THE MATERNAL HEALTH THEMATIC FUND

Keeping the momentum

Annual Report 2017
and Review of Phase II (2014-2017)

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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Winner of the 2018 photo contest for the MHTF Report cover.
Submitted by Arlene Alano, South Sudan Country Office.

By deploying midwives and other health professionals to areas where they are most needed, UNFPA ensures that women will continue to have access to safe deliveries and other life-saving maternal and newborn care services to help reduce high maternal deaths in South Sudan.

TABLE OF CONTENTS

ii ACKNOWLEDGEMENTS
iii ACRONYMS
v FOREWORD
vi EXECUTIVE SUMMARY

PART 1 OVERVIEW OF THE MHTF 1

PART 2 CATALYSING CHANGE 4
- 2.1 The Phase II theory of change 4
- 2.2 MHTF contributions to stronger health systems 6
- 2.3 The MHTF's catalytic role 8
- 2.4 Innovations 9

PART 3 KEY RESULTS 2014 to 2017: OPTIMIZING EQUITY, QUALITY AND ACCOUNTABILITY 11
- 3.1 Target achievement for Phase II 11
  - 3.1.1 Midwifery 13
  - 3.1.2 EmONC 13
  - 3.1.3 Obstetric fistula 15
  - 3.1.4 MDSR 15
  - 3.1.5 FTYM 18
- 3.2 Equity in access 19
  - 3.2.1 EmONC 19
  - 3.2.2 Obstetric fistula 21
- 3.3 Quality of care 22
  - 3.3.1 Midwifery 22
  - 3.3.2 EmONC 24
  - 3.3.3 MDSR 24
  - 3.3.4 Obstetric fistula 24
- 3.4 Accountability 24
  - 3.4.1 Governance and coordination 24
  - 3.4.2 Monitoring implementation by strengthening data collection, analysis and response systems 25
  - 3.4.3 Empowerment and advocacy 25
  - 3.4.4 Humanitarian response 25

PART 4 RESOURCES AND MANAGEMENT 27
- 4.1 Background 27
- 4.2 Thematic Trust Funds for Maternal Health and Obstetric Fistula 27

PART 5 CONCLUSION AND LOOKING FORWARD 31
- 5.1 Conclusion of Phase II 31
- 5.2 Looking forward to Phase III 31

ANNEXES 35
- 1: Strategic Interventions Per Outputs and Outcomes 36
- 2: Results Indicators Framework for 2014-2017 38
- 3: Estimation of maternal deaths averted, methodology 46
- 4A: Resources and Management – Approved Allocations, Expenditures and Financial Implementation Rates for Maternal Health and Fistula, 2016-2017 (including indirect costs), in dollars 47
- 4B: Changes in MHTF country budget allocations from 2016 to 2017 49
- 5: Partners in the Campaign to End Obstetric Fistula 51

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UNFPA acknowledges with gratitude the support of all of its country office staff in prioritizing maternal and newborn health (MNH) as part of a broader focus on sexual and reproductive health and rights (SRHR). UNFPA also acknowledges the diverse beneficiaries and actors in MHTF assistance, namely, governments, civil servants, civil society partners and health providers in 39 countries as well as six UNFPA regional offices.

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A special note of thanks goes to other individual donors, UN trust funds and foundations.

We also recognize the critical contributions of our civil society partners at global, regional and country levels in supporting the broader achievement of universal access to SRHR. They include the International Confederation of Midwives (ICM), the International Federation of Gynecology and Obstetrics (FIGO), the Maternal and Child Survival Program of the United States Agency for International Development (USAID), the International Society of Obstetric Fistula Surgeons (ISOFS), Operation Fistula, Columbia University's Averting Maternal Death and Disability Program, Johns Hopkins University and its Program for International Education in Gynecology and Obstetrics (Jhpiego), Women Deliver, and national and regional partners listed in Annex 3 for the Campaign to End Fistula. We value their significant roles as champions and technical experts in support of SRHR.

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

ACRONYMS

EmONC............................ Emergency Obstetric and Newborn Care
FIGO .... International Federation of Gynecology and Obstetrics
FTYM................................ First-Time Young Mothers
GIS..................................... Geographic Information System
H6 (formerly H4+) ..... UNAIDS, UNFPA, UNICEF, UN Women, World Bank Group, WHO
ICM .... International Confederation of Midwives
ICPD.................................. International Conference on Population and Development
ISOFS................................ International Society of Obstetric Fistula Surgeons
MDG................................. Millennium Development Goal
MDSR .... Maternal Death Surveillance and Response
M(P)DSR......................... Maternal (Perinatal) Death Surveillance and Response
MHTF .... Maternal Health Thematic Fund
MNH................................. Maternal and Newborn Health
NGO.................................. Non-Governmental Organization
RMNCAH........................ Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG .... Sustainable Development Goal
SRH .... Sexual and Reproductive Health
SRHR .... Sexual and Reproductive Health and Rights
SRMNAH......................... Sexual, Reproductive, Maternal, Newborn and Adolescent Health
UN Women..................... United Nations Entity for Gender Equality 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 Organization

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FOREWORD

by Dr. Natalia Kanem Executive Director, UNFPA

Every woman has the right to a healthy pregnancy and delivery and every newborn deserves a safe, healthy passage into this world. This is a basic human right. The Maternal Health Thematic Fund (MHTF) is the UNFPA flagship programme committed to upholding this right for women and newborns in some of the world's poorest communities.

Over the past nine years, the programme has increased equitable access to quality maternal and newborn health in 39 countries with the highest burden of death and disability. The programme has done this by supporting governments to build capacity and competence in the areas of midwifery, emergency obstetric and newborn care, maternal and perinatal death surveillance and response, and prevention and surgical treatment of obstetric fistula. It has also introduced targeted programmes focusing on first time young mothers to build and strengthen care-seeking behaviours among young women and improve their access to sexual and reproductive health services. Overall, the activities supported by the Maternal Health Thematic Fund have contributed to averting an estimated 119,127 maternal deaths since 2008.

This report highlights the important results the programme has achieved for women, girls and newborns in the countries it supports. It also illustrates UNFPA's commitment to end preventable maternal deaths and help realize Sustainable Development Goal 3 and Universal Health Coverage, so that every woman, girl and newborn can obtain the needed health services.

I have seen firsthand how investments in the programme are being utilized in evolving and difficult circumstances. The life-saving, women-centered care that midwives, trained with the support of the MHTF, are providing to Rohingya women and girls in the refugee camps in Bangladesh is just one example of the significant impact the programme has on some of the most disadvantaged communities in some of the most difficult settings.

To date, 85,000 midwives have been trained and are now providing invaluable health promotion and quality maternal and newborn health care services in countries most in need. In its second phase (2014-2017), the MHTF programme also introduced new interventions and innovations for improving access to quality care and accountability in key areas, which are outlined in this report.

Despite impressive results, however, huge challenges remain. Ensuring that no woman or newborn dies from preventable causes during pregnancy or childbirth requires enhanced and dedicated investments, partnerships, and scaled-up efforts. We at UNFPA remain committed to accelerating global efforts to reduce preventable maternal and newborn deaths and ensure that even marginalized, disadvantaged and underserved populations get access to quality maternal and newborn health services.

I take this opportunity to thank all our partners, including civil society organizations, multilateral actors, academic institutions, development partners and the donors that have played a critical role in achieving these results. Together, we can make a difference and ensure that every woman and newborn everywhere gets the care they deserve.

EXECUTIVE SUMMARY

The MHTF was established in 2008 to further enhance UNFPA's contribution to achieving the fifth Millennium Development Goal (MDG) on improving maternal health. Between 2008 and 2017, the MHTF contributed to averting 119,127 maternal deaths.

Through 2013, Phase I of the MHTF covered 40 countries with high maternal mortality and low resources. It offered three main programmes: The Emergency Obstetric and Newborn Care (EmONC) initiative in collaboration with Columbia University's Averting Maternal Death and Disability Program, the midwifery programme in collaboration with the International Confederation of Midwives (ICM), and the Campaign to End Fistula, which drew together several partners. Phase II started in 2014 with two new work areas on Maternal Death Surveillance and Response (MDSR) and First-Time Young Mothers (FTYM).

This report reviews the last year of Phase II, 2017, and provides an overview of Phase II as a whole. It concludes with lessons learned and a look forward to Phase III, which started in 2018, guided by a business plan with four outcomes.

All six "building blocks" of health system [1] strengthening were addressed during Phase II; it also furthered three core principles – equality in access to care, quality of care and accountability. Phase II highlighted the catalytic effect of the MHTF. Policy informed by the fund has included the United Nations General Assembly's passage of a bold resolution to end fistula within a generation. Midwifery was also mainstreamed in the United Nations Secretary-General's Global Strategy for Women, Children and Adolescent Health.

The MHTF leveraged external resources to support the development of different work areas, notably midwifery. Over $85 million was raised from Canada and Sweden for South Sudan alone to scale up midwifery services nationwide. The second *State of the World's Midwifery* report in 2014 helped promote global evidence-informed advocacy, which resulted in the rapid scale-up of national commitments for midwifery.

On midwifery, the focus in Phase II was to improve the competency of midwives through alignment of curricula to global ICM standards, and to strengthen associations and regulatory mechanisms. Almost all 39 countries that have been supported over the years by the MHTF (87 per cent) now implement ICM education standards; 77 per cent have integrated broader sexual and reproductive health (SRH) issues in their curricula. Over 15,300 midwives were supported by the MHTF in 2017 for pre-service education and in-service training.

On EmONC, Phase II supported six countries to develop their national network of EmONC facilities, using Geographic Information Systems (GIS) for maximizing population coverage. The MHTF also supported the monitoring of the availability and quality of care in EmONC facilities. Fifteen countries performed an assessment of EmONC services in 2016-17. Phase II also strengthened the integration of other SRH components in EmONC facilities.

1 Leadership/governance, health financing, health workforce, products and technologies, information and research, and service delivery (including community systems).

During Phase II, through the Campaign to End Fistula, the MHTF supported nearly 57,000 fistula repair surgeries, enabling women and girls to restore their health and hope, and reclaim their dignity. By 2017, 81 per cent of the 37 MHTF-supported countries on fistula had established a government-led national task force for obstetric fistula, 59 per cent had developed national strategies to eliminate fistula, and 78 per cent had routine and continuously available fistula treatment services in strategically selected hospitals.

The MHTF has strengthened prevention, identification, treatment, social reintegration and advocacy related to obstetric fistula. It has mobilized political commitment and government ownership, leading to increased investment in fistula-affected countries, including for national fistula eradication strategies that are costed, time-bound, integrated into safe surgery and maternal and newborn health policies, implemented through strategic action plans, and monitored by a government-led national fistula task force or existing platforms for Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH).

During Phase II, the MHTF assisted countries to set up MDSR frameworks to enhance accountability for the quality and equity of care, stressing the institutionalization of accountability, efficient deployment of resources and a rights-based approach to maternal and newborn care. By 2017, a national MDSR system had been initiated for the notification and review of all maternal deaths in 92 per cent of MHTF-supported countries.

Girls and young women giving birth for the first time, particularly those under the age of 20, often face a higher risk of reproductive morbidity and mortality. The MHTF has made specific improvements to the quality and demand for maternal health services for young mothers. By 2017, 18 MHTF-supported countries (46 per cent) had prioritized FTYM in their national health plans; 19 developed new outreach strategies for them.

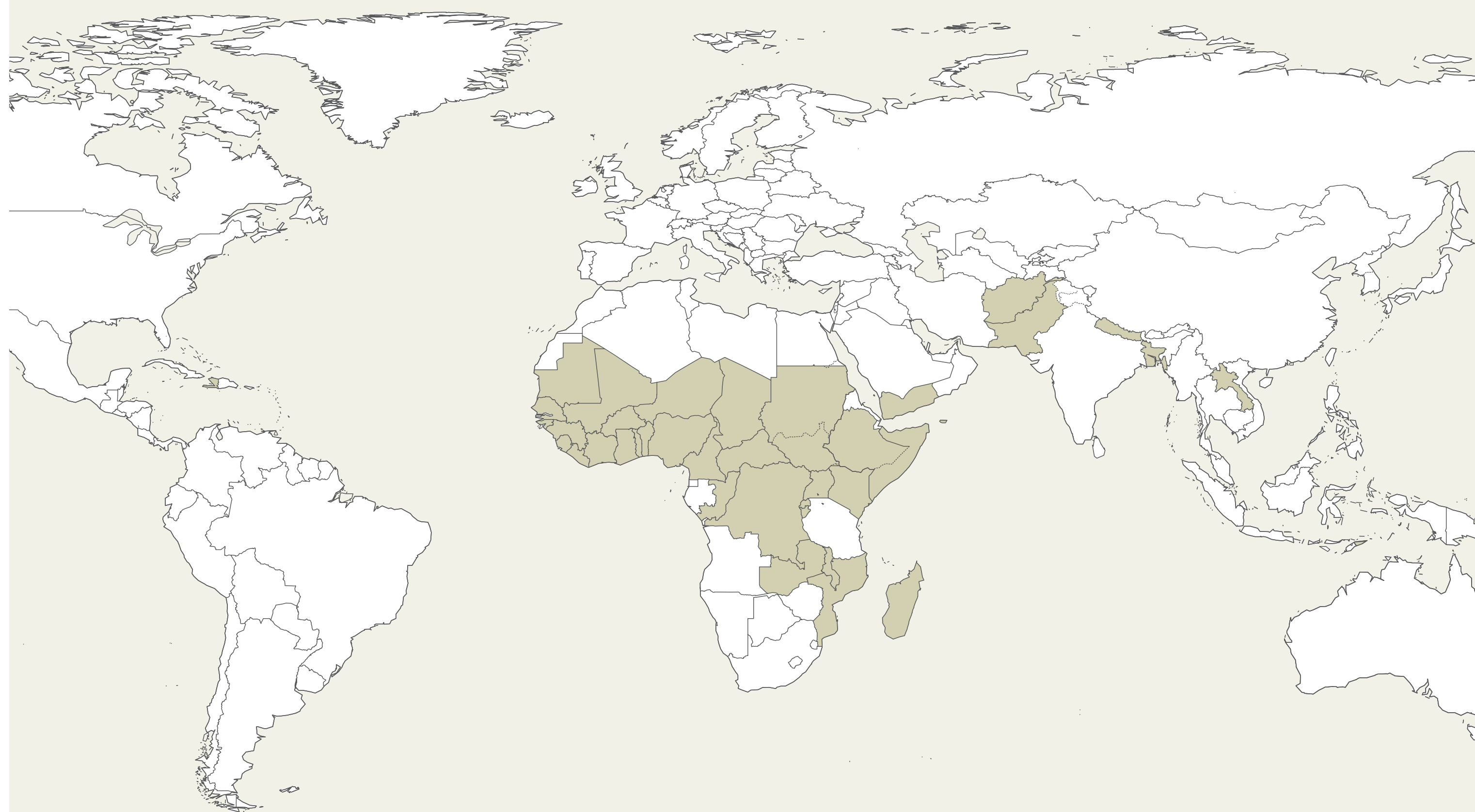
On the whole, the MHTF has demonstrated value for money, effective coordination and efficient management of resources, particularly at country level, and despite declining resources. A catalytic effect has encouraged several countries to mobilize additional national or international resources.

It is time for the MHTF to continue to build on past experiences and mobilize key players who can make ending preventable maternal mortality and ending fistula within a generation tangible realities. The most vulnerable women, children and adolescents still need to be reached to achieve the Sustainable Development Goals (SDGs).

Moving forward, the focus must be primarily on women and adolescent girls, including those who are young and vulnerable. A woman-centred approach should be geared towards detecting and addressing violations of their rights and integrity in all aspects of their reproductive lives. Other priorities are to promote innovation, including new technologies, and to advance evidence-based strategies, particularly in midwifery, fistula, M(P)DSR and EmONC.

FIGURE 1 Countries supported by the MHTF in Phase II

Afghanistan
Bangladesh
Benin
Burkina Faso
Burundi
Cameroon
Central African Republic
Chad
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Ethiopia
Ghana
Guinea
Guinea-Bissau
Haiti
Kenya
Lao People's Democratic Republic
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Nepal
Niger
Nigeria
Pakistan
Rwanda
Senegal
Sierra Leone
Somalia
South Sudan
Sudan
Timor-Leste
Togo
Uganda
Yemen
Zambia



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country territory, city or area or its authorities or the delimitation of its frontiers or boundaries.

A dotted line approximately represents the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not been agreed upon by the parties.

PART 1 OVERVIEW OF THE MHTF

The MHTF addresses the core pillars of health system strengthening to improve Maternal and Newnborn Health (MNH) in countries with the highest burdens of maternal and newborn mortality and morbidity. It covered 39 countries in Phase II, from 2014 to 2017 (Figure 1). The fund was established in 2008 to further enhance UNFPA's contribution to achieving the fifth MDG on improving maternal health.

In 2015, based on demonstrated results, the MHTF became one of UNFPA's central means to support attainment of the SDGs and the far-reaching 2030 Agenda for Sustainable Development,"[2] with its broad focus on economic, social and environmental factors that impact women's and girls' health and well-being. The MHTF is also an essential element of the United Nations Secretary-General's Every Woman, Every Child initiative.[3]

Background: 2000-2008

Motivated by the MDGs, UNFPA made several innovative changes in the early 2000s to further its overall mission to promote Sexual and Reproductive Health and Rights (SRHR). Among these were major initiatives in midwifery, EmONC and obstetric fistula. The Campaign to End Fistula was launched by UNFPA in 2003, the thematic fund for fistula following initiatives to address obstetric fistula in five particularly affected countries: Bangladesh, Benin, Ethiopia, Mauritania and Nigeria. The midwifery programme was established by UNFPA and the ICM in 2008, following a successful pilot programme from 2002 to 2007. Senior midwifery advisers were deployed to Bangladesh, Bolivia, Mozambique and Nepal with the support of the Swedish International Development Agency. The EmONC initiative resulted from collaboration between UNFPA and Columbia University's Averting Maternal Death and Disability Program. It sought to minimize delays in the provision of adequate maternal health care in India, Morocco, Mozambique and Nicaragua. The success of this pilot programme and the lessons learned from other initiatives for improving EmONC led to the development of the WHO's comprehensive *Monitoring Emergency Obstetric Care Handbook* in 2008.

In 2008, along the journey of the MHTF, the two thematic funds (Maternal health thematic fund and the Obstetric fistula trust fund) were pooled in an effort to integrate various initiatives on maternal health under one umbrella; therefore midwifery, obstetric fistula, EmONC and MDSR became part of the same results framework to better monitor the maternal health program of UNFPA.

Phase I: 2008-2013

Phase I of the MHTF aimed to support 12 countries per year until 2013. The countries were selected based on several health indicators, as well as their demonstrated commitment to improving maternal health. During Phase I, the MHTF adopted three UNFPA focus areas: midwifery, EmONC and Obstetric fistula; MDSR was added towards the later part of phase one (2011).

The midwifery focus helped establish national midwifery programmes in over 15 MHTF-supported countries by 2010. In 2011-2012, global midwifery standards were developed with the ICM to regulate midwifery education, practice and quality of care. By 2013, the MHTF had supported the training of 400 midwifery tutors as well as the strengthening of over 175 midwifery schools and training of over 35,000 midwives in 53 countries.

The EmONC initiative aided emergency obstetric care needs assessments in 32 countries by 2013. The results informed policy and the implementation of maternal health services. The MDSR initiative started in 30 countries but the adoption of surveillance and responses as a framework for the elimination of preventable maternal deaths took place only in 18 countries. The Campaign to End Fistula provided surgical treatment of obstetric fistula to over 47,201 women and girls in 43 countries by 2013.

2 See: https://sustainabledevelopment.un.org/post2015/transformingourworld.
3 See: www.everywomaneverychild.org.

Phase II: 2014-2017

Phase II of the MHTF continued to strengthen national capacity to improve maternal and newborn health, had a strong base of programming based on work force assessments in midwifery, EmONC assessments, initial data on prevalence of obstetric fistula. First time young mothers an additional area for piloting was also added in the second phase.

The midwifery programme helped establish training institutions in 33 countries, bringing the total number supported by the MHTF to 200. By 2015, 87% of MHTF-supported countries had implemented the ICM midwifery education standards, and the total number of midwives trained since the establishment of the MHTF reached 58,000 (in both MHTF supported countries and through technical and catalytic support in other countries). In 2016, the number reached 69,000 in over 70 countries and 85,000 in 2017 respectively.

