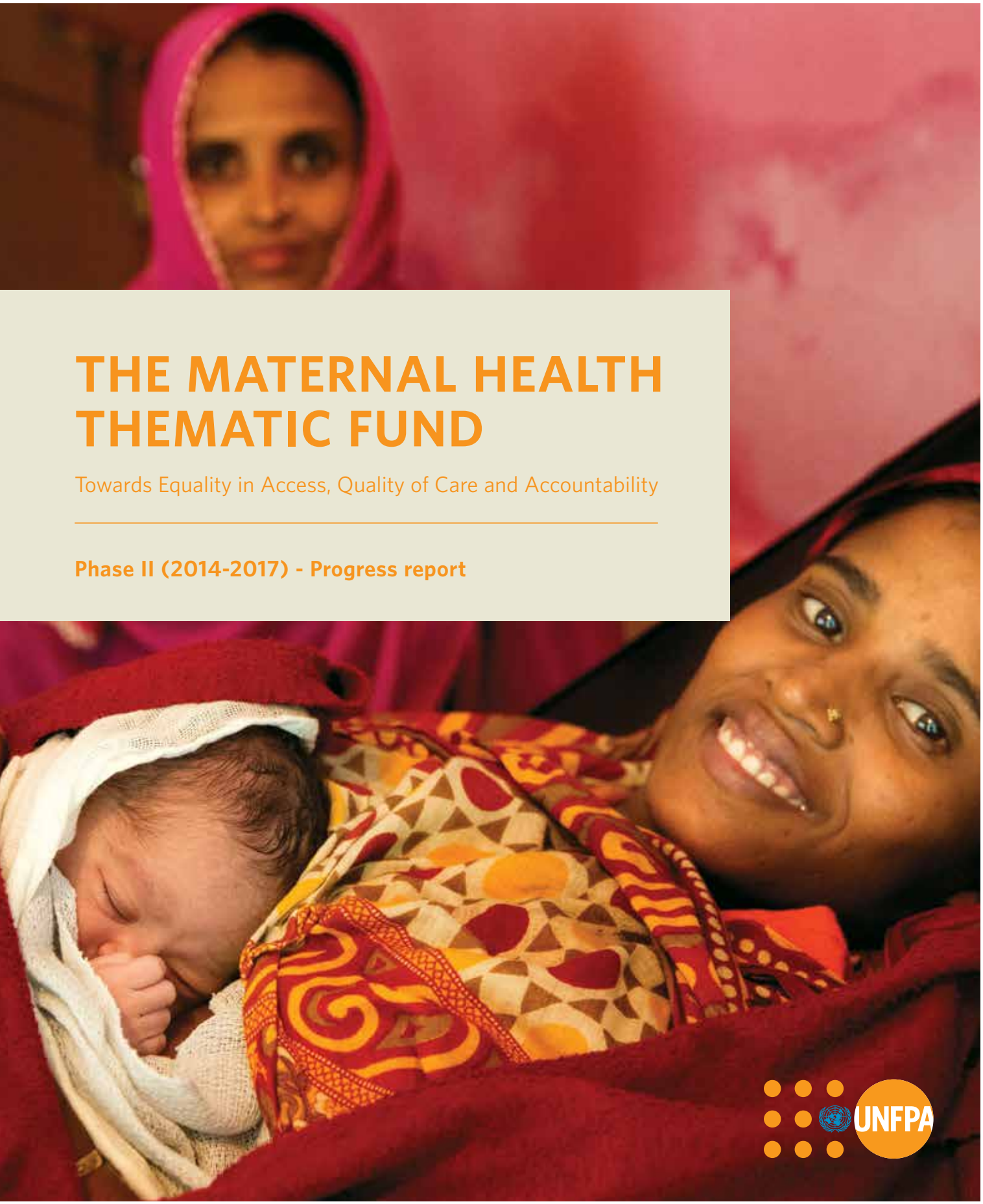

THE MATERNAL HEALTH THEMATIC FUND

Towards Equality in Access, Quality of Care and Accountability

Phase II (2014-2017) - Progress report

UNFPA

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

Cover photo:

Winner of the 2017 photo contest for the MHTF Report cover.
Submitted by Randi Anderson, Bangladesh Country Office.

