bill was advocated for and submitted to Parliament through the Minister of Health.

The Government of **Nepal** formally advocated for the Safe Motherhood and Reproductive Health Act and is currently undertaking steps for implementation. An executive plan for ensuring maternal and newborn health has been formulated. The Nepal Nursing Council has been renamed the Nepal Nursing and Midwifery Council, and UNFPA is collaborating with the Burnet Institute of Australia to develop a bridging course between nursing and professional midwifery. The council has established the Licensing and Test Competency Guidelines for midwives and tools for midwifery school accreditation.

Kenya's First Lady pioneered the National Fistula Strategic Framework and National Fistula Training Package for building the capacities of health-care

providers, now adopted by other stakeholders for fistula management. **Madagascar** and **Somalia** both have initiated costed national strategic plans to eliminate fistula. Somalia's National Fistula Taskforce met twice in 2019, continuing to advocate for fistula care and survivors. In **Nigeria**, UNFPA helped fund and support the Federal Ministry of Health in developing the first National Social and Behaviour Change Communication Strategy for Elimination of Obstetric Fistula (2020-2024), as well as the public-private partnership to end fistula by 2030 in Kaduna State.

The successful implementation of MHTF programming is contingent on the three cross-cutting principles of equity in access, quality of care and accountability. Prioritizing this integrated SRMNAH approach, the MHTF continued to implement catalytic programmes yielding quality results in 2019. Despite consistent efforts to build synergies with nationally implemented programmes, and other programmes funded by donors and partners (H6, the Partnership on Maternal Newborn and Child Health, SWEDD and Muskoka, among others), the MHTF remained constrained by a lack of adequate funding, which continues to prevent the scaled-up support required.



PART

3



Midwifery training, Mymensingh Nursing College, Bangladesh.
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MHTF RESOURCE MANAGEMENT

3.1 A BRIEF BACKGROUND

The MHTF comprises two multidonor funding streams: the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula.

In line with most multilateral organizations, UNFPA sees more and more resources earmarked for a specific purpose or region by donors. While it is positive that non-core resources continue to increase, it creates challenges for the organization to ensure that many pockets of non-core funds are not deployed in isolation but work together towards the realization of UNFPA's Strategic Plan. To that end, MHTF funds are allocated to countries based on a specific set of criteria to ensure that the funds will be used where they are most needed, and are fully aligned with other UNFPA resources and UNFPA's Strategic Plan.

For the MHTF, the criteria and weighting used in 2019 to calculate the needs of programme countries and allocate resources accordingly are shown in Figure 3.1.

In each category, each of the 32 MHTF-supported countries (see Annex 4) receives a score. Cumulatively, these scores 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 2019, the MHTF continued to work in countries with high maternal mortality rates, in accordance with its programme agreement. Funds were allocated to activities in 32 countries and by 5 regional offices (Arab States, Asia and the Pacific, East and Southern Africa, Latin America and the Caribbean, and West and Central Africa).

The MHTF's two funds have been programmatically integrated under the MHTF since 2009. See Annex 2 for approved allocations, expenditures and financial implementation rates.

Most funding for the Campaign to End Fistula is provided directly from the Thematic Fund for Maternal and Newborn Health, since this eases coordination and programme management. 3 per cent of overall funds for the MHTF and fistula programming was provided via the Thematic Fund for Obstetric Fistula.

3.2 CONTRIBUTIONS

As shown in Figure 3.2, US\$13.1 million was received by the Thematic Fund for Maternal and Newborn Health and more than US\$540,000 by the Thematic Fund for Obstetric Fistula in 2019. This was US\$9 million more than in 2018, when the two funds received a total of US\$4.1 million.

Figure 3.1 MHTF resource allocation criteria and weighting

MHTF resource allocation criteria and weighting	Weight, percentage
Maternal Mortality Ratio (MMR)	20
Skilled health personnel for MNH	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

Figure 3.2 Donor contributions to the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula in 2019 (in US\$)

Donors	Maternal & Newborn Health Fund	Fistula Fund	Total collected revenue*
Friends of UNFPA	45 702	25 695	71 397
Germany	1 319 902		1 319 902
Luxembourg	2 045 455	454 545	2 500 000
Poland		51 387	51 387
Sweden	9 542 016		9 542 016
Laerdal Global Health	4 665		4 665
Interest and adjustments	119 513	10 340	129 852
Total	13 077 252	541 968	13 619 220

Note: * indicates collected revenue, or actual amounts transferred from donors to UNFPA in 2019.

In the fourth quarter of 2018, the two funds received contributions for programmes in 2019 as detailed in Figure 3.3.