The EmONC initiativesupported three countries in achieving by 2017, 65 per cent of the international standard of 5 EmONC facilities per 500,000 population. By 2017, six countries were conducting national monitoring of EmONC services on a quarterly basis. The MHTF contributed to The Campaign to End Fistula and supported 57,000 fistula repairs during Phase II (in both MHTF supported countries and through technical and catalytic support in other countries). In addition, 22 countries developed national strategies to end obstetric fistula. MDSR was initiated in 36 MHTF-supported countries. By 2017, 19 countries had MDSR program at the national scale. The FTYM programme was added as the fifth thematic area under the MHTF and 10 countries were provided funding for the pilot in the second phase of MHTF. The first pilot started in Liberia in 2014, towards a long-term objective of increasing access to SRH information and services among FTYMs, starting with their first pregnancy. Nineteen countries have now made it a priority in their national health plans.

Phase III: 2018-2022

Phase III has a strong focus on integrating previous focus areas with sexual and reproductive rights, key populations such as adolescents, and other UNFPA thematic funds, such as UNFPA Supplies, the UNAIDS Unified Budget, Results and Accountability Framework, and the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation. Phase III will expand the MHTF's focus to other obstetric morbidities such as uterine prolapse, access to safe abortion (to the full extent of the law) and post-abortion care, and cervical cancer prevention.

As a unique United Nations programme focused on improving MNH through an innovative and integrated results-based approach, the MHTF will continue working to enable women and girls to make fundamental decisions about their own bodies, attain the highest possible standards of SRH and exercise their reproductive rights.

See Figure 2 for a quick overview of how the MHTF has evolved.

FIGURE 2 MHTF Roadmap 2008-2017 with key achievements in five thematic areas

PART 2 CATALYSING CHANGE

2.1 The Phase II theory of change

The goal of the UNFPA Strategic Plan 2014-2017 was "*to achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents and youth, and women, enabled by population dynamics, human rights, and gender equality.*"[4]

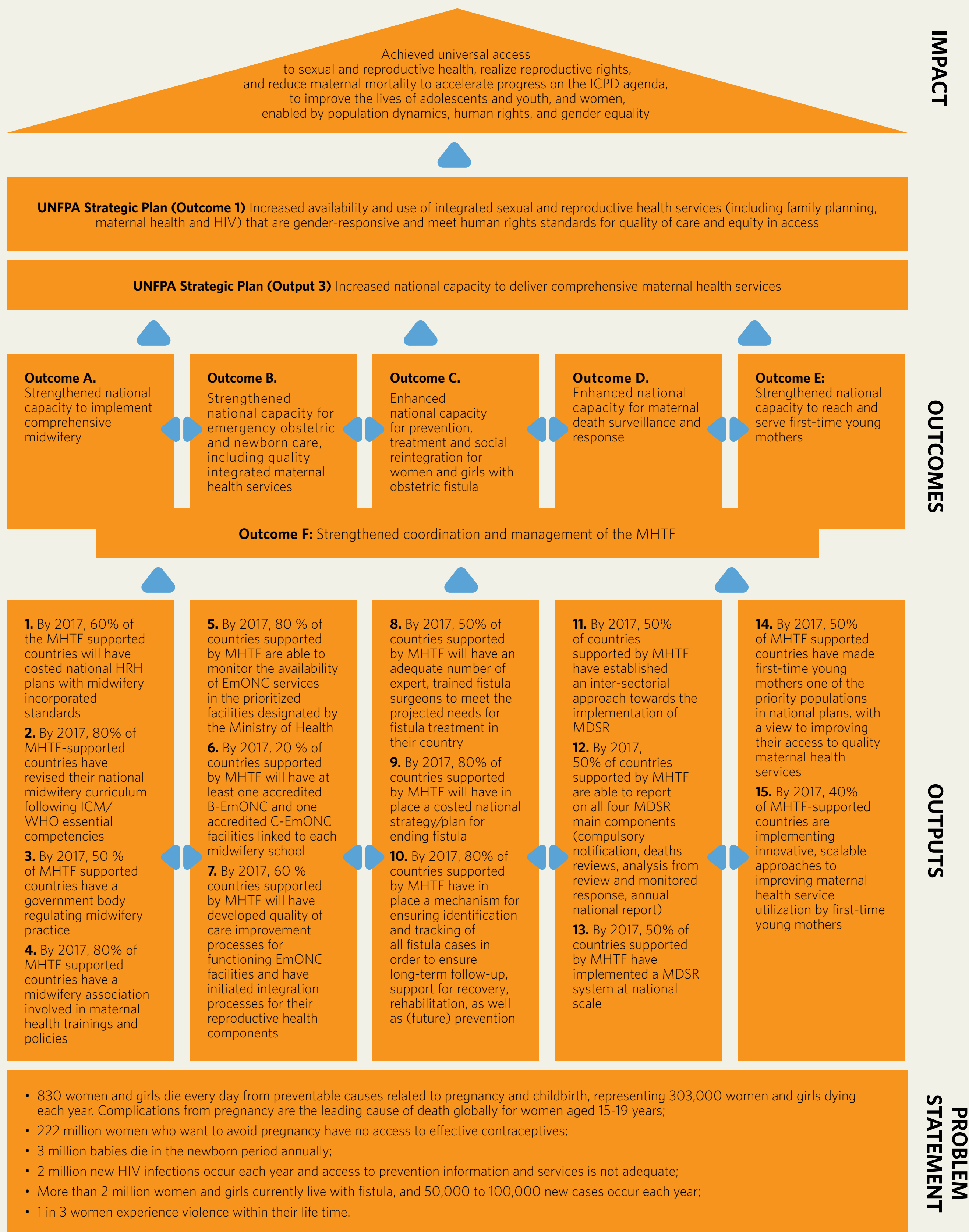
Outcome 1 of the plan contributes to this goal: "*Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.*"

The six outcomes of the MHTF Business Plan 2014-2017 are described in Figure 3. They are themselves driven by 15 outputs across five key intervention areas. Under its Results Indicators Framework,[5] the MHTF has defined indicators and strategic interventions to achieve its six outcomes.

4 UNFPA Strategic Plan 2014-2017, item four of the introduction to Annex 2: Outcome theories of change.
5 See Annex 4: Results Indicators Framework.

Seeking assistance during flooding in Nepal, pregnant women wait in line for services at UNFPA's mobile reproductive health camp. © UNFPA Nepal, September 2017. Photo submitted by Kristine Blokhus to the 2018 MHTF photo contest.

FIGURE 3 MHTF theory of change



2.2 MHTF contributions to stronger health systems

The MHTF made tangible contributions to strengthening health systems in 2017 and throughout Phase II. Maternal mortality reduction is a litmus test of health systems because it requires addressing all of their building blocks (Figure 4).

Contributions to leadership and governance have included supporting national governments to adjust and adapt SRMNAH policies and strategies. For example, the MHTF has supported the development of Sudan's new five-year strategy on Reproductive, Maternal, Newborn, Child, and Adolescent's health (RMNCAH), which is closely aligned to the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

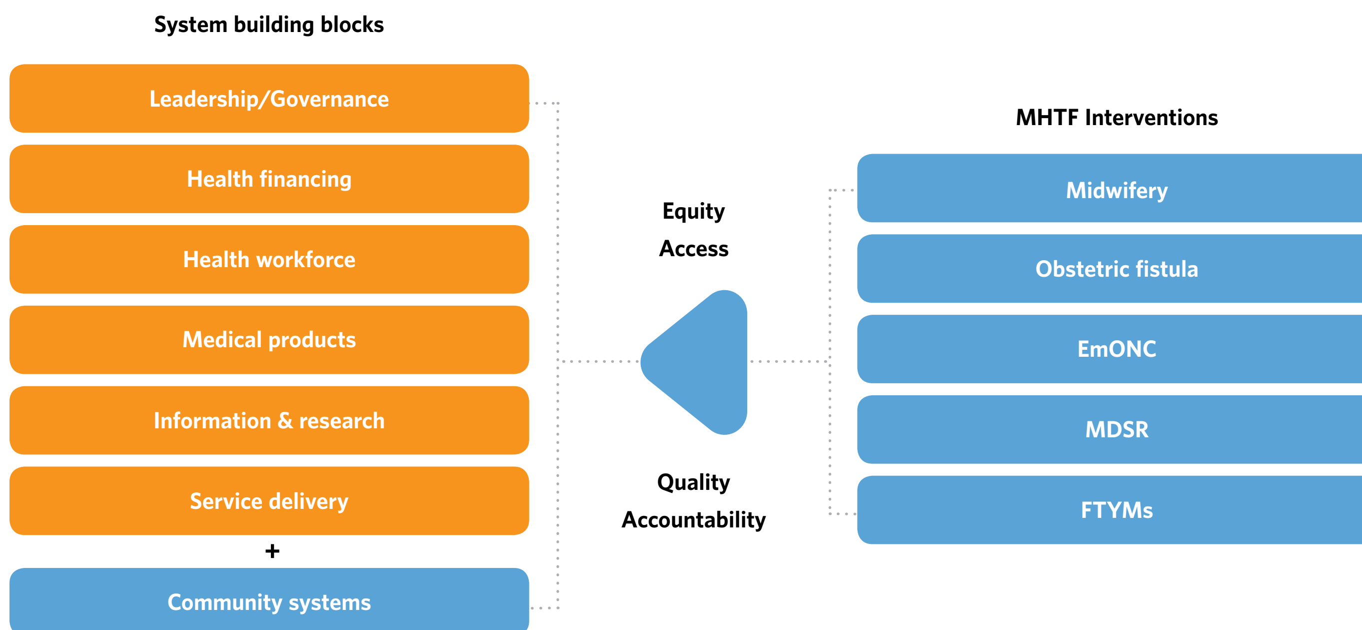
The MHTF has supported health financing to ensure that high-impact maternal health interventions and broader SRHR are delivered in an efficient and equitable manner, while recognizing that substantial additional resources (domestic and international, public and private) are necessary to fully achieve the maternal health and broader SRHR agenda.[6] Innovative approaches include Uganda using performance-based financing to incentivize village health teams to increase the identification and referral of fistula cases.

Mobilizing the leaders of the future

UNFPA's Latin America and Caribbean Regional Office, in collaboration with the Caribbean regional midwives association, organized the Young Midwifery Leaders Orientation Programme in 2016. Completed in early 2018, it helped establish a culture of leadership within ICM member associations so that competent midwives and midwifery services are available to all women and girls. Participants committed to lead efforts to enhance professional midwifery locally and regionally.

6 K. Stenberg et al., 2014, "Advancing social and economic development by investing in women's and children's health," *The Lancet* 383(9925): 1333-1354.

FIGURE 4 The MHTF and health systems strengthening



Source: WHO http://www.wpro.who.int/health_services/health_systems_framework/en/ .

Maternal health is heavily dependent on the health workforce and having skilled health personnel available 24/7, at different levels of the health system. At the global level, the MHTF has backed human resources initiatives through the *State of the World's Midwifery report*[7] and the United Nations Secretary-General's High-Level Commission on Health Employment and Economic Growth.[8] A new UNFPA Global Midwifery Strategy for 2018-2030 was drafted, reviewed and validated during 2017.

The MHTF helps strengthen the provision of maternal health commodities and supplies based on specific national needs. One example has been the design, development and procurement of two types of obstetric fistula repair kits with all necessary items for surgical repairs. During Phase II, 35 UNFPA country offices ordered 1,236 fistula Kit-1s and 1,477 fistula Kit-2s. The MHTF collaborates closely with UNFPA Supplies on the provision of these kits.

7 See: www.unfpa.org/sowmy
8 See: www.who.int/hrh/com-heeg/en/

To strengthen the quality of information and research, the MHTF supports data to inform and drive policy and programming on maternal health. During Phase II, it assisted countries to document best practices, scale up successful interventions and broaden policy directions, notably in MDSR work in East and Southern Africa. Several countries have adopted regular EmONC monitoring to track service availability, use and quality, and address gaps. Globally, UNFPA through MHTF is working with key United Nations entities on continued research around the improvement of maternal health, for example through the Ending Preventable Maternal Mortality (EPMM) technical group and the MPDSR global technical group.

Uwimana Josianne with her newborn baby in Rwanda's Nganzo Health Centre. © Mathias GAKWERERE, UNFPA Rwanda, September 2017. Photo submitted by Maureen TWAHIRWA for the 2018 MHTF photo contest

2.3 The MHTF's catalytic role

The MHTF was established at a time of limited focus on and resources for maternal health and broader SRHR. One of its objectives was to demonstrate results and attract diversified sources of finance to complement UNFPA's core resources (Figure 5).

During Phase II, the MHTF has more systematically documented results, best practices, lessons learned and emerging issues, and promoted South-South learning. As a result, additional funding from domestic and international sources has been mobilized by several MHTF-supported countries, such as Bangladesh, Ethiopia, Haiti, Mozambique, Sierra Leone, South Sudan, Uganda and Zambia.

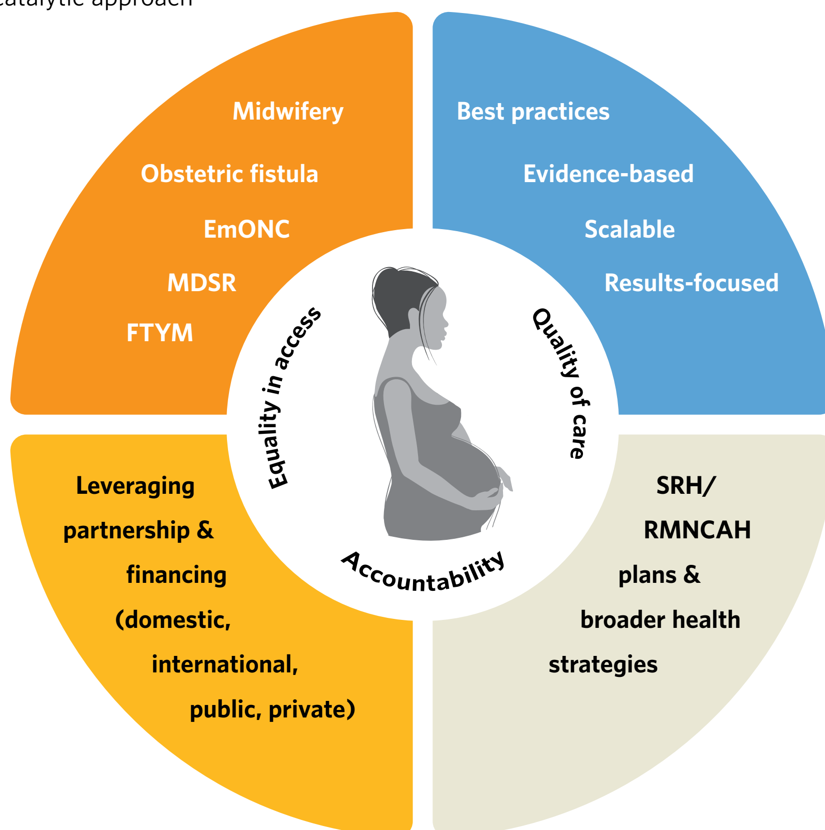
The MHTF has also leveraged the H6 partnership to support MNH interventions. Midwifery, EmONC and fistula technical experts at global and country level funded by the MHTF support H6-financed programmes, and have been instrumental in building synergies and catalytic impact, for instance, in Burkina Faso, the Democratic Republic of the Congo, Sierra Leone, Togo and Zambia.

Boosting investment in midwifery in Mozambique

In Mozambique, UNFPA demonstrated the importance of boosting the midwifery workforce and engaging multiple partners, and in doing so, mobilized donors and the Government to invest in midwifery. Agreements backing midwifery programmes have been signed by multiple partners.

UNFPA provided critical support to develop an investment case to advocate for human resources for health. As a result, funds exceeding $29.5 million were mobilized from the United Kingdom's Department for International Development for 2017 to 2020. Roughly half will go to UNFPA to promote maternal health initiatives supported by the MHTF.

FIGURE 5 The MHTF's catalytic approach



Scaling up professional midwifery in Bangladesh

The MHTF has had a huge impact in promoting a professional midwifery cadre in Bangladesh since 2010. Successes beginning with the MHTF have propelled additional funding from Canada, Sweden, the United Kingdom and emergency funds.

In 2010, the MHTF aided the launch of post basic training certifying nurses as midwives in accordance with ICM standards. In 2011, the Prime Minister made a strong commitment to the Every Woman Every Child Strategy; it entailed doubling the percentage of births attended by a skilled health worker by training an additional 3,000 midwives countrywide. By 2017, 1,600 midwives had graduated from the post basic training, and 515 midwives were serving in internships at 110 subdistrict hospitals.

The Bangladesh Midwifery Society was established in 2010. Today, it has grown to include 1,100 members and belongs to the ICM.

2.4 Innovations

Innovation has received increased focus during Phase II, particularly at the country level. In particular, the use of innovative technologies has been tested and promoted in Ethiopia and the United Republic of Tanzania for midwifery education, in Burundi for planning and monitoring EmONC facilities, and in five pilot countries for recording and analysing data related to obstetric fistula. These innovations, receiving technical support from technology institutes and financial support from international donors, have drawn the interest of a number of ministries of health.

Using GIS to plan EmONC in Burundi

Following a national workshop on EmONC facility network in 2017, the MHTF together with the University of Geneva organized a three-day training session for Burundian GIS experts on the AccessMod software.[9] Four subnational workshops involving 400 participants used the software and obstetric data to identify EmONC facilities in the 18 provinces of the country.

The proposed referral facility networks would cover 68 per cent of the population at 2 hour travel time. The network also details links between comprehensive and basic EmONC facilities, and the catchment area of each facility.

For example, in the province of Gitega, as shown in Figure 6, the exercise revealed that all maternity units, including those providing EmONC, cover 91 per cent of the population of the region at 2 hours travel time. However functional EmONC facilities able to manage obstetric

Breaking new ground in training health workers in remote areas

Through the Innovation Fund supported by Denmark, the MHTF launched the portable Mobile Learning System in 2016 at 22 training sites in Ethiopia and the United Republic of Tanzania. Targeted to midwives and health workers, the system improves knowledge and skills on key obstetric emergencies that typically cause over 90 per cent of maternal and newborn deaths and disabilities. Modules also address the prevention of female genital mutilation, danger signs in pregnancy and family planning.

Midwifery associations and ministries of health were engaged in the initiative from the start. Within nine months, over 3,000 health workers had been trained in the two countries. Results in the United Republic of Tanzania attracted an additional $75,000 in funding from the Government of Canada and Johnson & Johnson for the extension of the programme in Zanzibar. Impressed by the quality of the training, the midwifery association in Ethiopia has included it as a requirement for the in-service curriculum.

Ministries of health in both countries now want to scale up the Mobile Learning System. Ethiopia has purchased 40 kits for use at additional training sites. In May 2018, Rwanda launched the system at 10 training sites.

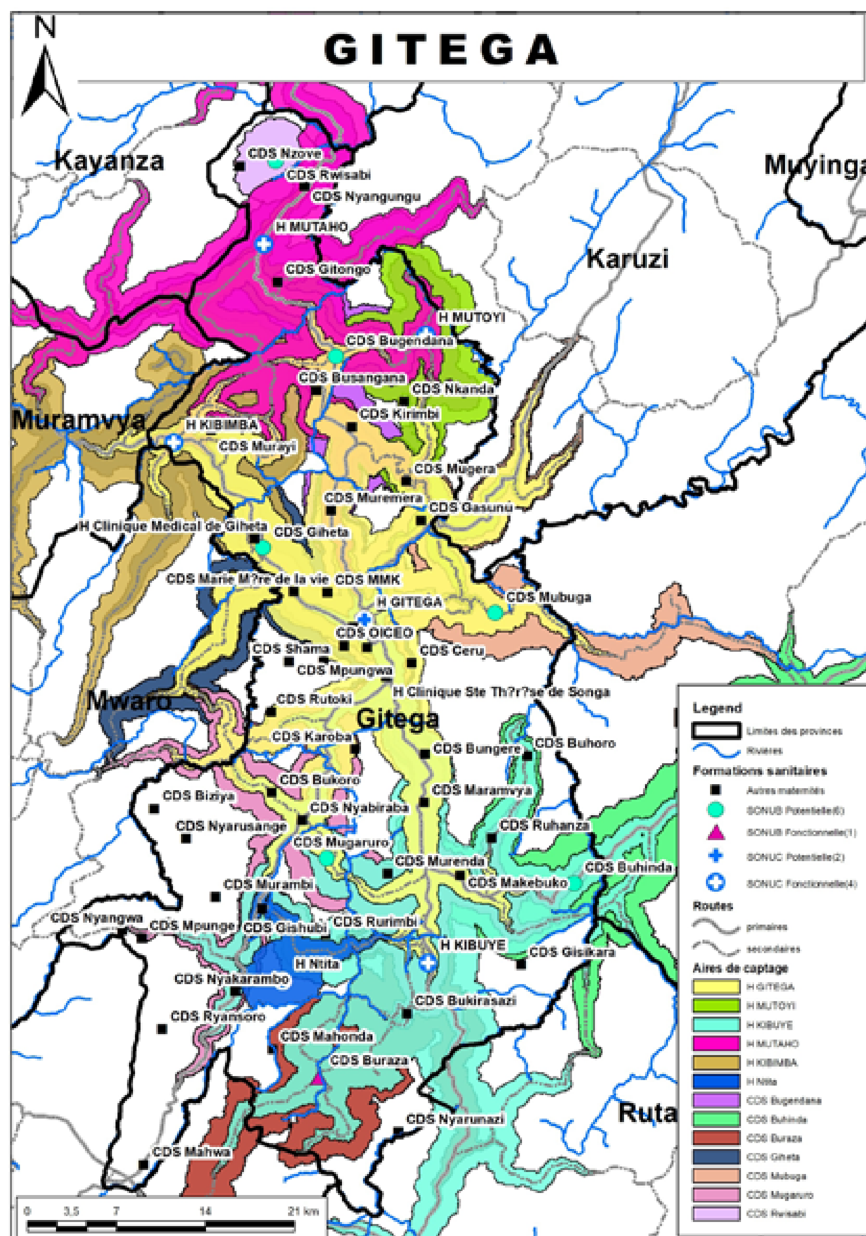
9 See: https://www.accessmod.org/

and neonatal emergency care 24/7 currently cover only 31 per cent of the population at 2 hour travel time. If they all become functioning, the EmONC facilities identified by the Ministry of Health would cover 61 per cent of the population at 2 hour travel time.