Rokshana Begum, 27 years old, gave birth to her third child at the Matabari union health facility on the island of Maheshkhali (Bangladesh) with her mother-in-law as her birth companion. Nira Khatun was her midwife, educated through a three-year diploma course that UNFPA supported. Nira was then given additional orientation and training on evidence-based routines and B-EmONC, and received regular support through a Facebook page dedicated to young midwives, She was deployed along with 20 other recent graduates through a cyclone response humanitarian project funded by UNFPA to reach communities most affected by Cyclone Roanu. It struck in May 2016 and destroyed Rokshana's house.

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ACKNOWLEDGEMENTS

UNFPA's Maternal Health Thematic Fund progress report on Phase II reflects many contributions from colleagues, countries, partners and stakeholders at all levels – country, regional and global. All are focused on and committed to ensuring continuous improvement in the health and well-being of women and girls around the globe.

We acknowledge, with gratitude, the commitment and support of countries in prioritizing maternal and newborn health (MNH) as part of a broader focus on sexual and reproductive health and rights (SRHR). We would also like to thank the governments of Austria, Germany, Iceland, Luxembourg, Poland and Sweden, the main donor of the Trust Fund, as well as key supporters of maternal health, including the governments of France, Norway and the United Kingdom. A special note of thanks goes to other individual donors, UN trust funds and foundations.

As always, our sincere thanks to our United Nations colleagues around the globe, including from the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), UN Women, the World Bank Group and the World Health Organization (WHO), for their collaboration and coordination on sexual, reproductive, maternal, newborn, child and adolescent health. Together, we continue to demonstrate our leadership, commitment and strong partnership through platforms such as the H6.

The results in this report encompass global, regional and, substantially, country level efforts, reflecting UNFPA's commitment to ensuring that every pregnancy is wanted and every childbirth is safe, and to the broader achievement of universal access to SRHR. We recognize the critical contributions from our programme partners, which 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), 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.

UNFPA appreciates the collective vision and commitment of all national governments, and international and other non-governmental organizations (NGOs). Our nurturing partnership with the private sector and civil society also needs special mention. We thank Friends of UNFPA, GE Health, Johnson & Johnson, the Laerdal Foundation and the UN Federal Credit Union (UNFCU).

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

FOREWORD

By Dr. Natalia Kanem
Acting Executive Director, UNFPA

The Maternal Health Thematic Fund (MHTF) is the UNFPA flagship programme for improving maternal and newborn health and well-being. Created in 2008 to boost global funding for and attention to maternal health, the MHTF has contributed to averting an estimated 92,000 maternal deaths through strategic interventions in 39 countries with some of the highest maternal mortality and morbidity in the world.

Pregnant women and their newborns are at highest risk of death and morbidity during labour, childbirth, and the first week after birth. The MHTF supports countries to strengthen their midwifery workforce and ensure equitable access to quality emergency obstetric and newborn care (EmONC) services. We also support countries to increase access to surgical treatment for obstetric fistula, facilitate social reintegration of fistula survivors, and strengthen accountability for quality of care at all levels of their health system by registering and addressing the causes of maternal deaths.

Despite considerable progress, more needs to be done to reach our ambitious global goals for reducing maternal mortality, ending preventable deaths of newborns, and ensuring universal access to sexual and reproductive health care by 2030.