Figure 3.3 Q4 2018 Donor Contributions to the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula (in US\$)

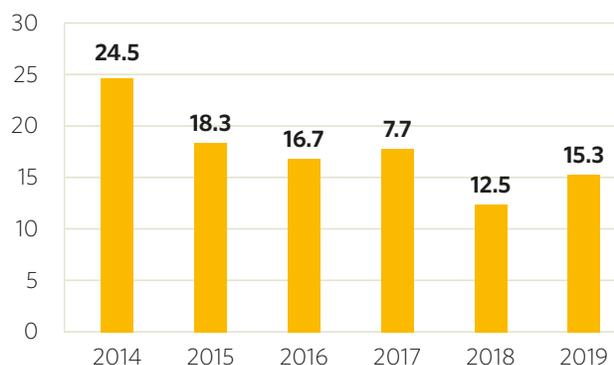
Donors	Maternal & Newborn Health Fund	Fistula Fund	Total collected revenue
Germany	1 620 813		1 620 813
Poland		61 893	61 893
Interest and adjustments	119 998	8 506	128 504
Total	1 740 812	70 398	1 811 210

3.3 OPERATING BUDGET

The operating budget for the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula in 2019 encompassed the end-of-year balance for 2018 plus income received during the first three quarters of 2019. Income received during the fourth quarter will typically be carried over to the following year, since it 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 services or goods have actually been carried out or handed over to the implementing partner.

As Figure 3.3 shows, the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula received US\$1,811,210 million in the fourth quarter of 2018 to be used in 2019. An additional US\$282,683 was carried over from the regular programme budget from 2018 to 2019. Further, US\$13,181,373 million was received in donor contributions during the first three quarters of 2019. This brought the total operating budget for the Thematic Fund for Maternal and Newborn Health to US\$15,275,266 million in 2019 (Figure 3.4).

Figure 3.4 Budgets for the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula from 2014 to 2019 (in mil. US\$)



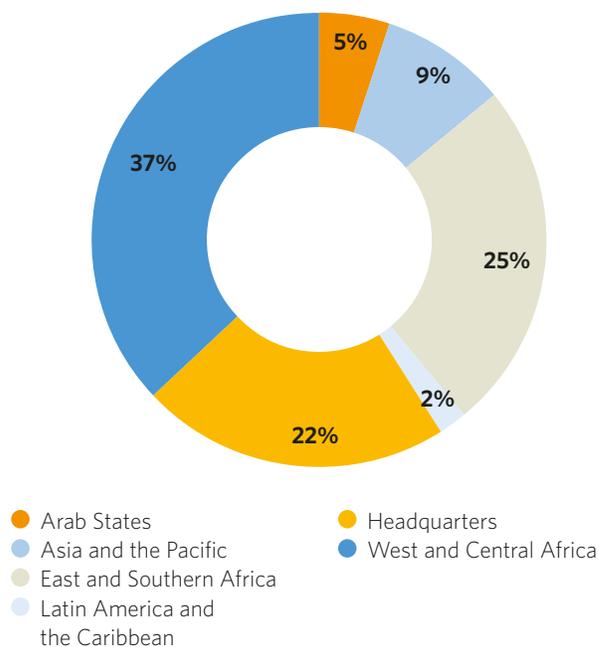
3.4 EXPENSES

In 2019, expenditures for maternal health through the Thematic Fund for Maternal and Newborn Health totaled US\$10.9 million (US\$10,891,909), compared to US\$12.1 million in 2018, 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 2019, spending by country and regional programmes accounted for 78 per cent of expenditures, whereas global activities accounted for 22 per cent. Included in the global activities are disbursements of US\$476,623 to international implementing partners. When accounting for the fact that international implementing partners use resources for country and regional level operations, the distribution was 83 per cent for countries and regions, and 17 per cent for global activities, which included technical assistance to countries provided for EmONC, MPDSR, Midwifery and Fistula by global experts.

Out of total expenditures, 13 per cent or US\$1.4 million was disbursed via NGOs; 31 per cent or US\$3.3 million via a governmental partner; and 55 per cent or US\$5.8 million via UNFPA directly.

Figure 3.5 Shares of expenditures for maternal and newborn health by region and globally in 2019



Among regions, West and Central Africa accounted for most of the expenses for maternal health, at 37 per cent (US\$4 million) of the total. East and Southern Africa came second at 25 per cent (US\$2.7 million). Headquarters expenses constituted 22 per cent (US\$2.4 million).¹⁵ Asia and the Pacific accounted for 9 per cent (US\$900,000), the Arab States for 5 per cent (US\$600,000), and Latin America and the Caribbean for 2 per cent (US\$300,000). See Figure 3.5.

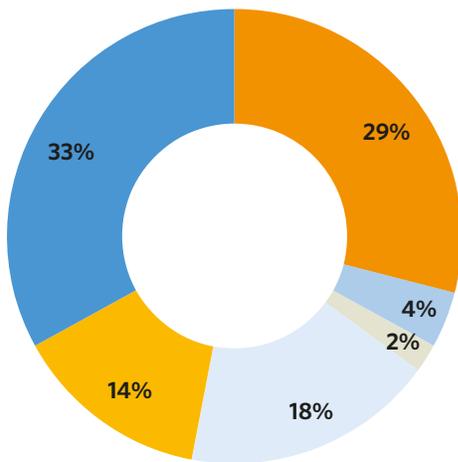
In 2019, expenditures on maternal health of US\$10.9 million represented a financial implementation rate of 71 per cent against the total operational budget of US\$15.3 million. The amount transferred to 32 country offices, 5 regional offices and headquarters units was US\$11.4 million.

¹⁵ Includes activities at headquarters and by implementing partners such as research institutions, NGOs, etc., the majority of which support activities at the country level.