Another finding from these workshops was the gap of 44 midwives in the identified EmONC facilities. Further, only three out of seven referral links between the four CEmONC and the BEmONC facilities are “green,” meaning that referrals for emergencies have no significant physical or financial barriers.

The next step is for the MoH to routinely monitor obstetric and neonatal activities and key SRH indicators in the national network of EmONC facilities and to address gaps in availability and quality of care. The MoH can also track the deployment of skilled birth attendants (obstetricians, midwives) and nurse anesthesiologists.

FIGURE 6 The catchment areas at 2 hour travel time for each identified EmONC facility in the region of Gitega



PART 3 KEY RESULTS 2014 TO 2017: OPTIMIZING EQUALITY, QUALITY AND ACCOUNTABILITY

In 2017 and throughout Phase II, the MHTF demonstrated impressive results through a menu of strategic interventions that countries can select to best fit their needs. The MHTF team, based at UNFPA headquarters, and supported by UNFPA regional offices, monitors country offices workplans, planning and reporting throughout the year. In 2017 and 2018, a survey collected quantitative and qualitative information on strategic interventions beyond the Results and Indicators Framework.

3.1 Target achievements for Phase II

As seen in Figure 7, 7 of 15 targets set for the 15 outputs of the MHTF Business Plan 2014-2017 were reached by the end of 2017. Five are on track, very close to completion, and three could not be assessed for lack of baseline data.

A fistula survivor who gave birth with the help of a midwife.
© Abraham Gelaw, UNFPA Ethiopia, April 2017.

FIGURE 7 Scorecard on MHTF achievements from 2014 to 2017

Outcomes	Output number	Output description and target set for 2017 (countries supported by the MHTF)	Baseline in 2013: # of countries	Target in 2017: # of countries	Progress in 2017: # of countries	Percentage of target reached
A - Midwifery	1	By 2017, 60% of MHTF-supported countries have costed national health human resources plans with midwifery incorporated	17	23	26	113
	2	By 2017, 80% of MHTF-supported countries have revised their national midwifery curriculum following ICM/WHO essential competencies	27	31	34	109
	3	By 2017, 50% of MHTF-supported countries have a government body regulating midwifery practice	22	20	29	145
	4	By 2017, 80% of MHTF-supported countries have a midwifery association involved in maternal health trainings and policies	11	31	32	103
B - Emergency Obstetric and Newborn Care (EmONC)	5	By 2017, 80% of countries supported by the MHTF are able to monitor the availability of EmONC services in the prioritized facilities designated by the Ministry of Health	2*	31	6	N/A
	6	By 2017, 20% of countries supported by the MHTF have at least one accredited basic EmONC and one accredited comprehensive EmONC facility linked to each midwifery school	16*	8	25	N/A
	7	By 2017, 60% of countries supported by the MHTF have developed quality of care improvement processes for functioning EmONC facilities and have initiated integration processes for their reproductive health components	14	23	22	95
C - Obstetric Fistula	8	By 2017, 50% of countries supported by the MHTF have an adequate number of expert, trained fistula surgeons to meet the projected needs for fistula treatment in their country	No data	20	9	N/A
	9	By 2017, 80% of countries supported by the MHTF have in place a costed national strategy/plan for ending fistula	16	31	22	71
	10	By 2017, 80% of countries supported by the MHTF have in place a mechanism for ensuring identification and tracking of all fistula cases in order to ensure long-term follow-up, support for recovery, rehabilitation as well as (future) prevention	7	31	15	48
D - Maternal Death Surveillance and Response (MDSR)	11	By 2017, 50% of countries supported by the MHTF have established an intersectoral approach towards the implementation of MDSR	6	20	23	115
	12	By 2017, 50% of countries supported by the MHTF are able to report on all four MDSR main components (compulsory notification, death reviews, analysis from reviews and monitored response, annual national report)	11*	20	15	75
	13	By 2017, 50% of countries supported by the MHTF have implemented a MDSR system at national scale	11	20	19	95
E - First Time Young Mothers (FTYM)	14	By 2017, 50% of MHTF-supported countries have made first-time young mothers one of the priority populations in national plans, with a view to improving their access to quality maternal health services	9	20	18	90
	15	By 2017, 40% of MHTF-supported countries are implementing innovative, scalable approaches to improving maternal health service utilization by first-time young mothers	4	16	19	119

**revised baseline based on 2015 data*

Green - achieved · Orange - on track · Red - not achieved · Grey - baseline and/or target not applicable

3.1.1 Midwifery

The 2017 targets under all four midwifery outputs were reached (see Figure 7). The main outputs are summarized in Figure 8.

By 2017, 26 out of 39 MHTF-supported countries (66 per cent) had costed national human resources for health (HRH) plans with midwifery incorporated and 34 countries (87 per cent) were implementing a competency-based midwifery training curriculum aligned to ICM/WHO standards (output 2).

During Phase II, 30 countries (77 per cent) integrated broader SRH issues (fistula, incontinence, cervical cancer, female genital mutilation, adolescent SRH and newborn care) in their curricula. They are also working towards providing respectful maternity care through their in-service training programmes.

By 2017, 97 per cent of MHTF-supported countries had links between midwifery pre-service education programmes and training centres/facilities for building competencies in clinical skills. Thirty-four countries (87 per cent) were engaged in in-service training to strengthen the competencies of midwives. Innovative e-learning had been launched in 15 countries, with strong potential for development. During Phase II, 27 countries (70 per cent) initiated a mentoring programme to assist junior midwives to improve their quality of care; 765 midwifery tutors received training and support from the MHTF.

In 2017, 15,358 midwives received education and/or training, encompassing 9,025 midwives with pre-service education (MHTF resources) and 6,333 with in-service training (MHTF and other UNFPA resources). In Phase II as a whole, more than 47,000 midwives were educated and trained.

In 29 countries, midwifery is being regulated by a midwifery council or board or another regulatory body (output 3), and a midwifery data registry has been introduced. In 2017, midwifery associations in 32 countries (82 per cent) had a budgeted strategic plan and are involved in maternal health training and policies (output 4). Thirty-three countries (85 per cent) have made the International Day of the Midwife a national advocacy event.

3.1.2 EmONC

For EmONC development, 2017 targets was almost reached for one out of three outputs, output 7 on supporting quality of care improvement processes for functioning EmONC facilities and initiating integration processes for their reproductive health components (Figure 9). Output 5 was the most challenging as it aimed at strengthening service availability and quality by supporting countries to identify functioning EmONC facilities, and set up a monitoring and response mechanism to address gaps.

By 2017, 19 MHTF-supported countries (49 per cent) reported on the availability of EmONC but only six countries reported this indicator through routine monitoring of

FIGURE 8 Outcome A – Midwifery: output achievements versus targets

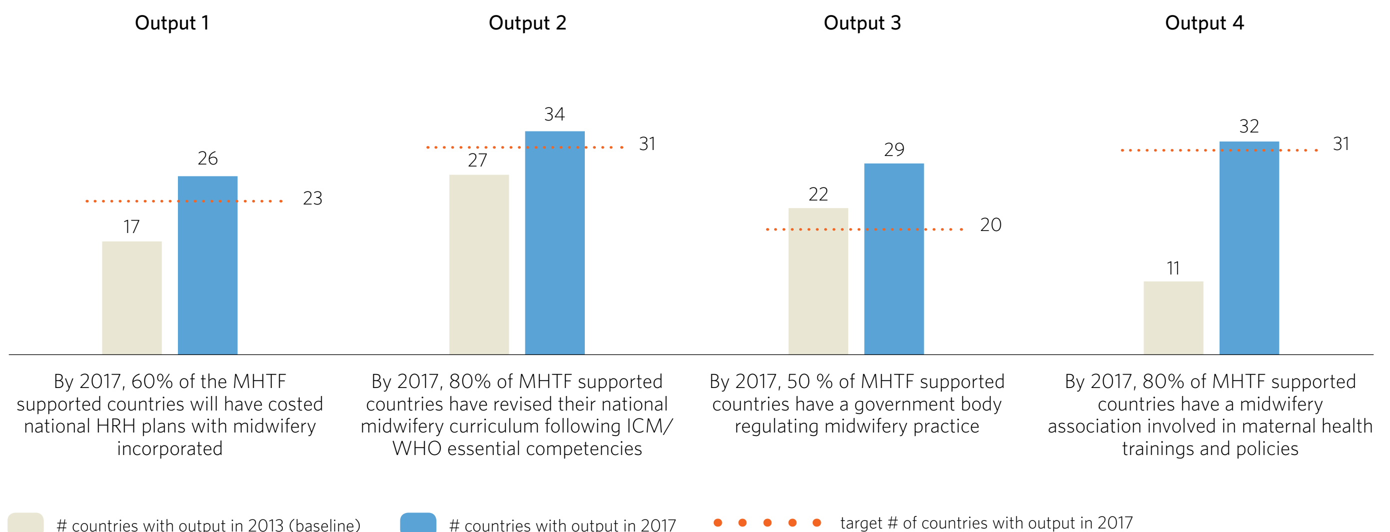
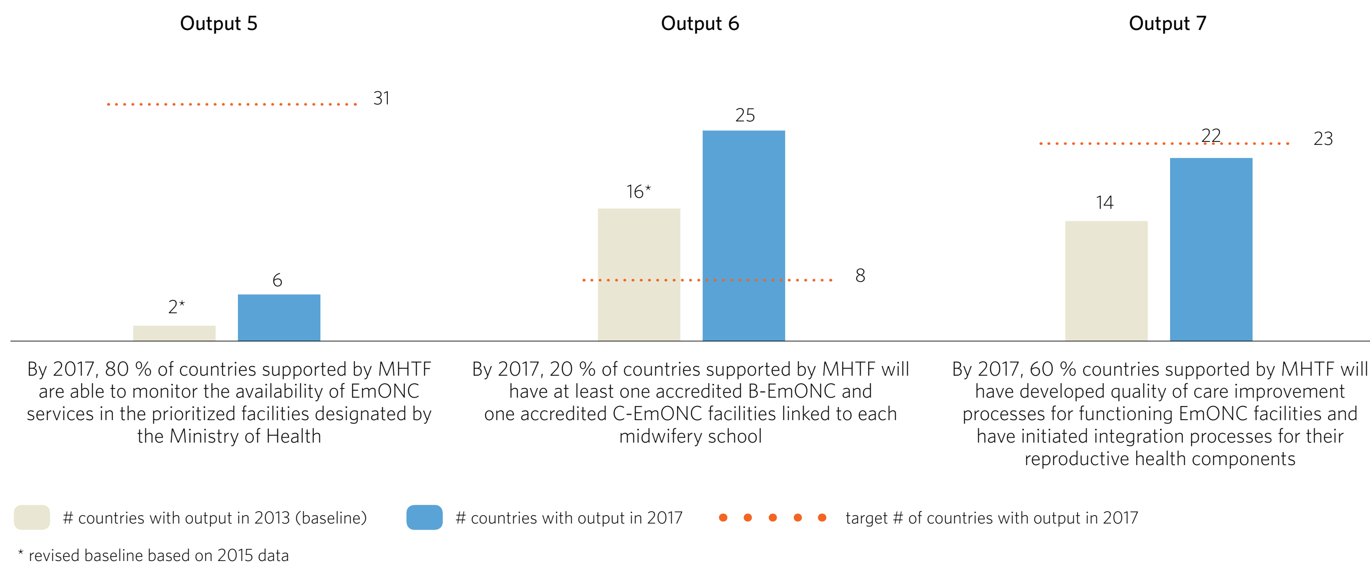


FIGURE 9 Outcome B – EmONC output achievements in 2013 and 2017



* revised baseline based on 2015 data

the EmONC network or through a health management information system (Burkina Faso, Haiti, Madagascar, Niger, Timor-Leste and Togo). The other countries conducted EmONC assessments (complete or rapid) to identify the number of functioning EmONC facilities.

The 2017 target for output 5 was defined based on information available in 2013. Different misunderstandings concerning the definition of the 'availability of EmONC' indicator resulted in an overestimation of the 2017 target. Instead of the former baseline of 21 countries, only two countries were able to effectively monitor this indicator in 2013. The number of comprehensive EmONC facilities is not far from the international standard in most countries, but there are major deficits in functioning basic EmONC facilities.

Eight countries (Bangladesh, Burkina Faso, Haiti, Madagascar, Nepal, Niger, Timor-Leste and Togo) are able to provide yearly updated data on EmONC indicators other than availability (e.g., EmONC met need; Direct Obstetric Case Fatality rate, etc) but 27 countries document the case fatality rate for direct obstetric complications in C-EmONC facilities.

Fourteen countries (36 per cent) have an EmONC facility mapping showing their geographical distribution, including the links between basic and comprehensive EmONC facilities. In 2017, Burkina Faso, Burundi, Haiti, Niger and Togo were able to define these links.

In 2017, EmONC was integrated in the health systems of 38 countries (97 per cent) and in a costed reproductive health strategic plan in 18 countries (46 per cent). Sixteen countries (41 per cent) have a budgeted plan to increase the number of functioning EmONC facilities. Twenty-two countries (56 per cent) updated reproductive health protocols to foster integration between maternal and reproductive health programmes (output 7).

By 2017, three countries (Burkina Faso, Haiti and Togo) had defined a national standard for basic EmONC facilities.

In 2017, the MHTF supported selected EmONC facilities in 14 countries with clinical practice for midwives during their pre-service education. By 2017, 25 countries had linked each midwifery school with at least one accredited B-EmONC facility and one C-EmONC facility for pre-service education (Output 6), reaching its 2017 target although not well defined given the lack of information available on this in 2013. Furthermore, 20 countries had defined accreditation criteria for these facilities; Finally, 17 countries had created training programmes for tutors who support clinical practice for midwives in these facilities.

3.1.3 Obstetric fistula

Although it has not been possible to calculate exactly the number of expert surgeons required to meet the needs of estimated fistula patients, their numbers have significantly increased over the four years of Phase II, with support and technical assistance from UNFPA and the Campaign to End Fistula. Thirty countries (81 per cent) now have a national task force to end fistula. The MHTF's output 10, on a mechanism to ensure identification and tracking of fistula cases to ensure long-term follow-up, is significant – 15 countries (40 per cent) have one (Figure 11).

In 2017, 29 out of 37 MHTF-supported countries on fistula (78 per cent) had routine and continuously available fistula treatment services in strategically selected hospitals. The MHTF played a key role, with 22 countries (59 per cent) indicating the contribution of the fund as a deciding factor in this achievement (Output 9). Twenty out of 37 MHTF-supported countries (54 per cent) indicated an increase in national capacities to mobilize resources for fistula. Fifteen countries monitored implementation of national fistula strategies.

In 19 countries, 174 fistula surgeons were trained in fistula repair and management through the support of UNFPA, the Campaign to End Fistula and partners. For 11 of these countries (58 per cent), the MHTF provided decisive support. To strengthen surgical teams for fistula, 1,380 health workers (apart from fistula surgeons), including anesthetists, nurses and midwives, were trained in fistula prevention, treatment, and management and care. In addition, 212 women and girls with fistula deemed incurable/inoperable were supported by the MHTF.

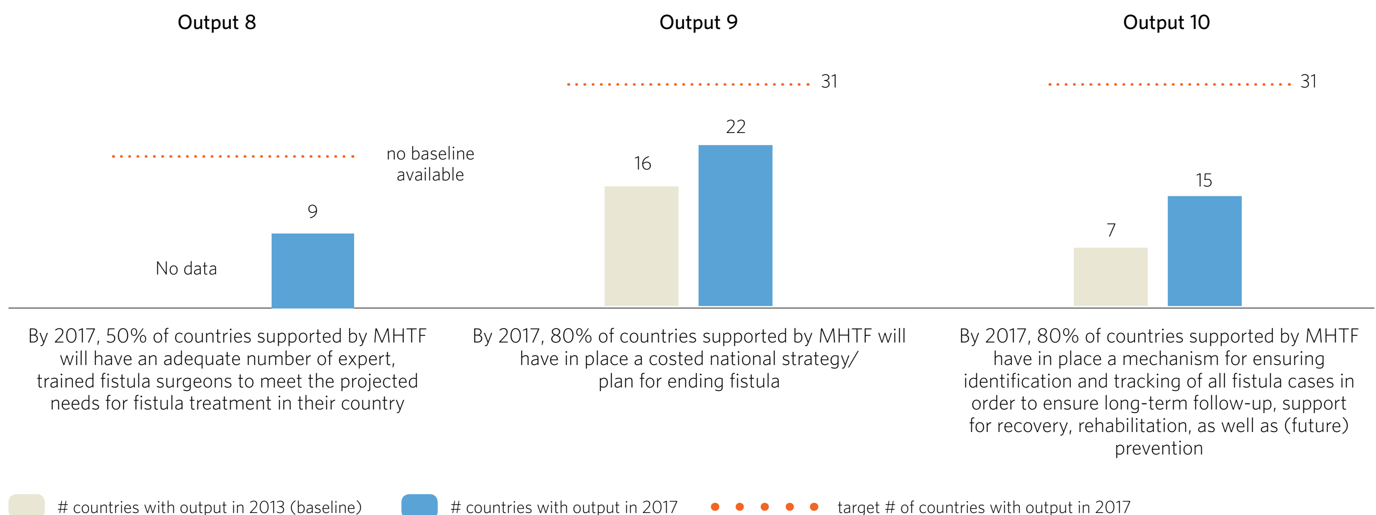
In 2017, 26,103 new cases of fistula were identified in 31 MHTF-supported countries. Over 8,200 women were repaired with MHTF support alone.

Globally, access to treatment for fistula still remains inadequate. In 2017, only 32 per cent of MHTF-supported countries reported having nationwide access to fistula treatment.

3.1.4 MDSR

Countries have made important progress in building an MDSR framework (Output 12). This includes four components defined by the MHTF: a functioning national MDSR committee, an MDSR national costed plan, mandatory maternal death notification, and national standards and tools adopted from WHO recommendations (these are the four components of MDSR as of 2015; previously they were defined as: compulsory notification, death reviews, analysis from reviews and monitored response, and the presence of an annual national report).