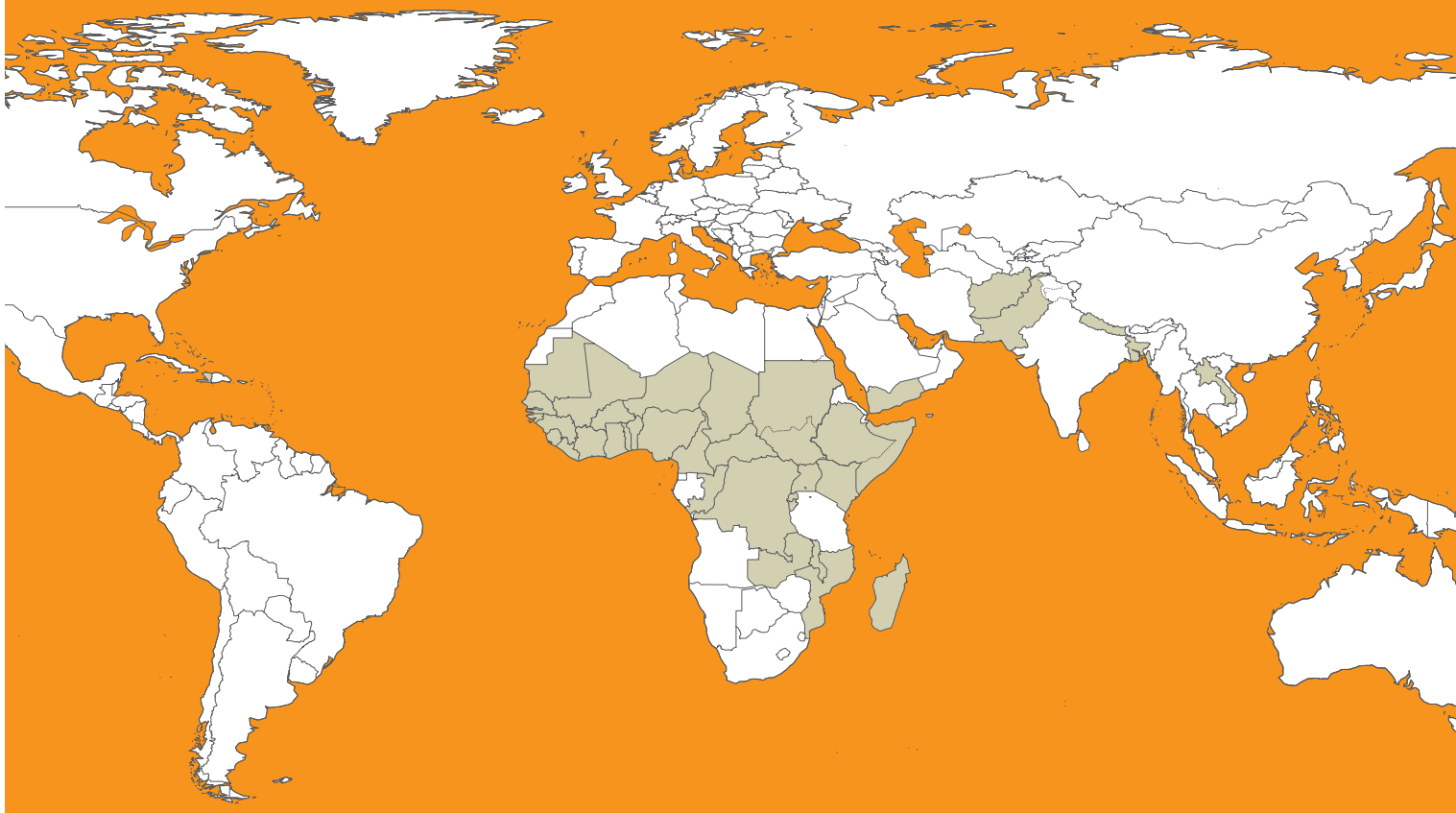
We at UNFPA remain committed to accelerating global efforts to improve the health and quality of life of all women and girls, especially those most marginalized, disadvantaged and underserved.

In collaboration with key partners, including civil society organizations, multilateral actors, academic institutions, and others, the MHTF will consolidate its investments to improve quality of care and ensure that women and adolescent girls, especially those furthest behind, can fully exercise their right to access integrated sexual and reproductive health services, free of coercion, discrimination and violence.

Dr. Babatunde Osotimehin, the late Executive Director of UNFPA, worked tirelessly to end preventable maternal deaths and ensure that every woman and girl has access to the sexual and reproductive health care she needs. He inspired all of us to push harder to reach those furthest behind, particularly the most vulnerable adolescent girls. He will be missed tremendously by all those who knew him and by the women, girls and young people he committed his life to serving. This report is dedicated to him.

Figure 1: 39 MHTF-supported Countries

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.

ACRONYMS

B-EmONC	Basic Emergency Obstetric and Newborn Care
C-EmONC	Comprehensive Emergency Obstetric and Newborn Care
EmONC	Emergency Obstetric and Newborn Care
FIGO	International Federation of Gynecology and Obstetrics
GIS	Geographic Information System
FTYM	First-Time Young Mothers
H6 (formerly H4+)	UNAIDS, UNFPA, UNICEF, UN Women, World Bank Group, WHO
HRH	Human Resources for Health
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
ISOFS	International Society of Obstetric Fistula Surgeons
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MHTF	Maternal Health Thematic Fund
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
NGO	Non-Governmental Organization
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goal
SRHR	Sexual and Reproductive Health and Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFCU	UN Federal Credit Union
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

UNFPA's Maternal Health Thematic Fund (MHTF) is a catalytic fund, aligned with country-led processes to address health system bottlenecks; promote innovations; strengthen partnership; and focus on scalable, high-impact interventions to improve and safeguard the health and well-being of women and girls. It supports evidence-based programming in 39 countries with the highest burden of maternal mortality and morbidity, taking an integrated approach that brings together the areas of midwifery, obstetric fistula, emergency obstetric and newborn care (EmONC), maternal death surveillance and response (MDSR) and first-time young mothers (FTYMs). All interventions are strategically selected to have the greatest impact. The Thematic Fund complements UNFPA Supplies; together, they work to enable women and girls to make fundamental decisions about their own bodies, attain the highest possible standard of sexual and reproductive health, and exercise their reproductive rights.