3.5 CATEGORIES OF EXPENDITURE

The total allocation to country, regional and global programmes in 2019 was US\$11.4 million, and the corresponding expenses were US\$10.9 million. Figure 3.6 presents the expenditure categories.

Figure 3.6 MHTF expenditures by category (in US\$)



- Technical staffing costs
\$3,106,733
- Supplies, commodities, materials
\$436,543
- Equipment, vehicles and furniture including depreciation
\$202,272
- Contractual services
\$1,979,864
- Travel
\$1,546,433
- Transfers and grants counterparts
\$10,842
- General operating and other direct costs
\$3,609,218

Figure 3.7 MHTF staff cost as a percentage of total expenses

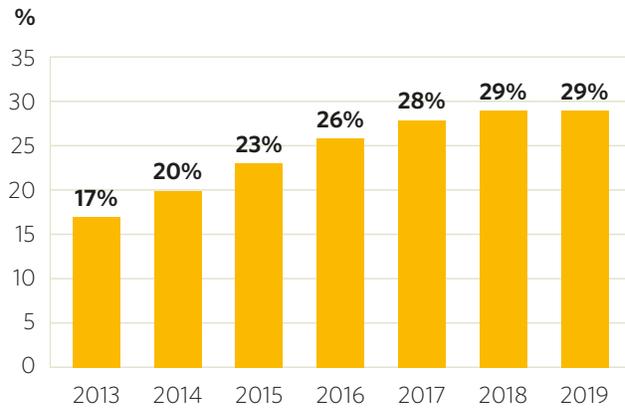
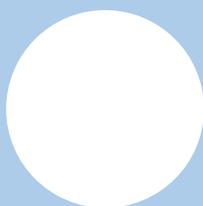
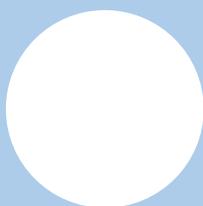
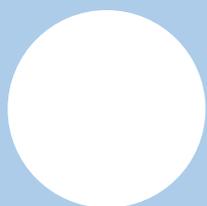


Figure 3.7 shows that there was no change in staff cost from 2018 to 2019.



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André RUGEMA, 2019.
Photo submitted by
Aimable Twiringiyimana
to the 2020 MHTF
photo contest.

PART



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MHTF photo
contest.

LESSONS LEARNED AND WAY FORWARD

CHALLENGES AND LESSONS LEARNED

While the integrated, transformative and catalytic interventions promoted by the MHTF in 2019 continued to bear fruit, challenges, both overarching and specific to particular streams of work, remained. The COVID-19 pandemic in 2020 has added to these challenges, including by impeding retrospective data collection for MHTF results in 2019.

Among the overarching challenges, the main impacts on the delivery of MHTF-supported programmes relate to:

Resource shortages in the push towards universal health coverage suggest that focused efforts are needed to ensure adequate funding for reproductive, maternal, newborn and adolescent health. There continues to be a US\$33.3 billion annual funding gap in achieving the health targets for women, children and adolescents in the Every Woman Every Child Global Strategy and health-related SDGs.

Limitations in national commitment/ownership and competing national priorities have an overall negative impact on programme implementation. In several countries, favourable policies exist. The lack of policy implementation on reproductive, maternal, newborn and child health in developing countries, however, presents a challenging environment for achieving intended results and scaling up successful initiatives. It is of utmost importance to advocate for the full inclusion of SRHR in the national policies for universal health coverage, including benefit packages. There is great potential for the global sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) community to jointly pursue the full implementation of regional and national commitments and strategies, including commitments made at the Nairobi Summit.

Weak national capacities in implementation and reliance on global expertise can make programme implementation costly and difficult to scale up. While over the years the MHTF has done extensive national capacity-building through programmes on midwifery, EmONC, fistula and MPDSR, big capacity gaps at the

national level continue to exist. Weak monitoring and weak national capacity adds to the challenges.

Poor coordination of SRMNCAH programmes at the national level and among their various components causes further impediments to the roll-out and implementation of MNH programmes.

Lessons from these challenges included:

Midwifery: Apart from limitations in national commitment, and resource and health system capacity constraints, midwifery continued to be impacted by a shortage of well-educated faculty and quality education; the lack of an enabling environment for midwives to practise to their full scope; inadequate mentorship and supportive supervision; weak interprofessional collaboration; poor regulatory frameworks and weak association leadership. Governments continued to struggle with issues of the deployment and retention of midwives, and to provide structured workforce policies that are well resourced and fully implemented.

Addressing these challenges calls for continued strong global, regional and national advocacy for investments in the midwifery profession, stakeholder engagement and workforce policy development. An enabling and supportive environment for midwives is a must, demanding leadership development within midwifery associations and the cultivation of a cadre of young midwifery leaders. Midwives need to be engaged in policy development and implementation, while further advocacy for the profession depends on an updated evidence base and data on midwifery. Plans are well underway for the generation of the next **State of the World's Midwifery Report**, slated for release in 2021. UNFPA and its partners will also launch a research paper on the impact of midwives.