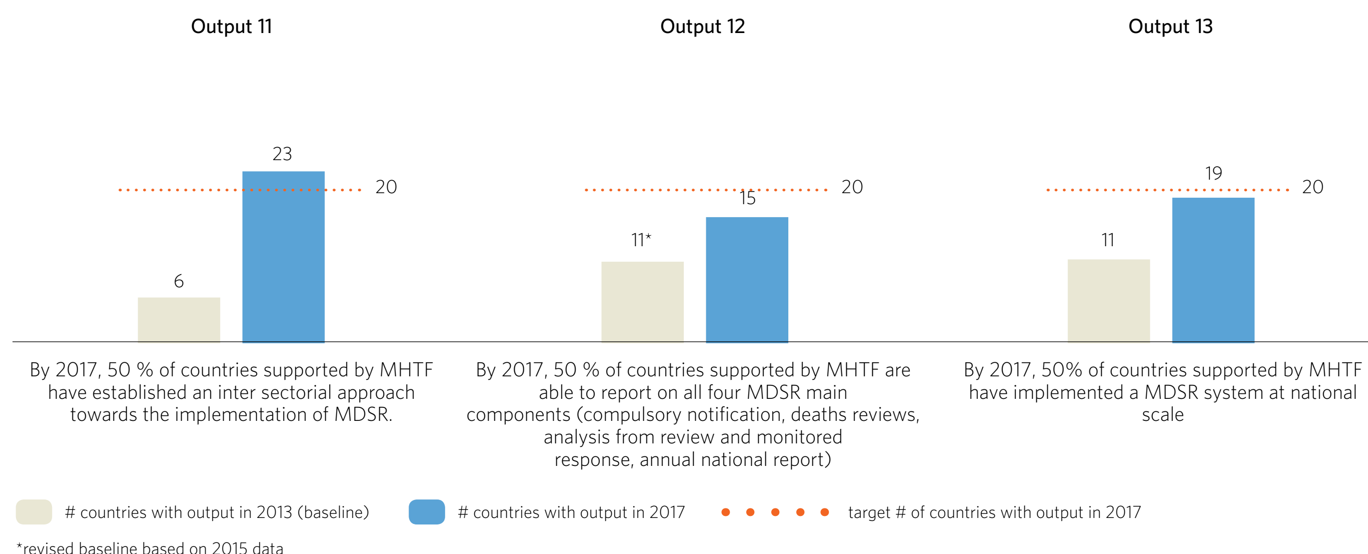
FIGURE 11 Outcome C – Obstetric Fistula: main outputs in 2013 and 2017



The surgical team of the Fistula Unit at the Al Thawra Hospital in Sana'a Yemen, established with the support of UNFPA.
© Abdul Rahman Mahmoud, UNFPA Yemen, February 2018.

Improvement has also occurred in three out of four components since 2015. Most notable has been progress in the number of functioning national MDSR committees, from 6 at baseline in 2013, to 18 in 2015, 19 in 2016 and 30 in 2017. In most countries, the committee is located within the Ministry of Health, without a multisectoral dimension. However, a national, intersectoral committee (output 11), currently available in 23 countries (61 per cent), is imperative in addressing the various causes and determinants of maternal and newborn deaths related to the health system and beyond.

FIGURE 12 Outcome D – MDSR: main outputs in 2013 and 2017



*revised baseline based on 2015 data

As more countries develop elements of the MDSR programme framework and monitors it, the percentage of maternal deaths, the percentage of maternal deaths reported and reviewed have similarly grown (Figure 13). From 2015 to 2017, the number of countries implementing MDSR at national scale increased from 11 to 19 and the number of countries with no notification of maternal deaths fell significantly, from 13 to 6. The number of countries where notification of maternal deaths exceeds 40 per cent of the total number of expected maternal deaths has risen from 2 to 5.

The number of countries with mandatory maternal death notification has also increased, from 27 in 2015 to 34 in 2017, leaving only 5 MHTF-supported countries without mandatory reporting. Although challenges remain in the quality and coverage of maternal death reviews, mandatory maternal death reporting is an essential step towards institutionalizing MDSR. Since 2016, the number of countries with national MDSR guidelines and tools has risen from 32 to 36 (92 per cent). The only framework indicator that has not seen improvement since 2015 is the MDSR costed plan; 21 countries had a national MDSR costed plan in 2015, but the number decreased to 12 in 2016 and has since stagnated, remaining an area for improvement.

Progress has been made in MDSR monitoring. The number of countries with an MDSR annual report increased from 11 in 2015 to 14 in 2016 and 15 in 2017; the number with MDSR monitoring in place increased from 14 in 2015 to 23 in 2016 and 27 in 2017. In the same time period, the number of reported maternal deaths that were reviewed increased (Figure 14). In 2015, 20 countries had no review, whereas in

FIGURE 13 Percentage of maternal deaths notified against number of expected maternal deaths

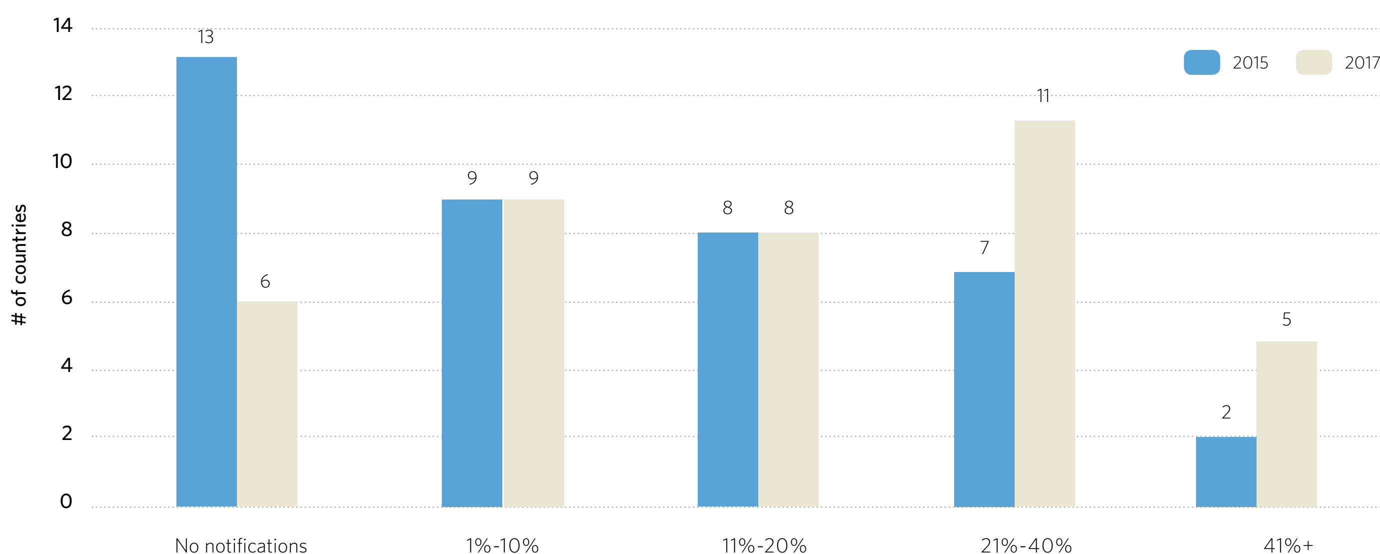
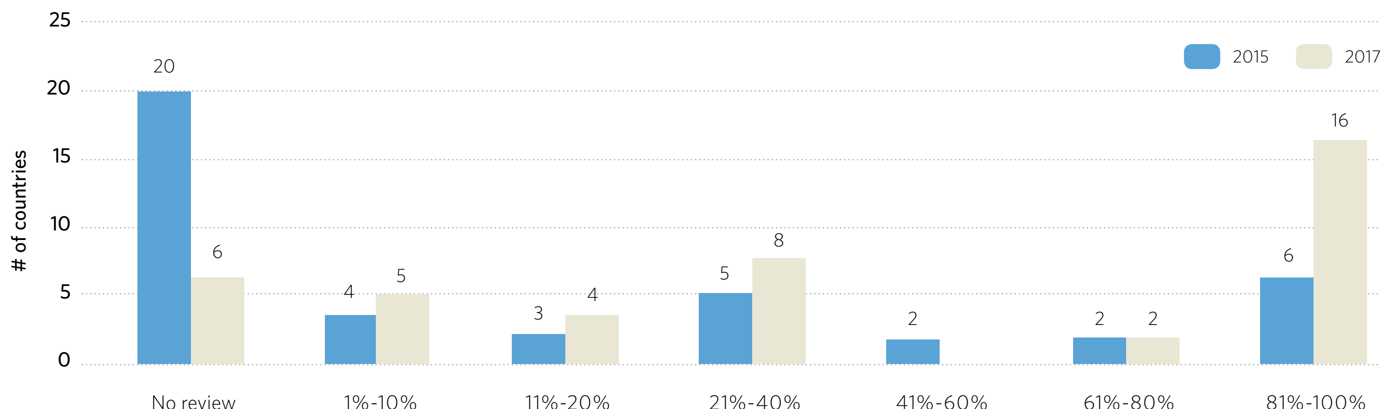


FIGURE 14 Percentage of maternal deaths notified that are reviewed



2016 and 2017, respectively, the shares dropped to 14 and 6. An upward trend is visible across all levels of review.

In Phase III, the focus will be on increasing maternal death reporting, followed by review and corrective actions, in order to improve the overall quality of maternal health care and strengthen accountability mechanisms. Another focus will be to integrate the perinatal component, tested in one country during Phase II, which will transform the name of the work area into Maternal Perinatal Death Surveillance and Response MPDSR.

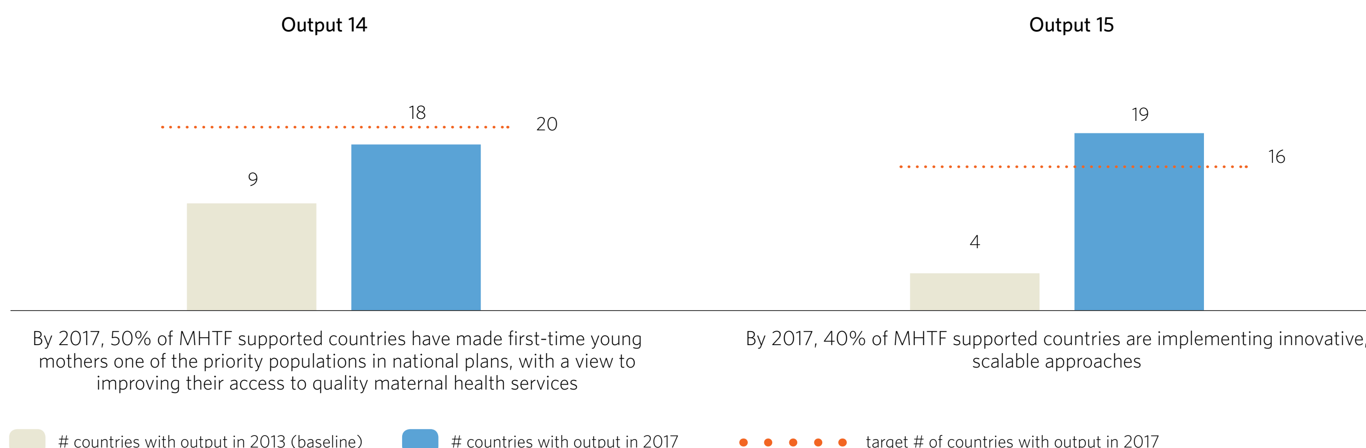
3.1.5 FTYM

After support for FTYM was introduced in 2013, the MHTF began working with countries to increase the number of young women delivering with a skilled birth attendant, to boost uptake of post-partum family planning, to prevent or space pregnancies, and to improve decision-making power related to SRHR. In 2017, 18 countries (46 per cent) had made FTYM one of the priority populations in their national plans, almost reaching the target of 20 countries by the end of 2017. At the same time, 19 countries (48 per cent) have defined and implemented at least one intervention strategy explicitly dedicated to FTYM (output 15), exceeding the goal of 16 countries by 2017. SRH data was disaggregated by age, including 10 to 14 years old, in 18 countries (46 per cent).

The following subsections highlight, with country examples, how MHTF strategic interventions contribute to the three cross-cutting principles of equality in access, quality of care and accountability, towards strengthening health systems at all levels.

A young mother waits to receive services at Tokora Health Centre IV in Moroto District, Uganda. © Martha Songa, UNFPA Uganda, September 2017.

FIGURE 15 Outcome E – FTYM: main outputs in 2013 and 2017



3.2 Equality in access

Equality in access to MNH care means ensuring that every woman and girl has the same opportunity to receive the information and care she needs, regardless of her income, socioeconomic standing, health status (e.g. disabilities), geographic location, cultural background, or her willingness and capacity to ask for services. Vulnerable groups such as adolescent mothers, poor women, women with disabilities, indigenous peoples, newborns, fistula survivors and isolated communities often have more needs but also more challenges in accessing health care. This is particularly true for specific services such as post-abortion care, post-partum family planning and social reintegration. Many women from vulnerable groups lack financial resources, and in too many cases, the attention they deserve is denied by the health-care system or some providers.

The MHTF is bound by the principle of equality in access. It has since its inception insisted on the role of communities (village-based associations, local committees, community leaders and civil society organizations) in identifying their own priorities, contributing to solutions and monitoring interventions. Work with indigenous peoples has facilitated access to MNH services, for example, in the Lao People's Democratic Republic and the Republic of the Congo.

3.2.1 EmONC

During this second phase, the MHTF has supported countries to strengthen access to EmONC services 24/7. By focusing on a limited number of EmONC facilities identified through objectives criteria and geographic data (using GIS/AccessMod - cf. Burundi case study on page 9), countries have strategically deploy their scarce available resources to make these facilities functioning while keeping a good coverage of the population within two-hour journey. The MHTF has also supported countries to monitor two UN recommended indicators on access to EmONC: the "availability of EmONC" and the "geographic distribution of EmONC facilities". Both are critical in improving equality in access to maternal and neonatal care. As highlighted in Figure 10, in 2017, 19 countries reported the "availability of EmONC' compared to 13 countries in 2013. The average EmONC availability for the 19 countries supported by MHTF with data is 36 per cent of the international standard of 5 EmONC facilities per 500,000 population. Timor-Leste has EmONC availability above the international standard. Niger reported EmONC availability at 83 per cent and the Republic of Congo reported EmONC availability at 76 per cent.

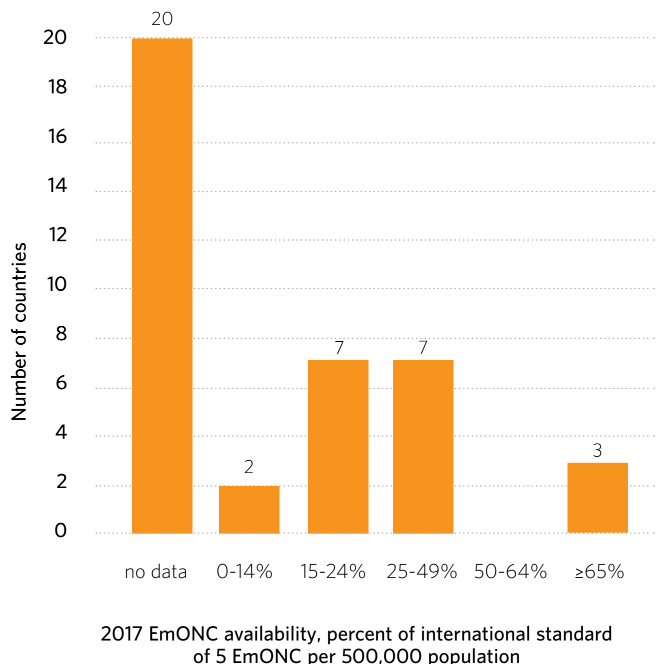
EmONC reaches indigenous peoples in the Republic of Congo

The MHTF has helped the Ministry of Health increase access to obstetric care for indigenous women in the Sangha department of the Republic of Congo.

In 2017, an anthropological mission sought to better understand obstetric care needs for both Bantou-speaking and indigenous peoples. The approach included workshops for health providers on the specific needs of indigenous women; training for community volunteers to liaise with them, inform them of their rights and encourage them to go to health clinics; training for traditional birth attendants on biomedical practices to enable them to practice in medical institutions; and the distribution of clothing kits, including hygiene kits, to pregnant indigenous women for antenatal visits.

As a result, the number of women receiving antenatal care and giving birth in health clinics and the hospital increased dramatically. In the first quarter of 2017, 10 women received antenatal care and 11 women gave birth in a medical facility, compared to 112 and 38 by the third quarter, respectively. Five million euros raised from the private sector will be used in 2018 to support similar efforts in two more districts.

FIGURE 10 EmONC availability in MHTF-supported countries compared to the international standard



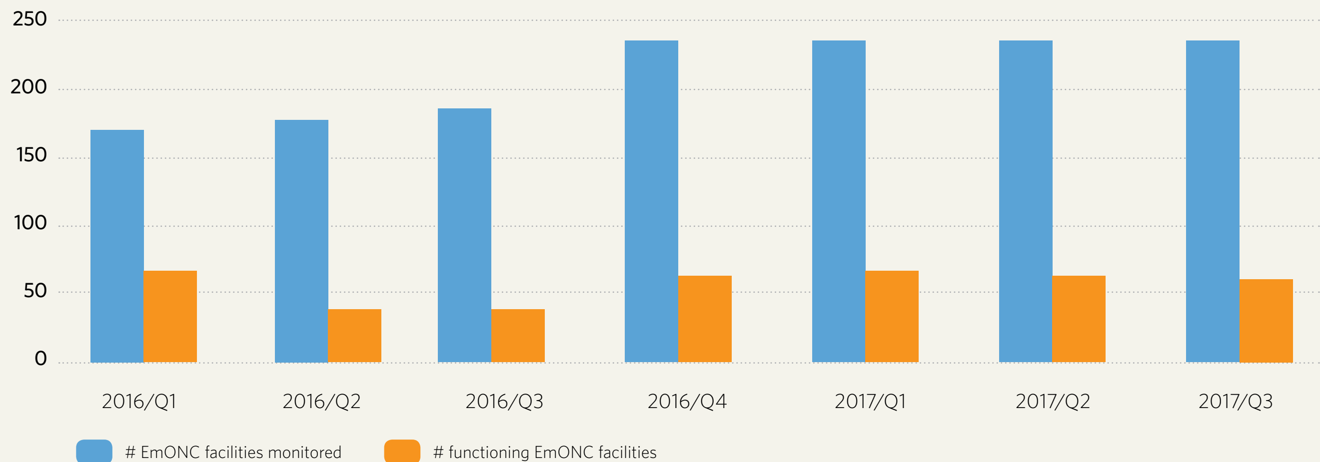
The MHTF also supports countries to facilitate the deployment of competent midwives across all health facilities, especially EmONC facilities. It has helped countries to elaborate national standards for EmONC facilities (especially basic EmONC facilities) that quantify staffing needs. To date, Burkina Faso, Haiti, Timor-Leste and Togo have defined such standards and calculated gaps in the number of midwives needed in EmONC facilities.

Madagascar extends EmONC monitoring

Following a national workshop in 2015, held with MHTF support, Madagascar's Ministry of Health and its partners decided to identify 254 health facilities to be upgraded to EmONC facilities and to form a national network (in line with the recommendation of 5 EmONC per 500,000 population). Monitoring took place on a quarterly basis in 2016 and 2017 at national scale in 254 EmONC facilities. It provided key maternal and newborn health information for health facility providers and for maternal health programme managers to identify and address gaps in the availability and quality of care.

In a country with only 38 per cent of pregnant women delivering in health facilities, the monitoring showed that the proportion of maternity units performing the seven basic signal functions for the management of obstetric emergencies was 26 per cent on average of the recommended 254 EmONC facilities and stagnant since 2016 (Figure 16). This is mostly due to the lack of midwives in EmONC facilities and low service utilization.

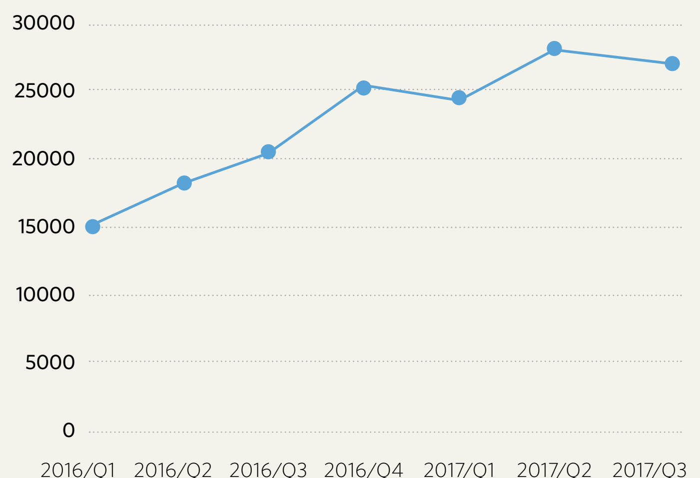
FIGURE 16 Number of functioning EmONC facilities in Madagascar, 2016-2017



Other indicators, such as EmONC met need, remain low as well, at 10 per cent (instead of 100 per cent, ideally). The Caesarean section rate is around 1.3 per cent, against an expected value above 5 per cent. An encouraging sign is that the number of deliveries performed in the EmONC network is rising (Figure 17).