This report highlights the key results achieved over Phase II of the MHTF, from 2014 to 2016, structured around the three cross-cutting principles of accountability, equality of access and quality of care, as outlined in the MHTF Business Plan Phase II (2014-2017).[1] The report foregrounds the MHTF's role in supporting health systems strengthening, and addresses its catalytic nature, its promotion of sustainability and its strong emphasis on advancing innovation. A vision and direction are outlined for the third phase of the MHTF, which will be further elaborated in a forthcoming Business Plan Phase III (2018-2021).

The MHTF during its second phase continued to demonstrate its unique value at the forefront of supporting countries to lead and accelerate the delivery of improved maternal health information and services for women and girls. It has assisted the development of national policies and programmes; strengthened national technical capacities and the collection, analysis and use of data; and backed global, regional and national advocacy for maternal health (and sexual and reproductive health more generally). It has reinforced UNFPA's role and visibility as a global maternal health leader and convener focused on evidence-based, high-impact interventions spanning clinical and health systems strengthening as well as multisectoral approaches, all under the umbrella of fundamental human rights and gender equality principles.

Headline results from 2014 to 2016 include 19,200 estimated maternal deaths averted[2] in the 39 MHTF-supported countries. Around 39,000 fistula surgical repairs were provided through targeted programming to "leave no one behind," in tandem with over 90 partners in the Campaign to End Fistula,[3] which also addresses the reintegration of survivors with their families and communities. In midwifery, the MHTF supported countries to develop and implement comprehensive policies for education and regulation with over 32,000 midwives[4] supported in both pre-service education and in-service training, and over 300 midwifery schools strengthened. The MHTF has helped countries to strengthen strategic planning, development and monitoring for national EmONC facility networks, with the "availability of EmONC" in 21 countries reaching on average 30 per cent

1 The report provides preliminary results of Phase II as one final year of implementation remains.

2 See Annex 2 on maternal deaths averted methodology.

3 See: www.endfistula.org

4 Based on UNFPA country reported data from 2014 to 2016

of the EmONC international standard[5]. Six countries had the capacity to regularly monitor the availability and quality of EmONC services. All 39 countries have initiated an MDSR programme; 70 per cent are implementing it at a national scale. An additional area of focus introduced in Phase II was first-time young mothers, aimed at increasing the number of deliveries with a skilled birth attendant, boosting uptake of post-partum family planning to prevent or space pregnancies, and enhancing agency in decision-making related to SRHR. As a result, 19 countries have prioritized FTYMs in their national reproductive, maternal, newborn, child and adolescent health (RMNCAH) plans.

Partnerships have been critical to the MHTF at all levels in Phase II – country, regional and global. UNFPA successfully drew on MHTF interventions and results to contribute to various initiatives and partnerships, including Every Woman, Every Child; the H6 Partnership; the Global Financing Facility; the Partnership for Maternal, Newborn and Child Health; and the Campaign on Accelerated Reduction of Maternal Mortality in Africa, to highlight a few.

In Phase II, the MHTF has comprised two multidonor funding streams: the Thematic Trust Fund for Maternal Health and the Thematic Fund for Obstetric Fistula. An operating budget of approximately $59.7 million from 2014 to 2016 has had an implementation rate above 90 per cent, with 81 per cent of funding targeting the country and regional levels. This underscores the MHTF's high absorption capacity with tangible results achieved, and a real opportunity to deliver more results with more resources.