Developing the clinical skills of midwives requires strong mentorship, preceptorship and supportive supervision programmes at both the pre- and in-service level. Pre-service curricula need to adhere to global standards. There is a strong need for faculty

development programmes. Innovative technologies for improving quality such as low-dose, high-frequency approaches, apps developed by the Maternity Foundation, and real-life training films developed by the Global Health Media Project as well as other simulation-based trainings need to be widely scaled up. Regular capacity-building of UNFPA midwifery and SRMNH staff is critical for planning and executing strong programmes using a harmonized approach. The tools and resources being developed in collaboration with the ICM, such as on respectful maternity care, mentorship guidelines, accreditation of schools, etc., will need to be disseminated, and global capacity built on their usage.

EmONC: Following the establishment of EmONC national networks, the continuous monitoring process proposed by the MHTF is critical.

Each step of the process to establish successful networks is important, however, from particular importance is government and ministry of health owner – and leadership. While GIS data and information are increasingly available in many low resource countries, they are not always in the public domain, requiring ministries of health to purchase them from private or para-public institutions. Better coordination among stakeholders should mitigate this issue. Other challenges include the lack of adequate information in health management information systems and poor data quality. Specific surveys are needed to address these issues. EmONC needs assessments remain the cornerstone of any EmONC facility development process. Health management information system and EmONC data need to be cross-referenced to improve data quality.

Another lesson is that for an EmONC facility network to become relevant and sustainable, it needs to be designed and developed at a national scale. The MHTF's approach has proven that it is possible to dramatically reduce the number of facilities without jeopardizing the obstetric service coverage of the population. With declining funding flows for MNH, government capacity to implement maternal health programmes at scale becomes severely curtailed. With fewer facilities to fund, governments can leverage resources for quality improvement, including through deployment of adequate human resources.

Another challenge faced while making EmONC networks functional is the limited competencies among obstetric service health providers, including midwives. This jeopardizes MNH health outcomes, a situation documented in Benin, Madagascar and Sudan. Skills are

lacking due to poor curricula and teaching programmes. Given the needs in EmONC facilities, midwives should be able to manage all deliveries, and also have decision-making power to decide where and to whom to refer. Unfortunately, these decision-making powers are missing. EmONC facilities remain weak, with important competency gaps and shortfalls in quality of care. These persistent concerns need to be globally discussed and tackled to reach the SDGs.

Fistula: Addressing the most marginalized and poorest-of-the-poor women and girls is always a challenge. Fistula as a symptom of failing health systems and represents the tip of the iceberg for poor quality of health care. Apart from fistula being a neglected condition, many women suffering from it are ostracized and not even aware that treatment exists or of how to access it. Aligning national fistula strategies to the new vision by United Nations Member States of ending fistula within a decade is essential to achieve elimination by 2030. In-country financial and human resources will be key. Funding for national fistula programmes remains inadequate. More broadly, ending fistula depends on funding for strengthening health systems and workforces, ensuring EmONC availability, and conducting quality data collection and analysis to inform programmes.

In addition to government ownership and leadership in allocating a greater proportion of national budgets to SRH, additional technical and financial support provided by the international community remains key for fistula-affected countries to eliminate the condition by 2030.

The increasing incidence of iatrogenic fistulas threatens progress made in improving access to surgery and demand for such services. Both obstetric and iatrogenic fistulas can, however, be prevented and eliminated with health system strengthening interventions to increase quality measures, including for surgical competence. Enhanced international and domestic technical and financial support to prevent fistula, especially in high-burden countries and fragile contexts, is critically needed. Beyond domestic resources and traditional official development assistance, public-private partnerships offer promising platforms to harness comparative advantages and strengths.

MPDSR programmes continue to face a variety of well-known obstacles, including a culture of blame, fear of retribution, a lack of skilled staff, stand-alone management and inadequate funds for implementing maternal review recommendations. Despite the

importance of MPDSR in improving both quality and accountability, these programmes are not yet well developed or supported by donors.

In Phase III, the MHTF continues to focus on countries' abilities to improve MPDSR programme management and implementation at scale, within maternal health programmes. Based on the experience of **Madagascar** and **Togo**, the MHTF has included maternal deaths notification and review in monitoring EmONC facilities in nine countries. MPDSR, when embedded in a holistic MNH approach, becomes easier to monitor, and can support quality improvements in facilities in charge of managing obstetric complications. The MHTF supports the development of tools for MPDSR programme monitoring and reporting at the subnational and national levels.

SRHR Integration: The MHTF works to ensure an integrated, comprehensive approach to SRHR. A few lessons learned to ensure that links are systematically made include increasing the capacity of UNFPA staff to understand programming gains and opportunities from SRHR integration. The UNFPA flagship technical guidance in 2019, "[Sexual and Reproductive Health and Rights – An Essential Element of Universal Health Coverage](#)", offers a useful starting point for building capacity and supporting country offices to operationalize a comprehensive approach to SRHR that fits into universal health coverage.

Countries should leverage long standing evidence that integration of a holistic life-course approach to SRH service provision and policy will decrease mortality and morbidity and enhance Universal Health Coverage. A sustainable approach calls for analysing national SRMNAH strategies, in- and pre-service training curricula, the skills and competencies of key SRH providers, and task-sharing and self-care policies. This can identify gaps and challenges to accessing comprehensive SRH services as well as opportunities for integration.