In general, Madagascar's EmONC facility network is weak, covering only 10 per cent of expected births. The geographic distribution of facilities needs to be analysed, and the network better mapped, including to estimate the catchment area for all maternities. Other indicators, such as those related to staff, equipment and referral, need to be better monitored at all levels, so that actions can be taken in response to shortfalls in service availability and quality. These actions have been included in MHTF support to Madagascar in 2018.

FIGURE 17 Number of deliveries in the EmONC facility network in Madagascar, 2016-2017



3.2.2 Obstetric fistula

In Phase II, the MHTF has supported the Campaign to End Fistula, which through its network of nearly 100 partners, has generated awareness of obstetric fistula globally and in remote places. It has improved the identification of women and girls with obstetric fistula, as well as rates of surgical repair and social rehabilitation. Overall, a gradual shift has taken place from a campaign approach towards the establishment of fistula services anchored in national health strategies, plan and budgets, and fully integrated into health systems through strategically selected hospitals that provide continuous and holistic fistula care (e.g., in Ethiopia, Madagascar and Uganda).

In Phase II, 29 of 37 countries supported by the MHTF on obstetric fistula reported having routine and continuously available treatment in strategically selected hospitals. Only 11 countries have fistula treatment services that cover all regions, however. Ten countries with full coverage have stated that the MHTF played a "deciding" or "significant" role in this process. A majority of countries (76 per cent, or 28 out of 37 countries) lack a sufficient number of treatment centres conducting surgical repairs on a regular basis.

Three Countries Empowering FTYMs and Adolescents

Over the last several years in Bangladesh, midwives have been trained to provide specialized maternal care. They did not receive any specific training on how to care for adolescents, however. As a result, young pregnant women felt like midwives were treating them as children and did not respect their autonomy.

The MHTF during Phase II supported the introduction of training to improve interactions with FTYMs. The midwives learned communication skills; how to practice a warm demeanor, empathy, patience and respect; and how to ensure privacy and confidentiality. The programme was initiated in 27 rural hospitals and extended to include mentoring of young women. Reactions have been very positive. Goals for 2018 are to improve the links between community health workers, midwives and FTYMs to further enhance access to SRH services.

Liberia started an action research project in 2014 in the suburbs of Monrovia aimed at adolescent and young women. "Big Belly Clubs" are small groups of 15 to 25 FTYMs that focus on education and counselling sessions. Community health workers, known as "big sisters," are recruited and trained to provide individual and group counselling. They also serve as mentors to the young women, creating personal relationships and providing individualized support. In monthly sessions, a locally designed booklet and flip chart with illustrations and easy-to-read text help explain what to expect during each month of pregnancy and after birth, and hygiene during and after pregnancy.

Clubs have had 80 to 95 per cent attendance on a regular basis and demonstrated some positive outcomes. From 2015 to 2016, almost all pregnant FTYMs attended at least one antenatal care visit, compared to the national average of 78 per cent. Of the 492 who enrolled during their first and second trimester, 295 (60 per cent) attended at least four visits before their delivery. Future goals encompass expanding the programme to include 12 months of post-partum follow-up and increasing education on family planning.

In Mozambique, the *Rapariga Biz* programme helps young girls meet with mentors once a week for four months to discuss personal situations that affect their lives and future. Girls are educated on a number of topics, including the risks of early pregnancy and childbirth, their rights over their own bodies and within relationships, family planning options and more. In the first year of the programme, participants had substantially lower rates of early pregnancy and child marriage than national averages.

Making strides on obstetric fistula in Ghana

Ghana launched its own campaign to end obstetric fistula in 2005, addressing three areas: awareness; identification and treatment; and rehabilitation and reintegration of survivors into their communities. A recent survey found a high incidence of fistula, between 1.6 and 1.8 cases per 1,000 deliveries, mainly concentrated in the Northern Region.

UNFPA collaborated with the Ministry of Health and the Ghana Health Service in the Northern region to develop mechanisms for identifying and tracking fistula cases. These involved fistula survivors empowered and trained as advocates. Surgical repair was provided free of charge in all fistula treatment centres. In 2016 and 2017, over 300 suspected cases were identified and 151 successfully repaired. Survivors also took part in livelihood training to make soap, fabrics, pastries and cosmetics, and learned basic entrepreneurship skills.

Among the good practices for improving case identification and treatment referral were the national celebration of the International Day to End Obstetric Fistula, free registration of clients under the national health insurance scheme, training of obstetric fistula advocates, sensitization and awareness creation about obstetric fistula on district and community radio stations, and establishment of hotlines were among the good practices for improving case identification and treatment referral.

3.3 Quality of care

One of the major factors in quality of care is the competence of health workers, particularly midwives. In Phase II, major efforts have been supported in both the pre-service and in-service training of midwives.

3.3.1 Midwifery

To improve the quality of midwifery, countries have taken several initiatives, including:

- Alignment of the national midwives curriculum to internationally agreed ICM/WHO standards;
- Strengthening of midwifery schools to improve competencies;
- Attachment of basic EmONC facilities to midwifery schools so that there is a direct interaction between training and practice;
- Development of a national in-service clinical refresher training package/manual;
- Distance learning for midwives such as through videos and e-learning (see the previous section on innovation);
- Support to midwifery councils and other regulatory bodies;
- Supportive supervision of midwives; and
- Establishment of mentoring programmes involving senior midwives supporting younger ones, particularly in remote areas. These programmes were piloted in Benin, Burkina Faso, Côte d'Ivoire, Ethiopia, Kenya, Madagascar, Sudan and Zambia. One bottleneck was the recruitment, training and support of mentors, teachers and trainers.

Mentoring midwives in Madagascar

In Madagascar, a 2017 evaluation of the midwifery mentoring programme found that from 2015 to 2016, the number of women attending antenatal consultations rose by 30 per cent. The number of women who gave birth in health facilities where providers were mentored also increased.

The most significant improvement concerned obstetric complications managed at basic EmONC health centres. The number detected and managed increased by more than 50 per cent during the third quarter of 2016, compared with the third quarter of 2015. Stillbirths have decreased while postnatal consultations tripled after a year of the programme.

3.3.2 EmONC

The quality of EmONC is measured by the case fatality rate per direct obstetric complication (according to WHO standards, it must be below 1 per cent), and the stillbirth and neonatal death rates. Figure 18 displays these indicators for six countries. Since 2013, the MHTF has supported six countries (Benin, Burkina Faso, Haiti, Madagascar, Nepal and Togo) to strengthen national capacities to monitor these quality of care indicators and to act on them.

3.3.3 MDSR

The MHTF has also supported countries to improve the quality of maternal deaths reviews, and ultimately to drive actions to reduce maternal deaths. MDSR contributes to higher quality of care by strengthening accountability at all levels of the health system.

3.3.4 Obstetric fistula

The MHTF has implemented several initiatives to improve quality of care for obstetric fistula:

- **Strengthening the skills of 486 obstetric fistula surgeons and their surgical care teams**, particularly through South-South collaboration and a mentoring programme in countries facing severe deficits in quality treatment (e.g., the Democratic Republic of the Congo, Nepal, Pakistan, the Republic of Congo and Sierra Leone).
- **Skills-building workshops at key global and regional meetings** (e.g., FIGO, the International Urogynecological Association, ISOFS).
- **Procurement of fistula repair kits** with all necessary items for surgical repairs. The kits were designed in collaboration with expert fistula surgeons from International Society of Obstetric Fistula Surgeons (ISOFS).
- **Fostering knowledge exchange on quality care for fistula treatment** by producing quarterly e-bulletins highlighting the latest research publications, relevant tools and resources in the field.

3.4 Accountability

Towards accountability for quality of care and ownership at all levels of health systems, the MHTF contributes to strengthening governance and coordination mechanisms; generating, sharing and enabling the use of data; empowering health system stakeholders and beneficiaries; and assisting in situations requiring a humanitarian response.

3.4.1 Governance and coordination

With midwives at the forefront in guaranteeing the rights of women and newborns to receive quality and respectful care, the MHTF helps foster an enabling professional environment and professional accountability. As stated in the 2014 *State of the World's Midwifery* report, "Supporting and protecting midwives by law (providing a legal right to practice) is an important acknowledgment of their worth."[10]

Other elements related to governance and accountability include helping countries to ensure that all deaths of women of reproductive age are notified, and that all probable maternal deaths are reviewed by experts to identify and address contributing factors, within the MDSR programme framework. Achieving his objective, though, still has a long way to go.

The MHTF has also helped countries set up national taskforces for supporting the development, implementation and monitoring of national strategies and action plans to end obstetric fistula.

10 Source: www.unfpa.org/sowmy, Chapter 2, English version, p. 27.

FIGURE 18 EmONC quality of care indicators in 2017

	Benin	Burkina Faso	Cameroon	Madagascar	Nepal	Timor-Leste	Togo
Case fatality rate for direct obstetric complications (%)	4.8	1.2	1.2	1.2	2.3	1.5	2.0
Intrapartum and very early neonatal death rate (per 1000 live births)	2.1	3.4	2.1	2.5	2.5	1.5	2.3

Sources: EmONC Needs Assessments, EmONC Rapid Assessments (UNFPA West and Central Africa Regional Office), EmONC monitoring.

3.4.2 Monitoring implementation by strengthening data collection, analysis and response systems

At the onset of Phase II, the MHTF facilitated data collection and analysis for the second *State of the World's Midwifery* report (2014), and supported its dissemination. With MHTF assistance, UNFPA's 15 country offices in the Arab States region developed a regional midwifery report in 2015; offices in Eastern and Southern Africa prepared a similar report in 2017.

Phase II aided (rapid) EmONC needs assessments in 18 countries, midwifery workforce assessments in countries defined by the WHO as having a high maternal health workforce burden (Afghanistan, Bangladesh, Ethiopia, Mozambique and the United Republic of Tanzania), and midwifery gap analyses in 33 countries. Conducted by national authorities, these exercises have been instrumental in developing new policies, procedures and monitoring systems. Seventeen countries (43 per cent) have an updated midwifery data registry, and 10 countries have regular data on midwifery workforce availability and deployment. The MHTF has also supported EmONC network development in six countries, and contributed to a revision of EmONC needs assessment collection tools, including with a new focus on newborn health.

Data are particularly difficult to gather and interpret for obstetric fistula, because this scourge mostly affects poor and marginalized women and girls, and because shame and lack of education cause underreporting. The MHTF continues to support data strengthening, especially for the identification of patients. By 2017, 27 countries (72 per cent) had reinforced systems to identify and register new obstetric fistula cases; 30 countries were monitoring an obstetric fistula programme, with improved tracking of the success rate of fistula repairs. At the global level, the MHTF is collaborating with the Johns Hopkins Bloomberg School of Public Health to generate the first global estimates of obstetric fistula prevalence and incidence.

3.4.3 Empowerment and advocacy

MHTF support for the development and use of data and for advocacy campaigns has helped bolster national commitments to strengthening midwifery, EmONC, MDSR and obstetric fistula responses.

Efforts to advance the leadership and empowerment of midwives occur through global, regional and national advocacy. Other interventions empower women suffering from obstetric fistula, mobilize governments to end fistula, sensitize communities on the causes of fistula, and connect women and girls to support, treatment and rehabilitation.

In the same spirit, UNFPA and the Campaign to End Fistula played a leading role in advocating the United Nations General Assembly resolution that created the International Day for Ending Fistula on 23 May of each year. This significant international achievement has amplified UNFPA's leadership within the United Nations system, and galvanized the global community to significantly increase awareness, support and advocacy for ending fistula across the globe.

In 2017, UNFPA and the Campaign to End Fistula received the UNFCU Women's Empowerment Award for contributions to ending obstetric fistula.

3.4.4 Humanitarian response

In 2017, several national or regional crises and climatic events particularly affected MHTF focus countries, including Afghanistan, the Central African Republic, Mali, Somalia, South Sudan and Yemen. UNFPA country offices helped account for the particular needs of affected regions and populations, influence national policies, conduct assessments and monitoring, and mobilize resources for these countries, as well as for a total of 14 countries during Phase II as a whole.

Task-shifting for midwives in Liberia

In **Liberia**, 21 health workers, including 19 senior midwives and two physician assistants, have enrolled in the task-shifting programme for obstetric care, where trained personnel who are not physicians perform specific services. From 2014 to early 2017, during training as obstetric clinicians, these health workers managed a total of 789 obstetric cases, including 473 Caesarean sections.

Mobilizing support at the United Nations General Assembly

At the 2017 meeting of the United Nations General Assembly, an MHTF event, "Towards Equality in Access, Quality of Care and Accountability for Improved Maternal Health," highlighted impacts of the fund in achieving the SDGs. A second event with the Campaign to End Fistula, "Securing Hope, Health & Dignity for All to Achieve the SDGs: Ending Obstetric Fistula within a Generation," presented recent achievements and identified next steps.

Based on the recommendations of the United Nations Secretary-General and supported by UNFPA advocacy, the General Assembly adopted a resolution with 135 Member State cosponsors on intensifying efforts to end obstetric fistula. The resolution called on the international community to support UNFPA and partners in the global Campaign to End Fistula. It encouraged Member States to contribute to ending obstetric fistula and improving maternal health as part of achieving the SDGs. For more, see: www.endfistula.org/publications/un-committee-resolution-fistula-2016.

Pakistani fistula survivor Razia Shamshad in New York in September 2017. © Lothar Mikulla, UNFPA, September 2017

For example, in the Ebola crisis in West Africa, UNFPA drew on the extensive experience of the MHTF midwifery programme. In collaboration with the governments of Guinea, Liberia and Sierra Leone, and other partners, it developed the Mano River midwifery response to restore resilient health systems for RMNCAH and prepare for the post-Ebola period.

In Yemen, obstetric fistula work continues despite conflict

With a large proportion of child marriages and adolescent pregnancies, Yemen is particularly exposed to the risk of obstetric fistula. Despite ongoing conflict, two UNFPA-supported fistula centres have treated 200 cases since 2012. The training of fistula surgeons continued in 2016 and 2017 in Addis Ababa, and operations were performed despite higher risks imposed by conflict-related logistics and insufficient equipment and drugs. Two obstetric fistula units at two referral hospitals, one in the south and one in the north, have operated since 2010. External support for fistula is limited, as most external donors have suspended their assistance to Yemen.

Advocacy for case detection and management is ensured by midwifery associations and non-governmental organizations (NGOs), and takes place with MHTF support through media, radio programmes, health educators and religious leaders. Social reintegration remains a problem within an unstable environment, however. With salaries often going unpaid, an established network of community volunteers, community midwives and fistula focal points needs incentives to support the referral system that connects the two regional fistula centres with other health facilities.

The breakdown of supply chains and a lack of government funding for public health facilities have undermined their functioning. They have resorted to levying user fees, a serious barrier for Yemenis who have been greatly impoverished by the crisis. Home delivery has increased and skilled birth attendance has dramatically declined.

PART 4 RESOURCES AND MANAGEMENT

4.1 Background

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

As is the case for most multilateral organizations, UNFPA has a growing share of resources earmarked for a specific purpose or region by donors. While non-core resources may continue to increase, it is challenging for the organization to ensure that many pockets of non-core funds work together towards the realization of UNFPA's Strategic Plan. To that effect, the newly established Non-Core Funds Management Unit has four priorities: a non-core funds management policy, a frequent and standardized monitoring system, a needs-based resource allocation system, and a work-planning process with an earlier start and greater involvement of UNFPA's regional offices.

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

4.2 Thematic Trust Funds for Maternal Health and Obstetric Fistula

Globally, as shown in Annex 1B, the approved allocation for the MHTF was slightly lower in 2017 than in 2016, $13.9 million versus $14.8 million, a 6.4 per cent reduction. This downward trend has continued throughout Phase II, as indicated in Figures 19 and 20.

As shown in Annex 1B, due to resource-related factors, the total budget for country allocations decreased in 2017 to $9.8 million compared to $11.3 million in 2016, a 14 per cent fall. As a result, all countries but five were granted a lower allocation than in 2016, from 1 per cent to 44 per cent less. Two countries received the same allocation, Mozambique and South Sudan, while three countries received a modest increase of 3 per cent to 7 per cent, the Republic of Congo, Timor-Leste and Togo.

A few countries, like Bangladesh, Ethiopia, Mozambique and South Sudan, compensated for the decline in MHTF funding by leveraging alternative sources.

FIGURE 19 Trends in MHTF allocations and expenditures throughout Phase II, in dollars

Year	2014	2015	2016	2017	All Phase II
Approved allocations	17,610,660	15,616,059	14,789,585	13,850,631	**61,868,935**
Expenditures	17,280,579	13,674,251	13,968,161	13,257,603	**58,180,593**
Implementation rates, percentage	98	88	94	96	**94**

FIGURE 20 Trends in income and expenditures for the two thematic funds during Phase II, in dollars

	Income ZZT03 Obstetric Fistula Trust Fund				Income ZZT06 Maternal Health Trust Fund			
Year	Beginning fund balance on 1 January	Income from donors	Other income/ loss	Total funding available	Beginning fund balance on 1 January	Income from donors	Other income/ loss	Total funding available
2014	298,667	431,77	2,281	732,725	60,974,207	3,649,195	(6.186,526)	58,436,876
2015	240,757	370,269	3,460	614,485	41,962,584	2,189,091	(1,679,468)	42,472,208
2016	350,337	366,824	4,258	721,419	29,063,766	1,593,043	(963,955)	29,692,855
2017	418,748	435,015	7,983	861,746	16,067,246	7,840,760	(43,801)	23,864,205

Expenditures

Year	ZZT03 Obstetric Fistula Trust Fund	ZZT06 Maternal Health Trust Fund
2014	491,968	16,788,611
2015	264,148	13,410,103
2016	334,119	13,634,042
2017	381,171	12,876,432

Ethiopia secures new support for EmONC, midwifery and obstetric fistula

The Government of Ethiopia has invested significant sums in improving maternal and newborn health since 2000. As a result, its maternal mortality ratio decreased by 60 per cent, from 897 per 100,000 live births in 2000 to 353 in 2015. The neonatal mortality ratio dropped from 45 per 1,000 live births to 29. One of the first recipients of the MHTF in 2008, Ethiopia has managed to compensate for declining MHTF funding by attracting alternative finance, as shown in Fig. 21.

FIGURE 21 MHTF funding in dollars in Ethiopia

Year	MHTF funding in dollars	MHTF and other sources
2013	1,500,000	1,000,000 contributed to the MDG pooled fund, the rest mainly for emergency obstetric newborn care and midwifery advisers' salaries at the UNFPA country office. For midwifery activities, Ethiopia used Swedish International Development Agency funds.
2014	1,000,000	500,000 contributed to the MDG pooled fund, the rest mainly for emergency obstetric newborn care and midwifery advisers' salaries. For midwifery activities, Ethiopia used Swedish International Development Agency and H6 funds.
2015	750,000	Funds for emergency obstetric newborn care, fistula and midwifery advisers' salaries. For midwifery activities, Ethiopia used H6 funds.
2016	540,000	Funds used for fistula, midwifery advisers' salaries and a few midwifery activities as most were covered under the H6 funds, including for the new EmONC needs assessment.
2017	474,017	Funds used for fistula, midwifery advisers' salaries and a few midwifery activities as most were covered under H6 funds.

Contributions

The Thematic Trust Fund for Maternal Health received $6.9 million in 2017, a 48 per cent decrease from 2016, when it received $13.4 million (Figure 22).

FIGURE 22 Total donor contributions to the Thematic Trust Fund for Maternal Health in 2017

Donors	Recognized revenue* in dollars	Collected revenue in dollars
Sweden	3,784,057	3,592,384
Germany	2,246,155	1,061,321
Luxembourg	2,027,748	2,027,748
Poland	98,728	98,728
Friends of UNFPA	94,087	94,087
GE Healthcare	25,000	25,000
TOTAL	**8,275,775**	**6,899,268**

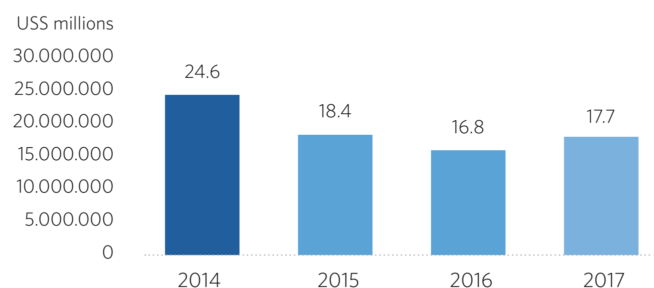
*Recognized revenue signifies new pledges, whereas collected revenue comprises the actual amounts transferred to UNFPA in 2017. For this report, the latter column is the most important. Recognized revenue is shown because it may appear in other financial statements for this programme.