In looking forward to UNFPA's new Strategic Plan (2018-2021), a third phase of the MHTF is now being elaborated to support the achievement of universal access to sexual and reproductive health, to realize reproductive rights and to reduce maternal mortality, all towards accelerating progress on the International Conference on Population and Development (ICPD) agenda.[6] This new phase will build on results achieved, capitalize on lessons learned and draw on emerging opportunities to offer support that is ambitious, far-reaching and innovative. Quality, equitable and accountable maternal health services will be at the heart of all activities, towards advancing improved health and well-being for women and girls, leaving no one behind and reaching the furthest behind first. The MHTF's commitment and vision is to emphatically change the maternal health paradigm from one where hundreds of thousands of women and girls in the developing world still die from preventable pregnancy-related causes or suffer a severe pregnancy-related morbidity, to one where women and girls have access to quality sexual and reproductive health services that allow them to survive and thrive, transform their lives and their societies, and drive realization of the 2030 Agenda for Sustainable Development.

5 At least five EmONC facilities (including at least one C-EmONC) for every 500,000 population, "Monitoring emergency obstetric care - a handbook", WHO, 2009.

6 See: www.unfpa.org/icpd

Training in midwifery skills for nurses. Masuba Midwifery School, Sierra Leone. © Lothar Mikulla, UNFPA, 2016. Photo submitted by for the MHTF photo contest.

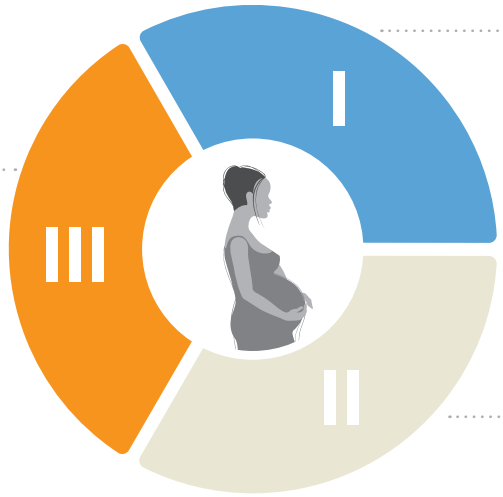
1 | INTRODUCTION

UNFPA's flagship MHTF is at the forefront in contributing to the United Nations Secretary-General's Every Woman, Every Child initiative,[7] and the far-reaching Transforming our world: the 2030 Agenda for Sustainable Development,[8] with its broad focus on economic, social and environmental factors that impact women's and girls' health and well-being. The MHTF is a unique United Nations programme, focused on improving MNH through an innovative and integrated results-based approach in 39 high-morbidity and mortality countries (see Figure 1). The Thematic Fund complements UNFPA Supplies;[9] together, they are working to enable women and girls to make fundamental decisions about their own bodies, attain the highest possible standard of sexual and reproductive health, and exercise their reproductive rights.

Phase II of the MHTF, from 2014 to 2016, has been set against a changing development paradigm – spanning the end of the Millennium Development Goals (MDGs) in 2015 and the beginning of the transformative 2030 Agenda.

The overall response in the first two years of Phase II has been supporting countries with the highest burden of maternal mortality to advance MDG 5 on improving maternal health, where progress was further behind than on any of the other MDGs. Particular attention was paid to reducing maternal mortality. The MHTF's tailored approach has been to support countries to accelerate action and further scale up proven, cost-effective interventions that can make a sizeable difference in women's and girl's health and well-being, particularly their maternal health. Knowing what works, and where and how much to invest, have been the cornerstone of the MHTF's second phase, built around the five key interventions of midwifery, obstetric fistula, EmONC, MDSR and FTYM, all under the cross-cutting human rights principles of equality in access, quality of care and accountability (Figure 2). These interventions are not stand alone – they are comprehensive, complementary and reinforce one another. For this reason, they have been strategically selected to have the greatest impact.

Figure 2: Cross-cutting MHTF principles



I. Equality in Access:

Ensures that every woman and girl has the same rights and opportunity to receive the information and services that she needs regardless of her income, socioeconomic, geographic and/or cultural status and empowered to demand these services

II. Quality of Care:

Quality of care is a key component of the right to health, and the route to equity and dignity for women and girls. Good quality of care requires appropriate use of effective clinical and non-clinical interventions, strengthened health infrastructure and optimum skills and attitude of health providers.

III. Accountability:

Accountability underpinned by human rights informs policy but also includes decision-making, performance evaluation, inclusiveness and transparency at all levels of the health system, from policy-making to the provision of services to women and girls as rights holders, including those under-served and marginalized.