Within the MHTF, there is a need to align the theory of change and workplan, and build in a more dedicated focus on integration during planning and reporting to identify opportunities, not only within MHTF, but also with other country programme initiatives. These could include adolescent and youth programming, prevention of gender-based violence, and increasing access to comprehensive abortion care (to the full extent of the law) including post abortion care. Such trends are seen in

many countries, yet a systematic approach would benefit the programme and accelerate progress.

Through the review of challenges and lessons learned in 2019, the MHTF can reorient the design and implementation of its catalytic programmes for optimal future outcomes. Close attention needs to be paid to monitoring and evaluation of all programmes to address core gaps.

WAY FORWARD

Drawing on lessons learned in previous years, the MHTF will continue to build on existing initiatives, making them more integrated, scaleable, holistic and comprehensive in the four key thematic areas: midwifery, EmONC, MPDSR, and obstetric fistula and other morbidities. Using the cross-cutting principles of equity in access, quality of care and accountability, the MHTF will follow a life cycle approach that is human rights-based and gender-sensitive, and work towards delivering an integrated package of essential SRMNAH interventions.

Building on the MHTF Business Plan for Phase III, a corporate strategy on MNH will be developed in 2020. This will enable cohesive organization-wide strategic results, and enhance links with other thematic funds, such as the Commodities Programme, the Humanitarian Fund and the Population Data Fund. The MHTF will seek out entry points and synergies with other ongoing programmes (by partners, bilateral organizations, the United Nations, the private sector) on contraceptive services and family planning, comprehensive abortion care (to the full extent of the law) including post abortion care, gender, ending harmful practices like child marriage and female genital mutilation, adolescent SRH and cervical cancer, among others. Strengthening national ownership and the capacities of staff, stakeholders and partners in implementing strong SRMNAH programmes will remain an area of focus.

The multi-year planning tool introduced in 2019 under Phase III has been well received. It has had a positive impact in terms of more holistic and longer-term planning, rather than on a year-to-year basis, and offers adequate flexibility to make changes annually based on shifts in needs or economic or political contexts. For this, however, the MHTF depends on multi-year pledges and sustainable levels of funding from donors. Efficient and accountable management of MHTF resources will remain a priority.

Among future major areas of focus are further improvements in the quality of midwifery care, particularly the clinical skills of faculty, students and clinicians through strong mentorship, preceptorship and supportive supervision programmes at both the pre- and in-service levels. A global pre-service midwifery curriculum, based on comprehensive standards and using innovative technologies, will be developed in collaboration with the ICM and partners like Johnson & Johnson. Other priorities are to expand use of innovative technologies; e- and m-learning modules; training films; apps; low-dose, high-frequency approaches; and GIS mapping technologies. In the face of the COVID-19 pandemic, the MHTF will continue to prioritize MNH, protect health workers, and implement cutting-edge, technology-based interventions to support women and their newborns. The MHTF will document how well-equipped, fully functional EmONC networks with adequate numbers of well-trained midwives can provide respectful maternity care, manage safe normal births, prevent conditions like fistula, competently deal with basic emergency situations and provide timely referrals. The MHTF will continue to strengthen countries' capacities to implement and manage strong MPDSR programmes.

Partnerships and synergies with other UNFPA initiatives like the UNFPA/UNICEF joint programme on female genital mutilation; UNFPA Supplies Programme (contraceptives and maternal health medicines); UNFPAs Comprehensive Sexuality Education Programme; the global H6 initiative; private sector; civil society; midwifery; and fistula campaign partners will remain crucial for policy advocacy, scalability, sustainability and impact. These and new strategic partnerships will be further scaled up to invoke

political will, including through the catalytic leveraging of national and other global resources for sustainable SRMNAH initiatives.

For further sustainability, the MHTF will highlight, document and disseminate its best practices, bring further visibility to its work and boost fundraising by targeting donors who have pledged global commitments to end preventable maternal and newborn mortality and morbidity.

At the United Nations high-level meeting on universal health coverage in New York in September 2019, all Member States approved a concise and action-oriented political declaration that includes reproductive, maternal, newborn and child health. Acknowledging that the health of women and newborns represents a critical window of opportunity for effective, lifesaving interventions, and prevention and health promotion, with effects throughout the life course, the MHTF will continue to develop its successful initiatives and take further steps to harness global efforts to advance universal health coverage.



Start emergency management
DETERMINING CAUSE OF BLEEDING
Check if placenta intact and complete
Check for bleeding tears
BIRTH PLACE
Fetal position (forceps only)

ATONIC UTERUS Continue massage Add 20-30 cc oxytocin to IV and release feet	RETAINED PLACENTA/PARTS Perform manual removal of the placenta	BLEEDING TEARS Inspect, identify
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Simulation Plan (Simulation)
(9b-15b) 9b-11b (Soram, Jimmy)
12b-15b (Chimmi, UC, SW)
Simulation Exercise (16b)
Simulation Station
17b-19b

ANNEX



ANNEX 1: 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, United Republic of 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 (RPMN)
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

ANNEX 2: DETAILED BUDGET ALLOCATIONS

The allocations are for both the Thematic Fund for Maternal and Newborn Health and the Thematic Fund for Obstetric Fistula.