Operating budget

The operating budget for the Thematic Trust Fund for Maternal Health in 2017 encompassed the end-of-year balance for 2016 plus income received during the first three quarters of 2017. Income received during the fourth quarter will typically be carried over to the following year, since it normally cannot be programmed and expended within that short time frame. In accordance with the International Public Sector Accounting Standards, transactions are only recorded as expenses when the services or goods have actually been carried out or handed over to the implementing partner.

The Thematic Trust Fund for Maternal Health received $12.5 million in the fourth quarter of 2016 to be used in 2017. An additional $3.1 million was carried over from the regular programme budget from 2016 to 2017. Further, $2.1 million was received in donor contributions during the first three quarters of 2017. This brought the total operational budget to $17.7 million in 2017 (Figure 23).

FIGURE 23 Operating budget for maternal health in Phase II, in millions of dollars



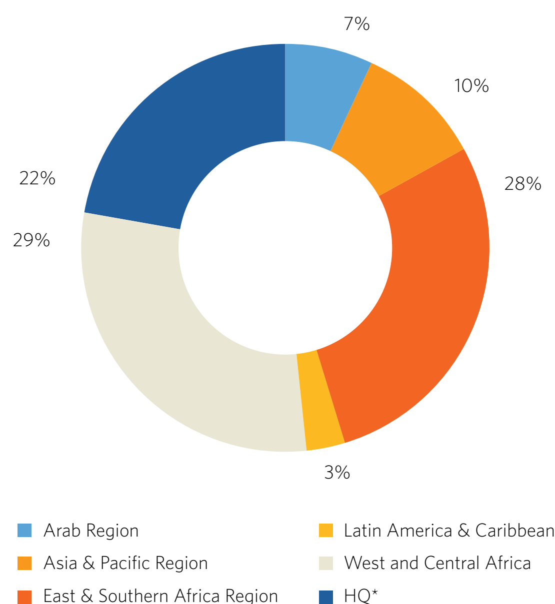
Expenses

As a result of declining allocations, expenditures also fell in 2017 (Figure 24). During 2017, spending by country and regional programmes accounted for 77 per cent of expenditures. Out of total expenditures, 17 per cent or $2.2 million was disbursed via NGOs; 24 per cent or $3.2 million via a governmental partner; and 59 per cent or $7.8 million via UNFPA directly.

As seen in Figure 24, West and Central Africa accounted for most of the funds allocated to maternal health, with 30 per cent ($4 million) of the total. East and Southern Africa came second at 28 per cent ($3.6 million). Global allocations constituted 22 per cent ($3 million) of which an additional 4.5 per cent ($602,400) was channeled to NGOs and other institutions (universities, institutes) for their interventions, particularly at country level. Asia and the Pacific accounted for 10 per cent ($1.4 million), the Arab States for 7 per cent ($877,000), and Latin America and the Caribbean for 3 per cent ($414,000).

Against approved allocations, the implementation rate was 96 per cent in 2017. This compares to 94 per cent in 2016, where total approved allocations were $14.8 million and expenses were $14 million for 39 countries, 2 regional offices and headquarters units.

FIGURE 24 Shares of expenditures for maternal health by region and globally in 2017



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

PART 5 CONCLUSION AND LOOKING FORWARD

5.1 Conclusion of Phase II

Since its inception in 2008, the MHTF has demonstrated its unique role in global health. Throughout Phase II (2014-2017), backed by a wealth of technical expertise, it provided global leadership and financial, technical and strategic support to governments and Ministries of Health in order to formulate, fund, implement, and monitor MNH and SRH strategies and programmes. In most countries, maternal health has been elevated as a priority, in line with human rights and gender equality principles. Competencies at all levels are improving. Countries have conducted needs assessments and programme evaluations based on improved data. The MHTF has helped develop the capacity of several countries to adapt to conflicts or natural disasters, and to better respect human rights to access quality sexual and reproductive health services.

Key results across the four years of Phase II are summarized in this report (cf. Figure 25). The results are good with six outputs out of 15 achieved, two almost achieved, and four on-track.

Between 2013 and 2017, the MHTF contributed to averting 48,105 maternal deaths. This figure totals 119,127 since the start of the MHTF in 2008.

Three countries (Lao People's Democratic Republic, Rwanda, Timor-Leste) supported by the MHTF have reached the MDG 5a of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio, and 12 have significantly progressed towards this goal, with a reduction in maternal mortality greater than 50 per cent since 1990. With the transition to the SDGs and the 2030 Agenda underway, the specific and unique approach of the MHTF, summarized in Figure 26, will continue to propel advances.

Despite these significant progress, however, key challenges remain. Financial constraints marked the four years of Phase II, with a regular decrease of resources year after year. Among other effects, the limited coverage of countries (up to 48 were planned for support in the initial business plan). Another constraint, alluded to in the plan's "risks and assumptions," entailed the ecological and political instability of many countries (internal conflicts, climatic disasters). UNFPA country teams in affected countries had to struggle and adjust, in close collaboration with governments, to find adequate responses and maintain a minimum package of MHTF activities. Partners have been instrumental in supporting this process.

5.2 Looking forward to Phase III

At the end of Phase II, UNFPA country and regional offices are extremely concerned that momentum be sustained and if possible strengthened. Their agenda is far from being reached. They see the MHTF as a catalyst not only for improved maternal and newborn health, but also for leveraging other funds, developing managerial capacity, improving the knowledge and competencies of service providers, and gaining the confidence of populations in maternal, newborn health and broader sexual and reproductive health.

Phase III will have a specific focus on those left furthest behind, e.g., adolescent girls, poor women, women with disabilities (including fistula) and indigenous women. It will support countries to scale up efforts to tailor integrated, high-quality policies and programmes for those who are most disadvantaged. The three principles of equity, quality of care and accountability will be at the heart of all activities.

The MHTF will continue to support countries to make the best-informed policy choices, based on the latest evidence, so that they can prioritize, plan, budget, implement, monitor and evaluate maternal and newborn health services that deliver results.

FIGURE 25 Summary of key results for Phase II

Midwifery

- Almost all countries (87 per cent) implement ICM education standards and 77 per cent have integrated broader SRH issues in their curricula.
- Over 15,300 midwives supported by the MHTF in 2017 (in both MHTF supported countries and through technical and catalytic support in other countries), both for pre-service education (9,000) and in-service training (6,300).
- In 2017, 765 midwifery tutors were trained with MHTF support.
- A national board or council is in place in 74 per cent of MHTF-supported countries.
- National associations with a costed plan are in place in 70 per cent of MHTF-supported countries.

MDSR

- By 2017, 92 per cent of MHTF-supported countries have initiated an MDSR programme, and 87 per cent have mandatory reporting of maternal deaths.
- A national MDSR system has been implemented to notify and review all maternal deaths at national scale in 19 countries (48 per cent) of MHTF-supported countries, and MDSR monitoring is in place in 70 per cent.
- Only 12 countries (31 per cent) had an MDSR costed plan by 2017.
- In 2017, only 6 MHTF-supported countries had not reported review of maternal deaths.
- Five countries have initiated the integration of perinatal deaths (MPDSR).

FTYM

In 2017, 18 countries (46 per cent) prioritized FTYM in their national health plans; 19 have developed new outreach strategies for FTYMs.

EmONC

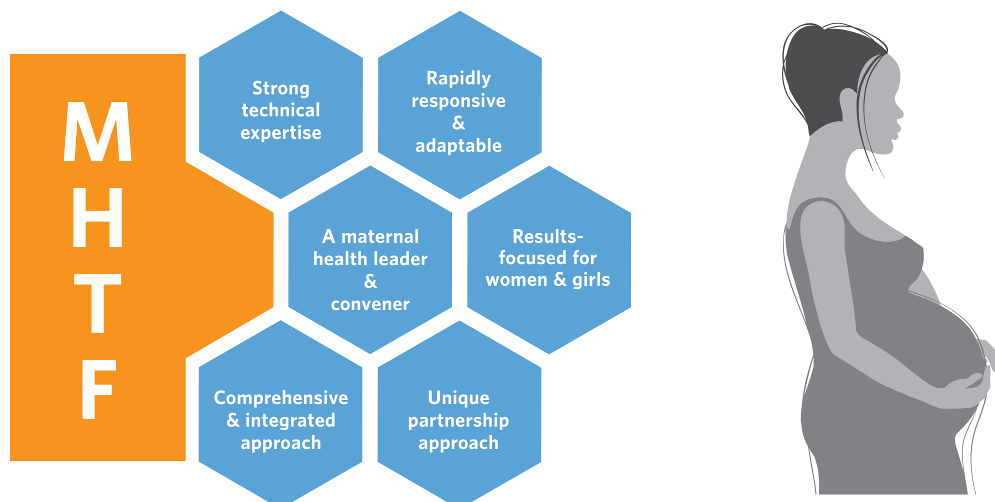
- Availability of EmONC was measured in 49 per cent of MHTF-supported countries, and 36 per cent have a mapping of EmONC facilities of the country.
- Fifteen countries performed an EmONC needs assessment in 2016-17 (complete or rapid) to monitor the availability and quality of EmONC services. Since 2008, 50 countries have completed such assessment.
- Twenty-two countries (56 per cent) have integrated SRH protocols in their EmONC activities.
- By 2017, 25 MHTF-supported countries linked each midwifery school to at least one EmONC facility, and 7 had set up training programmes for tutors.

Fistula

Campaign to End Fistula

- Over 57,000 surgical repairs were supported (in both MHTF supported countries and through technical and catalytic support in other countries) during Phase II.
- Partnership with Johns Hopkins University, generated/published new data on the incidence of stillbirth linked to obstetric fistula.
- By 2017, 78 per cent of the 37 MHTF-supported countries for fistula had routine and continuously available treatment services in strategically selected hospitals with 22 countries indicating the MHTF as a deciding factor for this result.
- By 2017, 81 per cent of MHTF-supported countries had established a government-led national task force for obstetric fistula, and 59 per cent had developed national strategies to eliminate fistula.
- Over 26,100 new cases of obstetric fistula were identified and 8,200 were repaired with MHTF support in 2017.
- UNFPA and the Campaign to End Fistula were honored globally for leadership in gender equality, women's empowerment and alleviation of poverty by being selected to receive the 2017 UNFCU Foundation's Women's Empowerment Award.

FIGURE 26 The MHTF unique approach



Phase III will also strengthen integration and enhance complementarity between MHTF areas of work and other SRH components to have an even greater impact. A detailed business plan will guide implementation during 2018-2022, in line with the UNFPA Strategic Plan 2018-2021. Donors have been invited to support it.

Phase III will complement both core and non-core resources. It will entail working in tandem with UNFPA Supplies and in alignment with the new Midwifery Strategic Plan covering 2018 to 2030.

Several strategic orientations are grounded in lessons learned during the first two phases of the MHTF.

A continued focus on women, including young and vulnerable groups, as first targets. A woman-centred approach is geared towards detecting and addressing violations of their rights and integrity in all aspects of their reproductive lives. Without losing sight of the central goal of reducing maternal mortality, interventions will be extended to respond to women's other reproductive and maternal needs, including those related to morbidities other than obstetric fistula, such as urinary incontinence, uterine prolapse, chronic pelvic infections, pelvic inflammatory diseases, severe anaemia, psychological problems and gender-based violence. Other needs include early detection of cervical cancer, and access to safe abortion where legal. The centre of all activities will remain the maternity units/sections (functioning EmONC facility), provided that facilities are used not only as delivery rooms or operating theatres, but as places where all women can talk about their problems, and receive compassionate and competent attention. Community-based initiatives will be continued and strengthened. Opportunities to involve men and boys in improved maternal and newborn care will be further explored.

In midwifery, EmONC and obstetric fistula prevention, **integrate the particular needs of those left behind**, namely, adolescents, the poorest women, women with disabilities and indigenous women. Interventions need to always take the health and well-being of newborns into account as an indivisible part of maternal health. Several countries have started to integrate mother and newborn programmes. Perinatal deaths need to be included in MDSR to secure the full spectrum of data needed to improve quality of care, and avoid maternal and newborn deaths.

Promote innovation, and make use of new technologies, for example, by launching the Global Electronic Obstetric Fistula Register, and using GIS to locate EmONC facilities, calculate transport times for referrals of complicated cases, and identify populations covered by services.

Strengthen criteria for inclusion of countries. Over time, country situations change. Needs may increase in view of humanitarian crises or conflicts, and performance improve or decline due to bureaucratic changes. To rationalize the selection of countries, optimize overall MHTF results and make the best use of scarce resources, revised criteria were adopted in 2017. Countries will be selected at the beginning of each year, as has already started in 2018, according to these criteria, but also based on pledges and effective contributions from donors.

Promote evidence-based and data-based strategies, and use international advocacy, evidence and experience to further strengthen the basis for programming. The 2020 edition of the *State of the World's Midwifery* report and generation of new data to estimate fistula incidence globally and in high-burden countries will be some important sources of information.

Enhance accountability to improve quality of care and equity in all work areas, including through improvements in integrated MDSR programmes.

Mobilize political commitment, government ownership and increased investment in fistula-affected countries, supporting them to develop, implement, and monitor costed, time-bound national strategies for ending fistula within a generation (and shifting strategies away from campaign approaches).

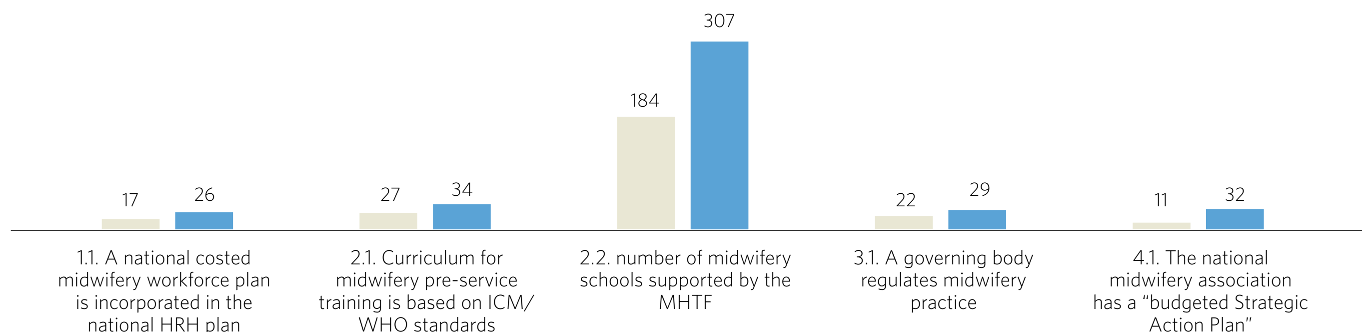
It is time for the MHTF to capitalize upon its global leadership role, build upon past experiences, galvanize the capacities of partners involved, and re-energize key players to make ending preventable maternal mortality and fistula within a generation tangible realities.

ANNEXES

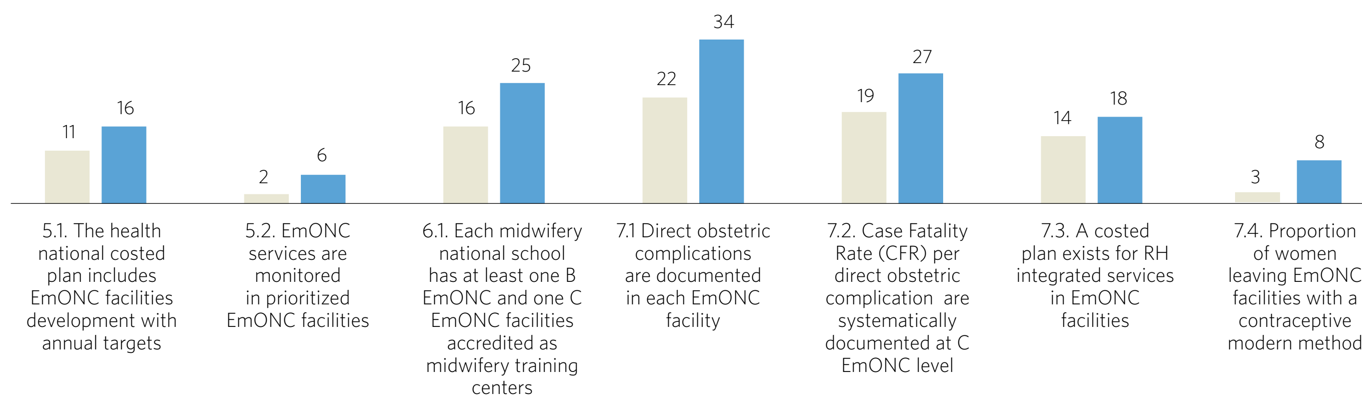
Annex 1: Strategic interventions per outputs and outcomes
Annex 2: Results indicators framework (2014-2017)
Annex 3: Maternal deaths averted, methodology
Annex 4A: Resources and management
Annex 4B: Changes in MHTF country budget allocations
Annex 5: Partners in the campaign to end fistula

ANNEX 1: STRATEGIC INTERVENTIONS INDICATORS PER OUTCOMES

Outcome A: Midwifery
Strategic Intervention Indicators: progress from 2013-2017

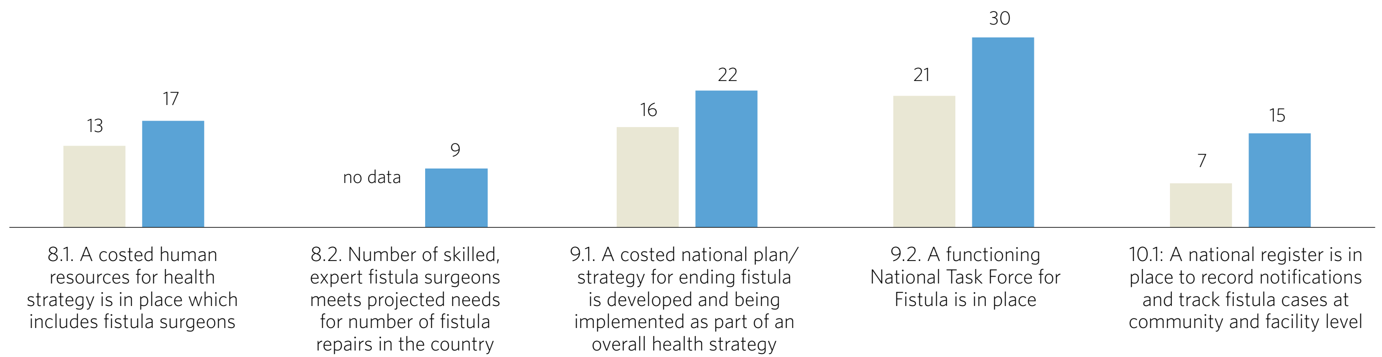


Outcome B: EmONC
Strategic Intervention Indicators: progress from 2013-2017

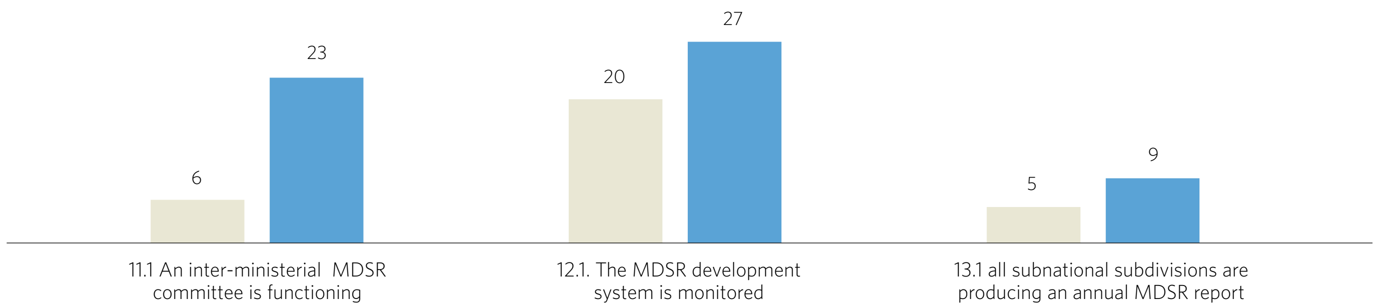


2013 2017

Outcome C: Fistula
Strategic Intervention Indicators: progress from 2013-2017



Outcome D: MDSR
Strategic Intervention Indicators: progress from 2013-2017



2013 2017

ANNEX 2: RESULTS INDICATORS FRAMEWORK FOR 2014-2017

Outcome A : Strengthened national capacity to implement comprehensive midwifery programs								
Outputs			By 2017, 60% of the MHTF supported countries will have costed national HRH plans with midwifery incorporated		By 2017, 80% of MHTF supported countries have revised their national midwifery curriculum following ICM/WHO essential competencies			
Indicators	Proportion of births attended by skilled health personnel for the poorest quintile of the population		A national costed midwifery workforce plan is incorporated in the national HRH plan		Curriculum for midwifery pre-service training is based on ICM/WHO standards		Number of midwifery school supported by the MHT	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
Afganistan			N	Y	Y	Y	0	2
Bangladesh	31,7%	50%	N	Y	Y	Y	16	38
Benin	60%	100%	Y	Y	Y	Y	1	2
Burkina Faso	50,5%	85%	Y	Y	Y	Y	8	8
Burundi	51%	60%	N	N	Y	Y	1	1
Cameroon	19,1%			N	Y	N	0	10
Central African Republic	33,1%	40%	Y	N	Y	Y	0	0
Chad			Y	Y	Y	Y	1	7
Congo			N	N	Y	N	2	1
Côte d'Ivoire	35%		Y	Y	Y	Y	5	5
Democratic Republic of the Congo			N	Y	Y	Y	6	12
Ethiopia	2%	13%	N	Y	Y	Y	31	33
Ghana	38,6%		N	Y	Y	Y	20	36
Guinea Conakri	45%		Y	Y	Y	Y	0	0
Guinea Bissau			Y	N	Y	Y	0	1
Haiti	9,6%	20%	N	N	Y	Y	1	1
Kenya	44%	65%	N	N	Y	Y	0	23
Lao People's Democratic Republic			Y	Y	N	Y	9	9
Liberia	61%	80%	N	Y	Y	Y	4	5/6
Madagascar	27%		N	Y	N	Y	6	6
Malawi	71%		Y	Y	Y	Y	1	14
Mali			Y	Y	Y	Y	5	5
Mauritania			Y	N	N	N	5	5
Mozambique			Y	Y	Y	Y	0	
Nepal			N	N	N	Y	0	2
Niger			Y	Y	N	Y	2	0
Nigeria	6%		N	Y	N	Y	0	25
Pakistan			Y	N	N	Y	1	49
Rwanda			N	N	N	Y	0	7
Senegal			N	Y	Y	Y	0	0
Sierra Leone			N	Y	N	N	0	0
Somalia			Y	Y	Y	Y	6	15
South Sudan			N	Y	Y	Y	1	5
Sudan			N	Y	N	Y	18	3
Timor-Leste			N	N	Y	Y	0	1
Togo	27%		N	Y	Y	Y	1	0
Uganda		70%	Y	Y	N	Y	18	20
Yemen	17%		N	N	Y	N	0	
Zambia			Y	Y	N	Y	15	15