7 See: www.everywomaneverychild.org

8 See: https://sustainabledevelopment.un.org/post2015/transformingourworld

9 UNFPA Supplies is a thematic fund dedicated to expanding access to family planning. It is the largest global funding mechanism dedicated to family planning, and the largest public sector supplier of contraceptives for low-income countries, accounting for some 40 per cent of the global procurement of these goods

With the elaboration and subsequent launch of the 2030 Agenda, the MHTF's approach, results and lessons learned ensured that it was in a strong position to effectively respond at all levels, particularly the country level, to transition between two global development paradigms. It placed a strong focus on completing the unfinished agenda of MDG 5, while at the same time embracing the 2030 Agenda and assisting countries to initiate measures to achieve the Sustainable Development Goals (SDGs), specifically SDG 3, to ensure healthy lives and promote well-being for all at all ages.[10]

Human rights and gender equality are principles central to realizing the 2030 Agenda, and the MHTF continues to emphasize these as essential drivers of and contributors to improved health and well-being, including maternal health, in all levels of its engagement and programming.[11] MHTF interventions work to ensure and uphold priority attention to women's and girl's human rights in all processes and programmes, but also takes a targeted approach. They reinforce the centrality of women and girls to ensure that their maternal health and broader SRHR are grounded in human rights, and key to ensuring their health and well-being. With an emphasis on the principle of human rights-based accountability, the MHTF works to ensure that the most marginalized and excluded women and girls can access maternal health (and broader SRHR) information and services, and that they can voice their concerns, claim their rights without fear of reprisal and seek remedies when their rights are violated. Tangible examples have included FTYM, obstetric fistula and midwifery programmes.

The second phase of the MHTF has unfolded against increasing fragility, conflict, instability and upheaval, the likes of which have not been seen since the Second World War. A number of countries supported by the MHTF have confronted these issues, including the Central African Republic, Haiti, Somalia, South Sudan and Yemen. In its approach, the MHTF has reinforced UNFPA's overall position on programming in humanitarian situations, that is, to enhance the nexus between humanitarian and development assistance, and to lay foundations for rapid recovery by building resilient development.

10 Specific targets to which the MHTF contributes under SDG 3 include: target 3.1: By 2030, reduce the global maternal mortality ratio [the number of women who die of pregnancy-related issues] to less than 70 per 100,000 live births; target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under -5 mortality to at least as low as 25 per 1,000 live births; target 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

11 In accordance with the ICPD Programme of Action and the Beijing Platform for Action, and the outcome documents of their reviews.

Putting human rights and gender equality at the heart of the MHTF

FTYM: Girls and young women giving birth for the first time often face a higher risk of reproductive morbidity and mortality, particularly if they are under the age of 20. Young mothers are also a large cohort in many countries, accounting for a significant proportion of births in any given year. The MHTF has worked towards supporting specific improvements in the quality of maternal health services to make them more responsive to younger mothers' needs, while at the same time addressing demand for such services. Ensuring that adolescent and young mothers have access to quality services at first contact tends to be an important predictive factor of continued lifelong service use, even across generations.

Obstetric fistula: The MHTF is supporting the most vulnerable groups of women and girls who develop obstetric fistula as a consequence of the lack of timely referral and access to quality skilled care at birth. In collaboration with the Campaign to End Fistula, the fund has contributed to over 39,000 fistula surgical repairs, alongside the reintegration of women and girls in their families and communities, providing many fistula survivors with renewed hope and opportunities.

Midwives provide maternal health services to women and girls who are the most marginalized and disadvantaged. By supporting midwifery workforce assessments, the MHTF is assisting countries to ensure the availability of midwives even in the most remote, hard-to-reach or challenging contexts. Through its work on midwifery education, the MHTF has supported over 300 midwifery schools and curricula, and over 32,000 midwives* in both pre-service and in-service training, towards providing women and girls with better quality prenatal and delivery care service. Assistance linked to midwifery regulation and licensing mechanisms helps to improve the quality of services and strengthen the professional rights of midwives.

* Based on UNFPA country reported data from 2014 to 2016

In the Ebola crisis in West Africa, UNFPA drew on the extensive experience of the MHTF midwifery programme, and in collaboration with the governments of Guinea, Liberia and Sierra Leone and other partners developed and initiated the Mano River midwifery response to restore resilient health systems for RMNCAH and prepare for the post-Ebola period. In Somalia, the MHTF is presently supporting 11 comprehensive EmONC (C-EmONC) facilities across the three zones, complementing other partner resources. A health systems approach includes essential rehabilitation, capacity-building in the form of basic EmONC (B-EmONC) and C-EmONC trainings, the provision of equipment, topping up of running costs, and the provision of essential life-saving supplies and commodities through the supply system. All of these efforts contribute to a resilient health system that will be in a stronger position to respond to future shocks.