Regional office/ country office/glob- al technical support	2018 (MHTF & Fistula)				Utilization rate
	2018 Allocation Ceiling	2018 Funds transferred	2018 Expenses USD		
Arab Region					
Arab States Reg. Office/Cairo	107 000	107 000	104 882	98%	
Republic of Yemen	107 000	107 000	77 496	72%	
Somalia - Mogadiscio	281 283	225 026	219 227	97%	
Sudan - Khartoum	353 039	284 855	262 368	92%	
Total	848 322	723 881	663 973	92%	
Asia & Pacific Region					
Afghanistan - Kabul	346 194	346 195	344 022	99%	
Bangladesh - Dhaka	166 806	133 445	105 235	79%	
Lao - Vientiane	428 238	613 847	449 688	73%	
Nepal - Kathmandu	180 848	180 849	124 835	69%	
Pakistan - Islamabad	321 481	257 185	216 567	84%	
Regional Office/ Bangkok	53 500	53 500	11 154	21%	
Timor Leste	158 462	158 391	137 113	87%	
Total	1 655 528	1 743 412	1 388 614	80%	
East & South Africa Region					
Burundi - Bujumbura	397 834	397 834	397 437	100%	
Dem Rep Congo - Kinshasa	545 810	545 811	483 784	89%	
Ethiopia - Addis Ababa	495 619	495 620	457 819	92%	
Kenya - Nairobi	280 915	278 200	267 129	96%	
Madagascar - Antananarivo	403 490	403 490	356 203	88%	
Malawi - Lilongwe	227 766	193 779	130 344	67%	
Mozambique - Maputo	214 138	214 000	82 346	38%	
Regional Office/ E&SA Region	172 260	136 960	127 498	93%	
Rwanda - Kigali	257 412	257 410	252 057	98%	
South Sudan - Juba	128 400	102 720	53 591	52%	
Uganda - Kampala	353 039	353 036	344 251	98%	
Zambia - Lusaka	275 071	275 064	268 907	98%	
Total	3 751 755	3 653 924	3 221 366	88%	

2019 (MHTF & Fistula)					
	2019 Allocation Ceiling	2019 Funds transferred	2019 Expenses USD	Utilization rate	Change in expenses 2019 vs.2018
	107 000	74 900	62 431	83%	(42 451)
	-	-	-	0%	(77 496)
	308 760	308 759	282 999	92%	63 772
	481 500	338 058	245 248	73%	(17 120)
	897 260	721 717	590 678	82%	(73 295)
	-	-	(32)	0%	(344 054)
	214 000	149 800	147 128	98%	41 893
	328 058	328 115	327 594	100%	(122 094)
	246 100	203 297	186 982	92%	62 147
	-	-	(191)	0%	(216 758)
	107 000	107 000	100 556	94%	89 402
	327 848	224 700	174 049	77%	36 936
	1 223 006	1 012 912	936 083	92%	(452 531)
	428 000	428 000	400 098	93%	2 661
	327 924	328 267	335 421	102%	(148 363)
	453 424	604 500	325 234	54%	(132 585)
	321 000	224 700	149 996	67%	(117 133)
	424 279	424 278	402 979	95%	46 776
	171 682	85 865	77 496	90%	(52 848)
	321 000	196 577	191 949	98%	109 603
	171 200	171 200	104 498	61%	(23 000)
	332 608	332 609	148 015	45%	(104 042)
	-	-	(6 741)	0%	(60 332)
	310 623	310 300	295 070	95%	(49 181)
	321 000	270 710	264 612	98%	(4 295)
	3 582 740	3 377 006	2 688 627	80%	(532 739)

NB: Includes data for ZZT03 and ZZT06

	2018 (MHTF & Fistula)				
Regional office/ country office/glob- al technical support	2018 Allocation Ceiling	2018 Funds transferred	2018 Expenses USD	Utilization rate	
Latin America & Caribbean					
Haiti - Port-au-Prince	328 667	328 668	317 829	97%	
Regional Office/ Panama City	87 740	78 966	77 928	99%	
Total	416 407	407 634	395 757	97%	
OED Directorate					
Non-Core Funds Management Unit	184 786	184 786	183 321	99%	
Technical Division					
Sexual and RH Branch	2 660 506	2 660 506	2 319 253	87%	
Western and Central Africa					
Benin - Cotonou	327 813	327 813	302 467	92%	
Burkina Faso - Ouagadougou	360 403	288 323	282 629	98%	
Cameroon - Yaounde	107 000	85 600	57 246	67%	
Central African Republic	86 548	77 893	77 372	99%	
Chad - N'Djamena	503 967	403 173	387 739	96%	
Congo - Brazzaville	255 463	255 463	198 412	78%	
Cote D'Ivoire - Abidjan	353 004	353 005	388 896	110%	
Ghana - Accra	302 920	302 921	251 748	83%	
Guinea - Conakry	224 800	256 800	247 364	96%	
Guinea-Bissau	133 049	103 434	97 600	94%	
Liberia - Monrovia	216 228	-	16 650	0%	
Mali - Bamako	107 000	97 905	68 305	70%	
Mauritania - Nouakchott	173 829	130 566	114 274	88%	
Niger - Niamey	389 733	389 732	387 247	99%	
Nigeria - Abuja	302 920	302 917	282 187	93%	
Regional Office/ W&CA Region	172 260	88 275	65 265	74%	
Senegal - Dakar	197 433	204 313	252 057	123%	
Sierra Leone - Freetown	388 117	388 115	340 174	88%	
Togo - Lome	158 462	158 360	154 183	97%	
Total	4 760 947	4 214 608	3 971 815	94%	
GRAND TOTAL	14 278 251	13 588 751	12 144 099	89%	