	By 2017, 50 % of MHTF supported countries have a government body regulating midwifery practice		By 2017, 80% of MHTF supported countries have a midwifery association involved in maternal health trainings and policies	
	A governing body regulates midwifery practice		The national midwifery association has a "budgeted Strategic Action Plan"	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**
	N	Y	N	Y
	N	Y	N	Y
	Y	Y	N	Y
	Y	Y	Y	Y
	N	N	N	Y
	N	N	Y	N
	Y	Y	N	N
	N	N	N	Y
	Y	Y	N	Y
	Y	Y	Y	Y
	N	N	Y	Y
	N	Y	Y	Y
	Y	Y	Y	Y
	Y	Y	Y	Y
		N	N	Y
	N	N	N	Y
	Y	Y	N	Y
	Y	Y	N	Y
	Y	Y	Y	Y
	Y	Y	N	Y
	Y	Y	Y	N
	Y	Y	Y	Y
	Y	Y	N	Y
	N	Y	N	N
	Y	Y	Y	Y
	N	Y	N	Y
	Y	Y	N	Y
	Y	Y	N	Y
	Y	Y	N	Y
	N	Y	N	Y
	Y	Y	N	N
	Y	Y	N	Y
	N	N	N	Y
	N	Y	N	Y
	N	N	N	N
	N	N	N	Y
	Y	Y	N	Y
	N	N	N	N
	Y	Y	N	Y

ANNEX 2: RESULTS INDICATORS FRAMEWORK FOR 2014-2017

Outcome B : Strengthened national capacity for quality integrated maternal health services, including emergency obstetric and new born care (EmONC)

Outputs			By 2017, 80 % of countries supported by MHTF are able to monitor the availability of EmONC services in the prioritized facilities designated by the MOH				By 2017, 20 % of countries supported by MHTF will have at least one accredited B-EmONC and one accredited C-EmONC facilities linked to each midwifery school	
Indicators	Proportion of women with major direct obstetric complications treated in EmONC facilities		The health national costed plan includes EmONC facilities development with annual targets		EmONC services are monitored in prioritized EmONC facilities		Each midwifery national school has at least one B EmONC and one C EmONC facilities accredited as midwifery training centers	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
Afganistan			N	N	N	N	N	Y
Bangladesh			N	Y	N	N	N	Y
Benin	23%	75%	Y	Y	N	N	Y	Y
Burkina Faso	18%	80%	Y	Y	N	Y	Y	Y
Burundi	18%	20%	N	N	N	N	Y	N
Cameroon			N	N	N	N	N	N
Central African Republic	29%	40%	N	N	N	N	Y	N
Chad			N	N	N	N	N	N
Congo			Y	N	N	N	N	Y
Côte d'Ivoire	39%		N	Y	N	N	N	N
Democratic Republic of the Congo			Y	Y	N	N	N	Y
Ethiopia				Y	N	N	N	N
Ghana			Y	Y	N	N	Y	Y
Guinea Conakri			Y	Y	N	N	N	Y
Guinea Bissau			Y	N	N	N	N	Y
Haiti	20%	10%	N	N	Y	Y	Y	Y
Kenya	3,70%		Y	Y	N	N	Y	Y
Lao People's Democratic Republic			N	Y	N	N	N	Y
Liberia			N	N	N	N	Y	Y
Madagascar			N	N	N	Y	Y	Y
Malawi			Y	N	N	N		N
Mali			N	N	N	N	Y	N
Mauritania			N	N	N	N	N	N
Mozambique			N	Y	N	N	N	Y
Nepal			N	N	N	N		N
Niger			Y	Y	N	Y	N	Y
Nigeria			N	N	N	N	Y	Y
Pakistan			N	N	N	N	N	Y
Rwanda			N	N	N	N		Y
Senegal			N	Y	N	N	N	Y
Sierra Leone			N	N	N	N	Y	Y
Somalia			N	N	N	N	Y	Y
South Sudan			N	N	N	N	N	N
Sudan			Y	N	N	N	N	Y
Timor-Leste			N	Y	N	Y	N	N
Togo		80%	N	N	Y	Y	N	N
Uganda			N	Y	N	N	Y	Y
Yemen	40%		N	N	N	N	Y	N
Zambia			N	Y	N	N	Y	Y

	By 2017, 60 % countries supported by MHTF will have developed quality of care improvement processes for functioning EmONC facilities and have initiated integration processes for their reproductive health components							
	Direct obstetric complications are documented in each EmONC facility		Case Fatality Rate (CFR) per direct obstetric complication are systematically documented at C EmONC level		A costed plan exists for RH integrated services in EmONC facilities		Proportion of women leaving EmONC facilities with a contraceptive modern method	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
	Y	Y	N	Y		Y		
	Y	Y		Y	N	N	55%	65%
	Y	Y	N	Y	N	Y		
	Y	Y	Y	Y	Y	Y		
	Y	Y		Y	N	N		
	N	N	N	N		N		
	N	Y	N	Y	N	N		
	N	Y	N	Y	N	N		
	N	Y	N	Y	Y	N		80%
	N	N	N		Y	Y		
	Y	Y	Y	Y	N	N		
		Y	Y	Y	Y	N		
	Y	Y		Y	Y	Y	97%	
		Y	Y	Y	Y	Y	68%	
		Y	Y	N	Y	N		
	Y	Y	N	Y	N	Y		25%
	Y	Y	Y	Y	N	N		
	N	Y	N	Y	N	Y		
	Y	Y	Y	Y	N	Y		
	N	N	N	Y	Y	Y		
	Y	Y	Y	Y	N	N		
	Y	Y	Y	N	Y	N		
	N	Y	N	N	Y	Y		
	Y	Y	Y		Y	N		
	Y	N	Y	Y	N	N		
	Y	Y	Y	Y	Y	Y		25%
	Y	Y	Y	Y	Y	N		
	Y	Y	Y	Y	N	N		
		Y		Y	N	Y		
	Y	Y	Y	Y	Y	Y		
	Y	Y	Y	Y	N	N		
	Y	Y	Y	Y	N	N		5%
	N	Y	N		N	N		
	N	Y	N	N	N	N		
	N	Y	N	N	N	Y		5%
	Y	Y	Y	Y	N	Y		10%
	Y	Y	Y		-	Y		5%
		N	N	N	N	N		
	N	Y	N		N	Y		

ANNEX 2: RESULTS INDICATORS FRAMEWORK FOR 2014-2017

Outcome C : Enhancing national capacity for prevention, treatment and social reintegration for obstetric fistula

Outputs			By 2017, 50% of countries supported by MHTF will have an adequate number of expert, trained fistula surgeons to meet the projected needs for fistula treatment in their country			
Indicators	Proportion of women/girls living with fistula who received surgical treatment		A costed human resources for health strategy is in place which includes fistula surgeons		Number of skilled, expert fistula surgeons meets projected needs for number of fistula repairs in the country	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
Afganistan			N	Y		Y
Bangladesh			N	N		
Benin	125	75%	Y	Y		Y
Burkina Faso	24%	80%	Y	Y		
Burundi	12%	20%	N	N		
Cameroon			N	N		Y
Central African Republic		40%	Y	N		
Chad			N	N	6/450	
Congo			N	N		Y
Côte d'Ivoire	I: 400 P: 5000		Y	Y		
Democratic Republic of the Congo			N	Y		
Ethiopia	I: 3500 P:37500	I:1319 P:24080	Y	Y		
Ghana			N	N		
Guinea Conakri			Y	Y	15	
Guinea Bissau			N	N		Y
Haiti		10%	N	N		
Kenya			N	Y		Y
Lao People's Democratic Republic			N	N		
Liberia			Y	Y		
Madagascar			N	N		
Malawi			Y	N		
Mali			Y	Y		
Mauritania			N	N	2	
Mozambique			N	Y		Y
Nepal			N	N		N
Niger			Y	Y		N
Nigeria			N	N		N
Pakistan			N	N		N
Rwanda			N	N		N
Senegal			Y	Y	110/64	
Sierra Leone			N	Y		Y
Somalia			N	N		
South Sudan			N	Y		N
Sudan			N	N		N
Timor-Leste			N	N		N
Togo	344	80%	N	Y		Y
Uganda	68%	90%	Y	Y		N
Yemen			N	N	4	
Zambia			Y	N		N

	By 2017, 80% of countries supported by MHTF will have in place a costed national strategy/plan for ending fistula				By 2017, 80% of countries supported by MHTF have in place a mechanism for ensuring identification and tracking of all fistula cases in order to ensure long-term follow-up, support for recovery, rehabilitation, as well as (future) prevention					
	A costed national plan/strategy for ending fistula is developed and being implemented as part of an overall health strategy		A functioning National Task Force for Fistula is in place		A national register is in place to record notifications and track fistula cases at community and facility level		Proportion (or number if denominator is unknown) of new and existing estimated girls and women living with fistula cases who are notified (at facility and community levels)		Proportion (or number if denominator is unknown) of girls and women living with fistula cases who are repaired	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**		**2017**
	N	Y	N	Y	N	Y		N		
	N	Y	N	Y	N	N				
	Y	Y	N	N	N	Y	136	200	105	200
	Y	Y	Y	Y	Y	Y	180	338		228
	N	N	Y	Y	N	N	750			400
	Y	Y	Y	Y	N	N				500
	N	N	Y	Y	N	Y		500	175	
	N	N	Y	N	N	N				
	Y	Y	N	Y	Y	Y		60%		
	Y	Y	Y	Y	N	N	799	700	251	400
	N	Y	N	Y	N	N				
	Y	Y	Y	Y	N	Y				
	N	Y	N	Y	N	Y				
	Y	Y	Y	Y	N	Y		100		100
	Y	Y	Y	Y	Y	Y				
		N	N	N		N				
	N	N	Y	Y	N	N		90%		800
		N								
	Y	N	Y	Y	Y	Y	50		1317	
	N	Y	Y	Y	N				245	1500
	N	Y	Y	Y	N	N				
	Y	Y	Y	Y		Y				
	N	N	N	N	N	N		50		50
	Y	Y	Y	Y	N	N		NA		25%
	N	N	Y	Y	N				371	50%
	N	Y	Y	Y	N	Y		600		
	Y	Y	Y	Y	N	N		N: 12K E:148K		500
	N	N	N	N	Y	N			567	
	N	N	N	N	N	N				
	Y	Y	Y	Y	Y	N	100	400		
	Y	Y	N	Y	Y	Y				260
	N	N	N	Y	N	N			447	150
	N	Y	N	Y	N	Y		1500		600
	N	N	N	Y	N	N				
	N	N	N	N	N					
	Y	Y	Y	Y	N	N		100		50
	Y	Y	Y	Y	N	Y	1200	5000	1700	3000
	N	N	N	N	N			100%		90%
	N	N	N	Y	N	N				2072

ANNEX 2: RESULTS INDICATORS FRAMEWORK FOR 2014-2017

Outcome D : Enhanced national capacity for maternal death surveillance and response								
Outputs			By 2017, 50 % of countries supported by MHTF have established an inter sectorial approach towards the implementation of MDSR.		By 2017, 50 % of countries supported by MHTF are able to report on all four MDSR main components (compulsory notification, deaths reviews, analysis from review and monitored response, annual national report)		By 2017, 50 % of countries supported by MHTF have implemented a MDSR system at national scale	
Indicators	Maternal deaths that are notified at a) facility level; b) at community level reach 80 % of expected deaths notified as defined every year for a) and b)		An inter-ministerial MDSR committee is functioning		The MDSR development system is monitored		All subnational subdivisions are producing an annual MDSR report	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
Afganistan			N	Y	N	N	N	N
Bangladesh			N	Y	N	Y	N	N
Benin			N	Y	N	Y	N	Y
Burkina Faso		Y	Y	Y	Y	Y	Y	Y
Burundi			N	N	Y	N	N	N
Cameroon				N		N	N	N
Central African Republic			N	N	Y	Y	N	N
Chad			N	N	Y	N	N	N
Congo			N	N	Y	Y	Y	N
Côte d'Ivoire			N	Y	Y	Y	N	N
Democratic Republic of the Congo			N	Y	Y	Y	N	N
Ethiopia				Y		Y	N	N
Ghana				Y	N	Y	N	N
Guinea Conakri				Y	Y	N	Y	N
Guinea Bissau			N	Y		N	N	N
Haiti			N	N	N	N	N	N
Kenya		Y	N	Y	Y	Y	N	N
Lao People's Democratic Republic			Y	Y	Y	Y	N	Y
Liberia			N	Y	Y	Y	N	Y
Madagascar			N	N	Y	N	N	N
Malawi			Y	Y	Y	Y	Y	N
Mali			N	Y	N	Y	Y	N
Mauritania			N	N	N	Y	N	N
Mozambique			Y	Y	N	Y	N	Y
Nepal			N	N		Y	N	N
Niger			Y	Y	Y	Y	N	Y
Nigeria			N	Y	N	Y	N	N
Pakistan			N	N	N	N	N	N
Rwanda			N	Y	Y	Y	N	N
Senegal			N	Y	Y	Y	N	N
Sierra Leone			N	Y	Y	Y	N	Y
Somalia			N	N	N	Y	N	N
South Sudan			N	N	N	N	N	N
Sudan			Y	Y	Y	Y	N	Y
Timor-Leste			N	Y	N	Y	N	N
Togo		Y	N	N	Y	N	N	Y
Uganda			N	N	Y	Y	N	N
Yemen			N	N	N	N	N	N
Zambia			N	N	N	Y	N	N

Outcome E : Strengthened national capacity to reach and serve first-time young mothers

Outputs					By 2017, 50% of MHTF supported countries have made first-time young mothers one of the priority populations in national plans, with a view to improving their access to quality maternal health services		By 2017, 40% of MHTF supported countries are implementing innovative, scalable approaches to improving maternal health service utilization by first-time young mothers	
Indicators	Age-disaggregated ANC utilization: Percentage of girls and women aged 15-19 and 20-24 who had a live birth that received antenatal care provided by a doctor, nurse, or midwife at least once during pregnancy, and at least four times during pregnancy		Age-disaggregated Skilled Birth Attendance: Percentage of births to girls and women 15-19 and 20-24 attended by skilled health personnel (doctors, nurses or midwives)		First-time young mothers are a priority population in the national RMNCH plan		At least one innovative, scalable approach to improving maternal health service utilization by first-time young mothers is implemented	
	2013 (baseline)	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**	**2013 (baseline)**	**2017**
Afganistan					N	Y	N	Y
Bangladesh					N	N	N	N
Benin	86%	90%	84%		Y	N	Y	Y
Burkina Faso	< 20 y. o. : 96,3%		< 20 y. o. : 68,5%		Y	Y		Y
Burundi			73%		N	N	N	N
Cameroon					N		N	
Central African Republic	< 20 y. o. : 69%				N	Y	Y	Y
Chad					N	Y	N	Y
Congo					N	Y	N	Y
Côte d'Ivoire			58%		N	N	N	Y
Democratic Republic of the Congo					N	Y	N	N
Ethiopia	20%		19%			N		
Ghana					Y	N	Y	Y
Guinea Conakri						N	N	N
Guinea Bissau						N		
Haiti					N	N	N	Y
Kenya	88.5% 93%		46.6% 42.7%		N	Y	N	
Lao People's Democratic Republic					N		N	
Liberia	97%				N	Y	N	Y
Madagascar	< 20 y. o. : 80,9%		< 20 y. o. : 42.4%		Y	N	N	Y
Malawi					Y			
Mali					N	N	N	
Mauritania					N	Y	N	N
Mozambique					N	N	N	
Nepal						Y		
Niger					N	Y	N	
Nigeria	"61% for at least one visit		N		N	Y	N	Y
Pakistan	51% for at least four visits"		38%		N	N	N	N
Rwanda	75,9%		55%		N	N	N	Y
Senegal					Y	Y	N	N
Sierra Leone					Y	Y		Y
Somalia					N	Y	N	
South Sudan					N	Y	N	Y
Sudan								
Timor-Leste					N	N	N	N
Togo					Y		N	Y
Uganda	72%		59%		N	Y	N	Y
Yemen					Y	N	Y	Y
Zambia					N	Y	N	Y

ANNEX 3: ESTIMATION OF MATERNAL DEATHS AVERTED, METHODOLOGY

For each country, maternal mortality ratio estimates for the years 1990, 1995, 2000, 2005, 2013 and 2015 were taken from *Trends in maternal mortality: 1990 to 2015* (estimates by the WHO, UNICEF, UNFPA, the World Bank Group and the United Nations Population Division). Estimates for intervening years and for 2017 were interpolated assuming a linear trend. For each country, estimates of the number of live births in each year from 1990 to 2017 were taken from the United Nations Population Division's World Population Prospects website using the medium variant estimates.

For each country, the number of maternal deaths in each year from 1990 to 2017 was calculated as follows:
- MMRy * By/100,000
- Where MMR = maternal mortality ratio, y = year and B = number of births.

For each country, the number of maternal deaths that would have occurred in each year from 1990 to 2017 had the country's maternal mortality ratio remained at its 2009 level was calculated for each year from 2010 to 2017 as follows:
- MMR 2009 * By/100,000
- Where MMR = maternal mortality ratio, y = year and B = number of births.

For each country, the number of lives saved in each year was calculated by subtracting the actual number of maternal deaths for that year from the counterfactual number of maternal deaths for that year. The numbers for 2010 to 2017 inclusive were summed to give an estimate of the total number of deaths averted since 2010. In order to better estimate the influence of the MHTF in this result, the total of deaths averted in each country was weighted by the proportion of the population that is targeted by MHTF-supported activities in midwifery, EmONC development and MDSR. It was assumed that the elasticity relating to population coverage and obstetric fistula was less than 1.

This calculation finds that the MHTF has contributed to averting 48,105 maternal deaths from 2013 to 2017. The estimated number of averted maternal deaths to which the MHTF has contributed since its inception in 2008 is 119,127.