The following chapters elaborate in detail the substantive work, results realized and resources used by the MHTF from 2014 to 2016. The final chapter sets out a broad vision for moving forward into its third phase, starting in 2018.

MHTF responding to natural disasters – Haiti

Hurricane Matthew struck Haiti in late 2016, leaving significant and widespread damage. As part of the response, 10 newly graduated nurse-midwives from the national midwifery school funded through the MHTF were able to provide integrated sexual and reproductive health services to people affected by the disaster. The nurse-midwives held frequent mobile clinics in the southern part of the country and offered a wide range of services, including clinical management of rape. They were also able to ensure that SRHR issues remained a priority in the post-disaster setting.

Love and commitment
© Nadia Todres, UNFPA Haiti, 2016. Photo submitted by Marielle Sander for the 2017 MHTF photo contest.

Devika Kurmi (33) carries home fodder in Bithuwa, Kapilvastu district, of Nepal. She got married at 14 and has three children. Early pregnancy is high in Nepal's rural villages like Bithuwa, leaving girls vulnerable to obstetric fistula. In the area of maternal health, UNFPA is supporting the government's District Health Office in Kapilvastu. © Santosh Chhetri, UNFPA Nepal. Photo submitted for the 2017 MHTF photo contest.

2 | ENABLERS AND DRIVERS OF CHANGE

2.1 Phase II of the MHTF – theory of change

The goal of the UNFPA Strategic Plan 2014-2017 *"is 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."*[12]

Contributing to this goal is outcome 1 (of 4): *"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."*

As described in Figure 3, during its second phase, the MHTF has contributed to outcome 1 and, more specifically, to output 3 under this outcome: *"Increased national capacity to deliver comprehensive maternal health services."* In support of this goal, the following six outcomes were identified for the MHTF:

- Outcome A. Strengthened national capacity to implement comprehensive midwifery programmes;
- Outcome B. Strengthened national capacity for EmONC, including quality integrated maternal health services;
- Outcome C. Enhanced national capacity for prevention, treatment and social reintegration for women and girls with obstetric fistula;
- Outcome D. Enhanced national capacity for MDSR;
- Outcome E: Strengthened national capacity to reach and serve first-time young mothers;
- Outcome F: Strengthened coordination and management of the MHTF.

These six outcomes are themselves driven by 15 outputs across the five key intervention areas of the MHTF. As part of its Results Indicators Framework,[13] the MHTF has defined indicators and strategic interventions to contribute to the achievements of its six outcomes. They are described in the next section.

12 UNFPA Strategic Plan 2014-2017, item four of the introduction to Annex 2: Outcome theories of change.

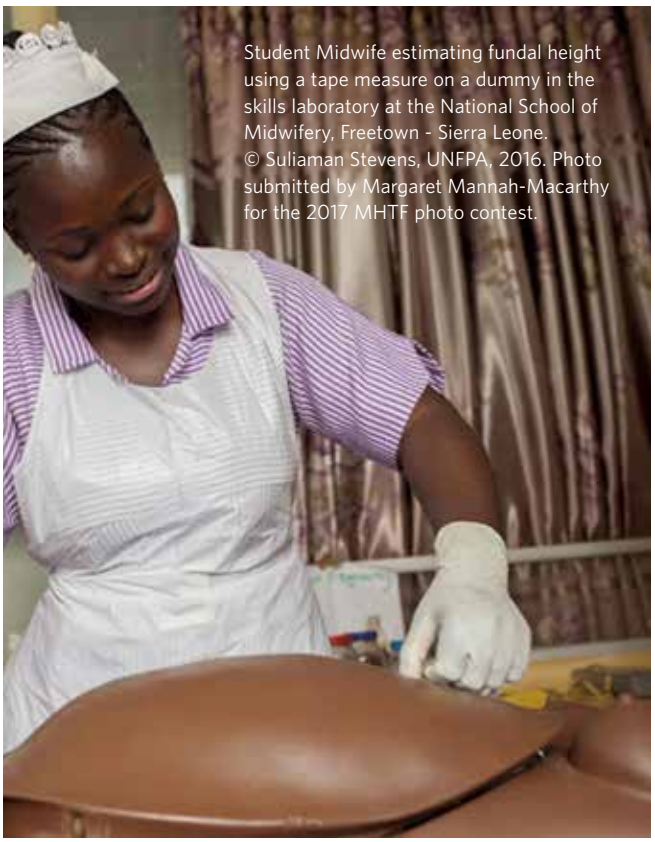
13 See Annex 4: Results Indicators Framework.