	2019 (MHTF & Fistula)				
	2019 Allocation Ceiling	2019 Funds transferred	2019 Expenses USD	Utilization rate	Change in expenses 2019 vs.2018
	324 198	162 099	158 648	98%	(159 181)
	107 000	107 000	106 819	100%	28 891
	431 198	269 099	265 467	99%	(130 290)
	142 297	142 297	128 385	90%	(54 936)
	2 243 842	2 243 842	2 243 842	100%	(75 411)
	482 305	337 613	305 392	90%	2 925
	453 424	448 076	456 163	102%	173 534
	-	-	(7 193)	0%	(64 439)
	-	-	-	0%	(77 372)
	260 316	260 316	327 124	126%	(60 615)
	374 500	374 500	328 028	88%	129 616
	443 710	413 306	376 282	91%	(12 614)
	231 569	231 570	234 578	101%	(17 170)
	326 061	326 062	328 862	101%	81 498
	162 099	111 597	66 451	60%	(31 149)
	208 412	145 868	91 277	63%	74 627
	-	473	(0)	0%	(68 305)
	231 569	162 099	157 374	97%	43 100
	540 330	540 330	450 369	83%	63 122
	303 880	278 346	260 882	94%	(21 305)
	171 200	119 840	112 596	94%	47 331
	293 189	293 300	194 081	66%	(57 976)
	434 127	155 053	63 506	41%	(276 668)
	428 000	428 042	293 056	68%	138 873
	5 344 691	4 626 391	4 038 827	87%	67 012
	13 865 033	12 393 263	10 891 909	88%	(1 252 190)

ANNEX 3: CALL TO ACTION AT THE MIDWIFERY SYMPOSIUM



4th Global Midwifery Symposium, Women Deliver

Empowered Midwives, Transformed Communities

Midwives Call for an Enabling Environment to Transform Maternal and Newborn Health Outcomes

2nd June 2019

Background

The evidence is clear. When midwives are educated to international standards, and midwifery includes the provisions of family planning, it could avert over 80% of all maternal deaths, stillbirths and newborn deaths¹. There is also strong evidence to support that women want individualized and respectful continuity of care provided by a professionally trained and qualified midwife close to where they live².

More than 50 short-, medium-, and long-term health outcomes are improved by care provided by midwives educated to International Confederation of Midwife (ICM) standards, licensed, regulated, working in inter-professional teams and fully integrated into the health system³. These include, reduced maternal and neonatal mortality and morbidity, reduced stillbirths and preterm births, decreased number of unnecessary interventions, and improved psychosocial and public health outcomes.

The World Health Organization (2018) recommends that midwife-led continuity-of-care, where a known midwife or group of midwives support a woman throughout the antenatal, intrapartum and postnatal continuum, is recommended for women in settings with well- functioning midwifery programs⁴.

An enabling environment is critical to the achievement of the impact of midwife-led continuity of care, including changes in the behaviour of health care practitioners and inter-professional collaboration to enable the use of evidence-based practices, provide more 'women-centred' care, improve inter-professional respect and provide the best healthcare experience to the woman. Local professional associations and institutions play important roles in this process and an all-inclusive and participatory process should be encouraged.

There are sociocultural, professional and economic barriers, arising from gender inequality, which must be addressed to improve the environment in which midwives live and work and enable them to give women the care we know they want⁵.

¹ Renfrew et al. 2014. Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *Lancet*. 384:1129-45

² International Confederation of Midwives, World Health Organization and White Ribbon Alliance. 2016. *Midwives' Voices Midwives' Realities*. WHO, Geneva

³ Renfrew et al. 2014. Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *Lancet*. 384:1129-45

⁴ World Health Organization. 2018. WHO recommendations: intrapartum care for a positive childbirth experience. WHO, Geneva

⁵ World Health Organization. 2016. WHO Recommendation on midwife-led continuity of care during pregnancy. [Online] Available at: <https://extranet.who.int/rhl/topics/improving-health-system-performance/implementation-strategies/who-recommendation-midwife-led-continuity-care-during-pregnancy>



An enabling environment for midwives constitutes complex and interacting elements which include effective inter-professional teamwork, a strong professional identity, sufficient resources, gender equity, integration into the broader health system and government and community support.

An investment in an enabling midwifery environment is a positive value proposition and:

- Improves midwifery education and practice
- Enhances motivation and midwifery retention everywhere but particularly where they are needed most
- Improves the quality of a full range of services needed for optimal women's health
- Empowers women (midwives and clients) and promotes person-centered care
- Improves the work life of all health workers engaged in caring for women.