ANNEX 4A: RESOURCES AND MANAGEMENT – Approved Allocations, Expenditures and Financial Implementation Rates for Maternal Health and Fistula, 2016-2017 (including indirect costs), in dollars

	2016 (ZZT03&ZZT06)			2017 (ZZT03&ZZT06)			
Regional office/country office/ global technical support/ partners	**Approved allocation**	**Expenses (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**	**Change in expenses 2016 vs. 2017**
East and Central Africa Regional Office/ Johannesburg							
East and Central Africa Regional Office/ Johannesburg	171,200	124,704	73%	168,000	149,937	89%	25,233
Western and Central Africa Regional Office/Dakar	-	-		100,000	103,991	104%	103,991
Benin	277,938	234,422	84%	296,810	284,814	96%	50,392
Burkina Faso	326,431	313,244	96%	270,880	273,186	101%	(40,058)
Burundi	398,856	373,150	94%	375,753	407,757	109%	34,607
Cameroon	123,050	103,014	84%	111,821	92,975	83%	(10,039)
Central African Republic	131,622	130,222	99%	100,000	28,517	29%	(101,705)
Chad	788,870	794,258	101%	568,174	351,235	62%	(443,023)
Congo	212,100	202,815	96%	192,006	207,717	108%	4,902
Côte d'Ivoire	399,745	369,340	92%	325,211	336,908	104%	(32,432)
Democratic Republic of the Congo	775,750	812,166	105%	615,348	633,513	103%	(178,653)
Ethiopia	1,125,658	413,681	37%	485,996	716,277	147%	302,595
Ghana	311,868	292,688	94%	282,479	255,190	90%	(37,498)
Guinea	171,400	170,168	99%	168,960	237,481	141%	67,313
Guinea-Bissau	81,793	35,827	44%	100,000	118,039	118%	82,212
Kenya	236,414	236,189	100%	215,041	208,422	97%	(27,766)
Liberia	121,017	124,418	103%	243,777	196,432	81%	72,014
Madagascar	456,890	450,221	99%	382,128	368,126	96%	(82,095)
Malawi	94,500	95,577	101%	171,189	151,038	88%	55,461
Mali	106,259	66,153	62%	100,000	101,167	101%	35,014
Mauritania	144,243	143,656	100%	130,650	130,450	100%	(13,207)
Mozambique	112,950	105,609	94%	160,946	131,134	81%	25,524
Niger	323,399	301,428	93%	292,924	281,825	96%	(19,603)
Nigeria	323,973	394,128	122%	271,292	303,850	112%	(90,278)
Rwanda	249,982	227,826	91%	193,471	206,206	107%	(21,619)
Senegal	199,144	195,392	98%	148,391	167,996	113%	(27,396)
Sierra Leone	265,902	463,155	174%	437,564	438,977	100%	(24,178)
South Sudan	107,000	109,249	102%	100,000	93,604	94%	(15,645)
Togo	136,900	134,835	98%	119,100	118,365	99%	(16,469)
Uganda	241,758	356,746	148%	328,550	316,716	96%	(40,031)
Zambia	376,684	334,284	89%	237,349	203,915	86%	(130,368)
Sub-Saharan Africa total	**8,793,296**	**8,108,565**	**92%**	**7,693,809**	**7,615,759**	**99%**	**(492,805)**
Arab States							
Regional Office/Cairo	-		0%		106,573		106,573
Somalia	274,925	258,875	94%	258,049	258,049	100%	(826)
Sudan	338,214	353,339	104%	335,396	414,900	124%	61,561
Yemen	104,076	96,966	93%	100,000	97,531	98%	565
Arab States total	**717,215**	**709,180**	**99%**	**693,445**	**877,053**	**126%**	**167,873**

ANNEX 4A: RESOURCES AND MANAGEMENT – Approved Allocations, Expenditures and Financial Implementation Rates for Maternal Health and Fistula, 2016-2017 (including indirect costs), in dollars

	2016 (ZZT03&ZZT06)			2017 (ZZT03&ZZT06)			
Regional office/country office/ global technical support/ partners	**Approved allocation**	**Expenses (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**	**Change in expenses 2016 vs. 2017**
Asia and the Pacific							
Regional Office/Bangkok	-	-	0%	-	106,528	0%	106,528
Afghanistan	404,620	404,746	99%	343,338	339,001	99%	(65,745)
Bangladesh	138,416	137,905	100%	125,372	125,368	100%	(12,537)
Lao People's Democratic Republic	339,361	337,561	99%	321,864	319,471	99%	(18,091)
Nepal	150,068	135,745	87%	135,926	118,138	87%	(17,607)
Pakistan	286,874	269,507	98%	241,626	236,332	98%	(33,175)
Timor-Leste	115,494	113,505	97%	119,100	116,024	97%	2,520
Asia and the Pacific total	**1,434,833**	**1,398,969**	**97%**	**1,287,226**	**1,360,862**	**106%**	**(38,107)**
Latin America and the Caribbean							
Regional Office/Panama City	87,740	86,951	109%	80,000	87,396	109%	445
Haiti	499,977	493,705	88%	370,540	326,480	88%	(167,225)
Latin America and the Caribbean total	**587,717**	**580,656**	**92%**	**450,540**	**413,875**	**92%**	**(166,780)**
Global technical support							
Global technical support, including implementing partners	2,984,475	2,708,484	77%	3,236,468	2,507,729	77%	(200,755)
Information and External Relations Division	-	-	0%	-	-	0%	-
Media and Communications Branch	272,049	272,333	100%	268,724	269,008	100%	(3,325)
Non-Core Funds Management Unit		186,813	97%	220,420	213,316	97%	26,503
Global technical support total	3,256,524	3,170,792	80%	3,725,612	2,990,053	80%	(180,738)
GRAND TOTAL	**14,789,585**	**13,968,161**	**94%**	**13,850,631**	**13,257,603**	**96%**	**(710,558)**

ANNEX 4B: CHANGES IN MHTF COUNTRY BUDGET ALLOCATIONS FROM 2016 TO 2017

Country M = Maternal health F = Obstetric fistula	2016 MHTF allocated budget based on total budget for countries of $11,375,368	Country budget allocation for 2017 based on revised formula and total budget for countries of $9,777,019 (overall budget reduction of -14%)	Percentage difference between 2017 and 2016 allocation
Afghanistan (M,F)	404,659	343,338	-15%
Bangladesh (M,F)	138,416	125,372	-9%
Benin (M,F)	341,876	296,810	-13%
Burkina Faso (M,F)	326,430	270,880	-17%
Burundi (M,F)	398,855	375,753	-6%
Cameroon (M,F)	123,455	111,821	-9%
Central African Republic (F)	177,644	100,000	-44%
Chad (M,F)	766,684	568,174	-26%
Congo (F)	180,000	192,006	7%
Côte d'Ivoire (M,F)	399,744	325,211	-19%
Democratic Republic of the Congo (M,F)	830,341	615,348	-26%
Ethiopia (M,F)	597,159	485,996	-19%
Ghana	311,868	282,479	-9%
Guinea (F)	170,547	168,960	-1%
Guinea-Bissau (F)	104,462	100,000	-4%
Haiti (M,F)	500,000	370,540	-26%
Kenya (F)	237,414	215,041	-9%
Lao People's Democratic Republic (M,F)	339,360	321,864	-5%
Liberia (M,F)	265,647	243,777	-8%
Madagascar (M,F)	457,003	382,128	-16%
Malawi (M,F)	189,000	171,189	-9%
Mali (M,F)	106,260	100,000	-6%
Mauritania (F)	144,243	130,650	-9%
Mozambique (M,F)	161,700	160,946	0%
Nepal (M,F)	150,068	135,926	-9%
Niger (M,F)	323,400	292,924	-9%
Nigeria (M,F)	323,973	271,292	-16%
Pakistan (M,F)	286,956	241,626	-16%
Rwanda (M,F)	213,600	193,471	-9%
Senegal (F)	163,830	148,391	-9%
Sierra Leone (M,F)	531,806	437,564	-18%
Somalia (F)	284,896	258,049	-9%
South Sudan (M,F)	100,000	100,000	0%
Sudan (M,F)	338,308	335,396	-1%
Timor-Leste (M,F)	115,500	119,100	3%
Togo	115,500	119,100	3%
Uganda (M,F)	404,250	328,550	-19%
Yemen	104,462	100,000	-4%
Zambia (M,F)	246,052	237,349	-4%
TOTAL	**11,375,368**	**9,777,019**	**-14%**

Increased allocation   Strongly (>20%) decreased allocation

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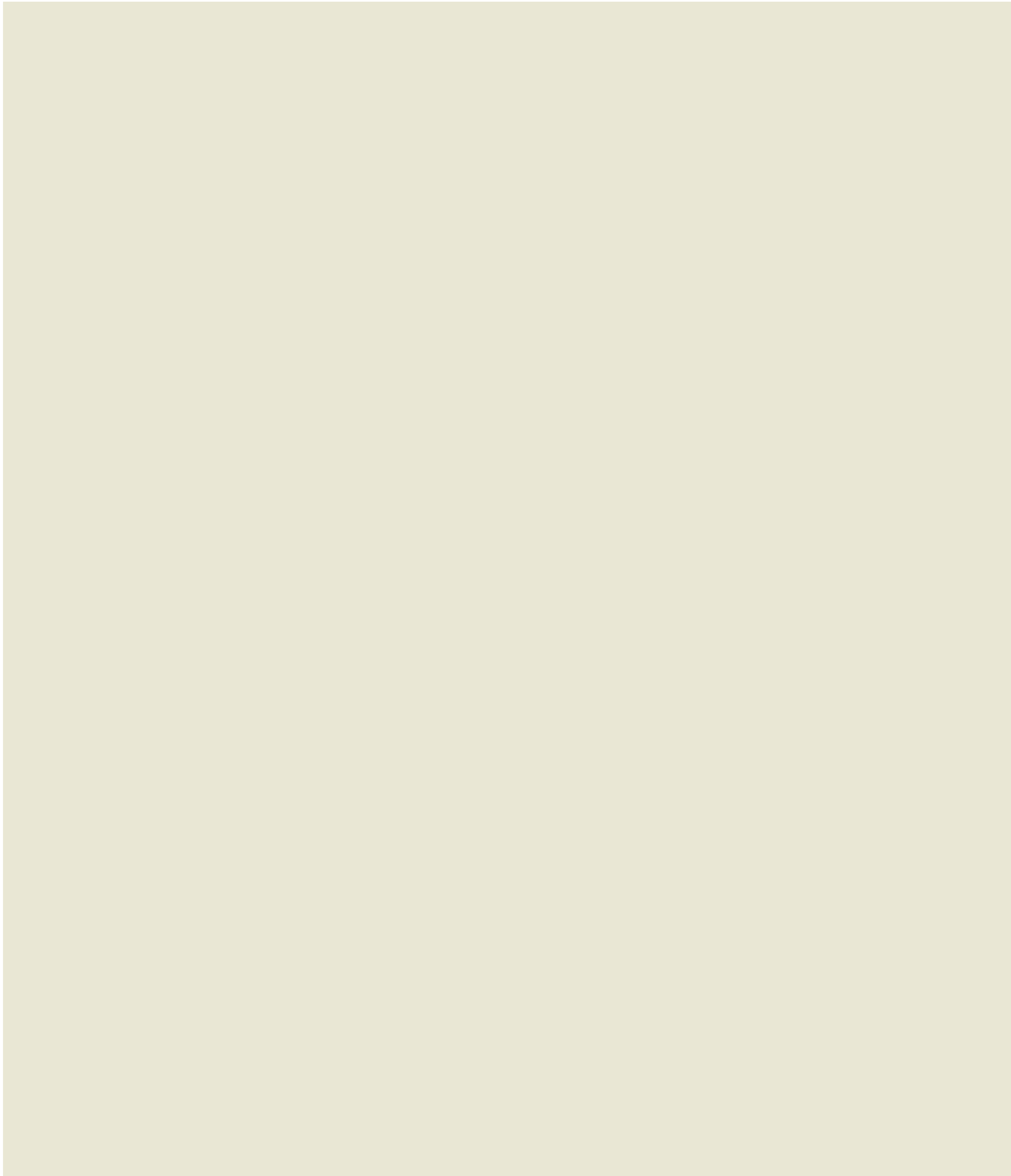
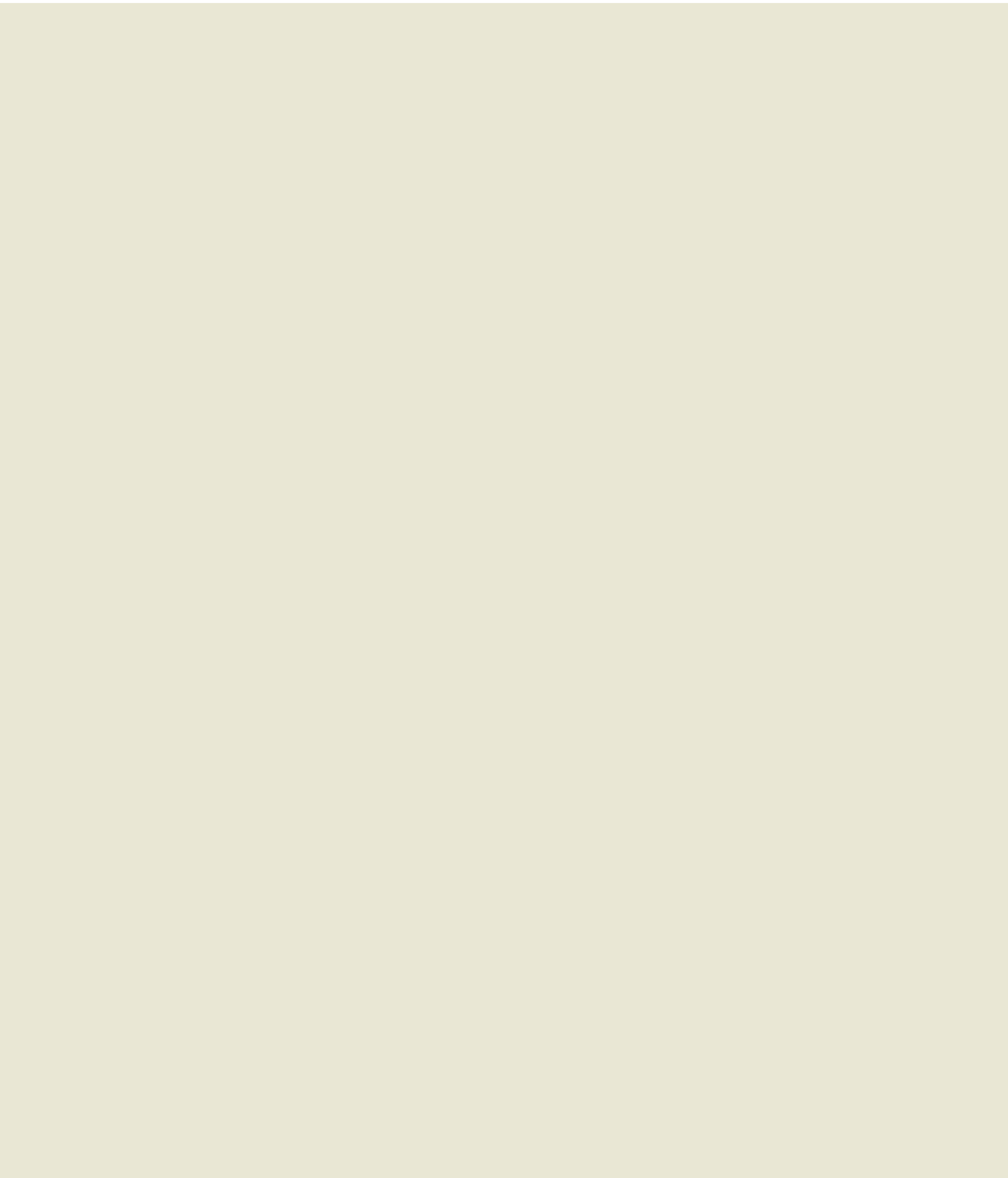
ANNEX 5: PARTNERS IN THE CAMPAIGN TO END OBSTETRIC FISTULA

Aden Hospital (Yemen), African Medical and Research Foundation, American College of Nurse-Midwives, Babbar Ruga Fistula Hospital (Nigeria), Bangladesh Medical Association, Bill & Melinda Gates Institute for Population and Reproductive Health, Bugando Medical Center (United Republic of Tanzania), CARE, Centers for Disease Control and Prevention, Centre Mère-Enfant (Chad), Centre National de Référence en Fistule Obstétricale (Niger), Centre National de Santé de la Reproduction & du Traitement des Fistules (Chad), Columbia University's Averting Maternal Death and Disability Program, Comprehensive Community Based Rehabilitation in Tanzania, CURE International Hospital of Kabul (Afghanistan), Direct Relief International, Dr. Abbo's National Fistula and Urogynaecology Center (Sudan), East Central and Southern Africa Association of Obstetrical and Gynecological Societies, EngenderHealth, Equilibres & Populations, Eritrea Women's Project, Family Care International, Fistula e.V., Fistula Foundation, Fistula Foundation Nigeria, Focus Fistula (Mozambique), Freedom from Fistula Foundation, Friends of UNFPA, Geneva Foundation for Medical Education and Research, Girls' Globe, Governess Films, Gynocare Fistula Center (Kenya), Hamlin Fistula (Ethiopia), Healing Hands of Joy (Ethiopia), Health and Development International, Health Poverty Action (Sierra Leone), Hope Again Fistula Support Organization (Uganda), Hope Foundation for Women and Children of Bangladesh, Human Rights Watch, Institut de Formation et de Recherche en Urologie et Santé de la Famille (Senegal), ICM, International Continence Society, FIGO, International Forum of Research Donors, International Nepal Fellowship, International Planned Parenthood Federation, ISOFS, International Urogynecological Association, International Women's Health Coalition, Islamic Development Bank, Johnson & Johnson, Johns Hopkins Bloomberg School of Public Health, Kupona Foundation, Lake Tanganyika Floating Health Clinic, Ligue d'Initiative et de Recherche Active Pour la Santé et l'Education de la Femme (Cameroon), London School of Hygiene and Tropical Medicine, Maputo Central Hospital (Mozambique), Médecins du Monde, Médecins Sans Frontières, Mercy Ships, Moi University (Kenya), Monze Hospital (Zambia), Mulago Hospital/ Medical School (Uganda), National Obstetric Fistula Centre, Abakiliki (Nigeria), Obstetrical and Gynecological Society of Bangladesh, One by One, Operation Fistula, Pakistan National Forum on Women's Health, Pan African Urological Surgeons' Association, Population Media Center, Psychology Beyond Borders, Regional Prevention of Maternal Mortality Network (Ghana), Royal College of Obstetricians and Gynaecologists, Sana'a Hospital (Yemen), Selian Fistula Project (United Republic of Tanzania), Société Africaine des Gynécologues-Obstétriciens, Société Internationale d'Urologiel, Solidarité Femmes Africaines, The Association for the Rehabilitation and Re-orientation of Women for Development (Uganda), Uganda Childbirth Injury Fund, UNFPA, USAID, University of Aberdeen, University Teaching Hospital of Yaoundé (Cameroon), Virgin Unite, White Ribbon Alliance, Women and Health Alliance International, Women's Health Organization International, Women's Hope International, Women's Missionary Society of the African Methodist Episcopal Church, WHO, World Vision, Worldwide Fistula Fund, Zonta International





The Maternal Health Thematic Fund

Towards Equality in Access, Quality of Care and Accountability
Phase II (2014-2017) - Progress Report

The MHTF's second phase (2014-2017) has been underpinned by 3 core principles of equality in access, quality of care and accountability to plan, program and realize results in 39 countries with some of the highest maternal morbidity and mortality. It is working to ensure that women and girls have access to quality maternal and newborn health services, which are key sexual and reproductive health and rights services, utilizing five high impact and evidence-based focus areas:

Midwifery:
- Training and deployment of midwives
- Ensuring midwifery regulation
- Strengthening midwifery associations

Emergency Obstetric and Newborn Care:
- Sufficient basic and comprehensive EmONC facilities that offer all essential services
- Establishment of efficient referral among facilities to create a health systems network
- Continued monitoring to ensure and improve quality of care

Maternal Death Surveillance and Response:
- Establishment of national scale systems
- Measurement ensuring quality data
- Efficient responses to identify causes of maternal mortality

The Campaign to End Fistula:
- Training of expert obstetric fistula surgeons
- Integration of obstetric fistula surgery into health systems for continuous care
- Identification of fistula cases for treatment, rehabilitation and social reintegration

First-Time Young Mothers:
- Outreach to young pregnant girls to ensure skilled assistance during pregnancy and childbirth
- Post-partum follow-up and longer term support groups
- Further identification of innovative and scalable approaches to reach FTYM

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