Call to Action

There is clear evidence that midwives, educated to ICM standards, licensed, regulated, working in inter-professional teams and fully integrated into the health system and practicing within an enabling environment will provide high quality care that transforms maternal and newborn health outcomes. To reach this goal, we call for continued advocacy for policies that increase the midwifery workforce but with increased focus on providing an educational, regulatory and practice infrastructure that is consistent with a midwifery model of care. We call for increased support to the development of regulatory structures that ensure that midwives have a scope of practice (SOP) consistent with ICM competencies and the needs of women in their communities. We call for prioritized implementation of the action plan to strengthen quality midwifery education outlined in the recently released Framework for Action- Strengthening Quality Midwifery Education for Universal Health Coverage 2030.

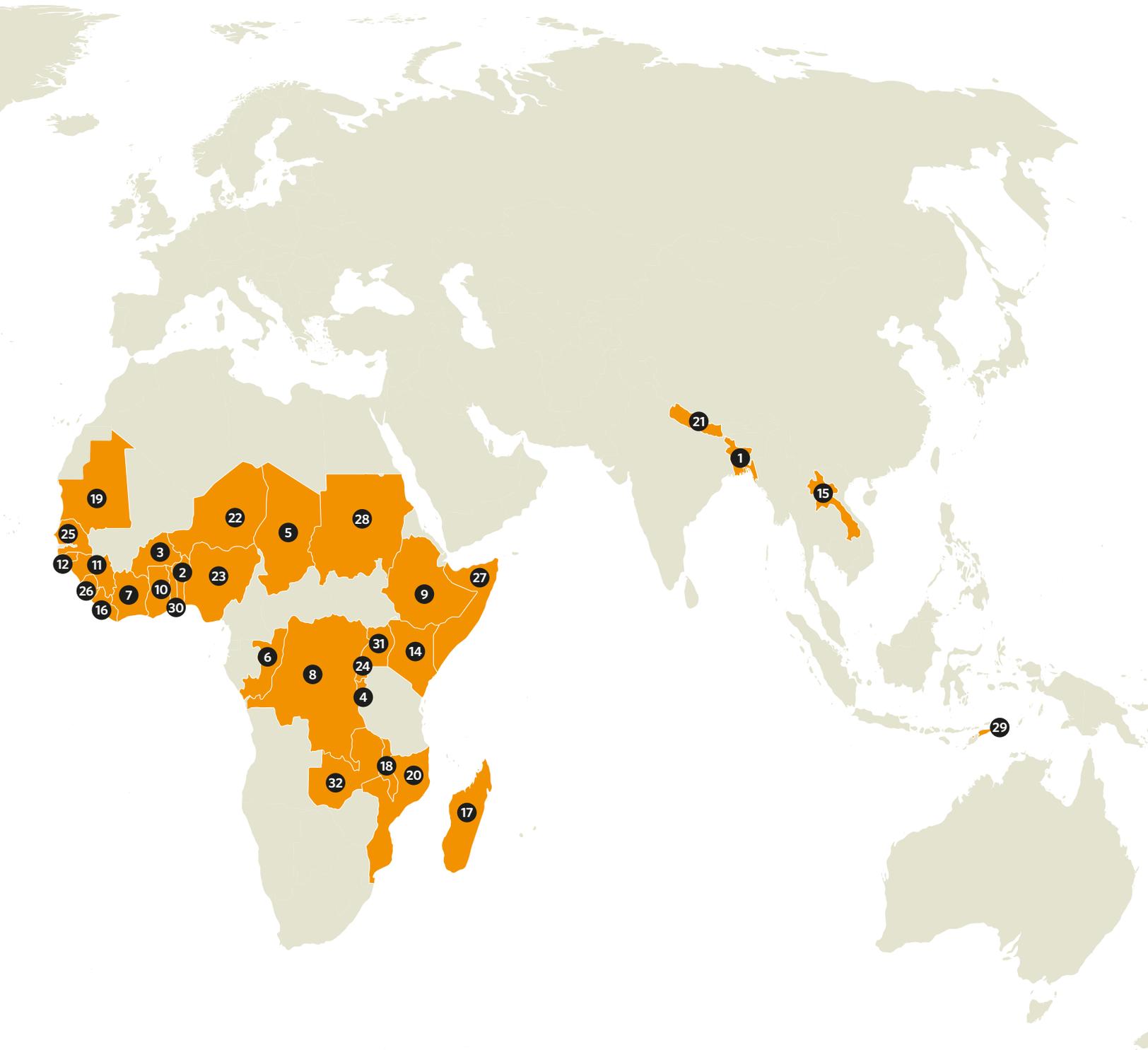
Every midwife must have the opportunity to work in an enabling environment. This environment must include a) ability to practice to her or his full SOP; b) ability to make and be accountable for independent decisions within the regulated SOP; c) a functional health infrastructure with adequate human resources, equipment and supplies; d) access to timely and respectful consultation, collaboration and referral; e) safety from physical and emotional harm; and f) equitable compensation.

We call for active and respectful collaboration between midwives and their nursing and medical colleagues in pursuit of the shared goal of accessible, high quality women's health and maternity care. This includes acknowledgement of and respect for their respective and essential roles around the pregnant and birthing woman. This acknowledgement and collaboration must occur between professional associations as well as within local and national health systems and agencies that regulate midwifery practice and on the "floor" of the facility. Midwives must be fully engaged in all local, national, regional and global policy decisions that affect their professional practice and the needs of women and their newborns in their communities.

ANNEX 4: MHTF-SUPPORTED COUNTRIES PHASE III.



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



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