2.2 Health systems strengthening

2.2.1 Setting the context

Ensuring universal access to quality maternal health services (and broader SRHR) that leads to better health outcomes for women and girls requires strong and equitable health systems. During this second phase, the MHTF has supported targeted and evidence-based interventions to more proactively focus on health systems strengthening. This has encompassed all aspects of the health systems building blocks – service delivery, data and evidence, commodities, the health workforce, financing and governance (Figure 4) – with the aim to improve MNH, and decrease maternal mortality and morbidity.

The MHTF's health systems strengthening approach has been tailored to respond to the specific needs of individual countries. It uses its five strategic interventions, with an emphasis on accountability, equality in access and quality of care. This ensures an integrated, sustained impact in terms of improving MNH, while at the same time recognizes that one size does not fit all. Through this unique approach, there has been a real opportunity to reinforce country leadership and enhance collaboration at all levels (global, regional and country). The process has entailed key government ministries (national and subnational), civil society organizations, communities, and broader partnerships such as the H6 and the World Bank Group Global Financing Facility mobilizing collectively around health systems strengthening with a focus on complementarity, integration and sustainability. All efforts uphold gender equality and a human rights-based approach.



Student Midwife estimating fundal height using a tape measure on a dummy in the skills laboratory at the National School of Midwifery, Freetown - Sierra Leone. © Suliaman Stevens, UNFPA, 2016. Photo submitted by Margaret Mannah-Macarthy for the 2017 MHTF photo contest.

Figure 4: The MHTF and health systems strengthening

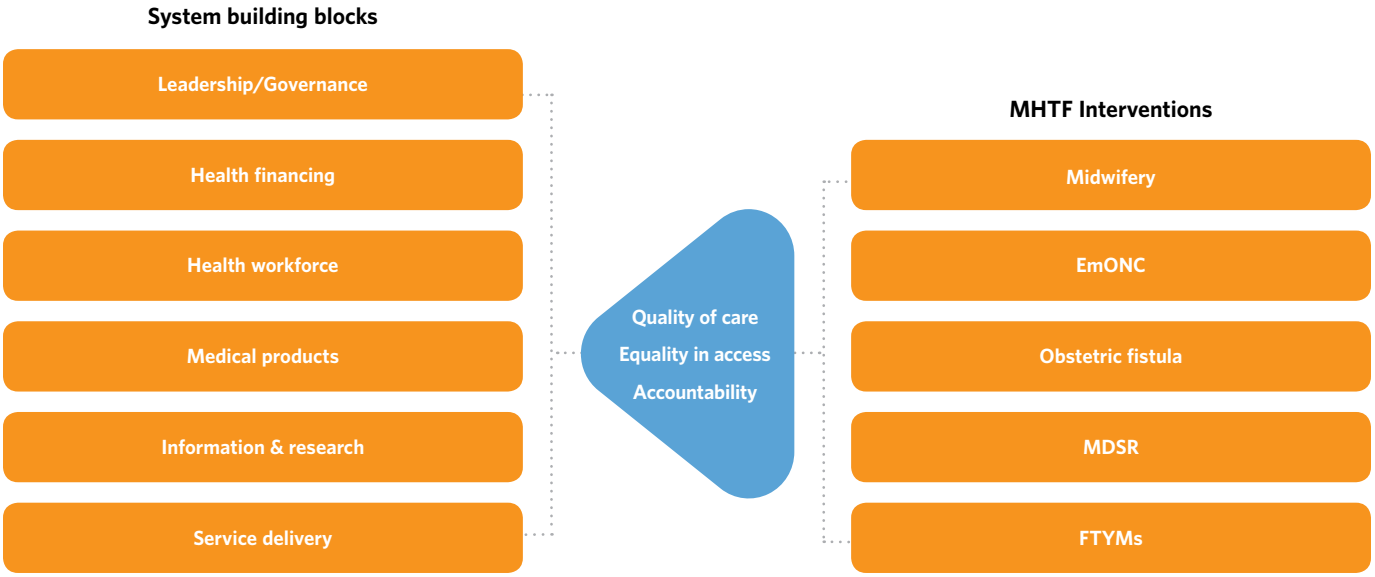
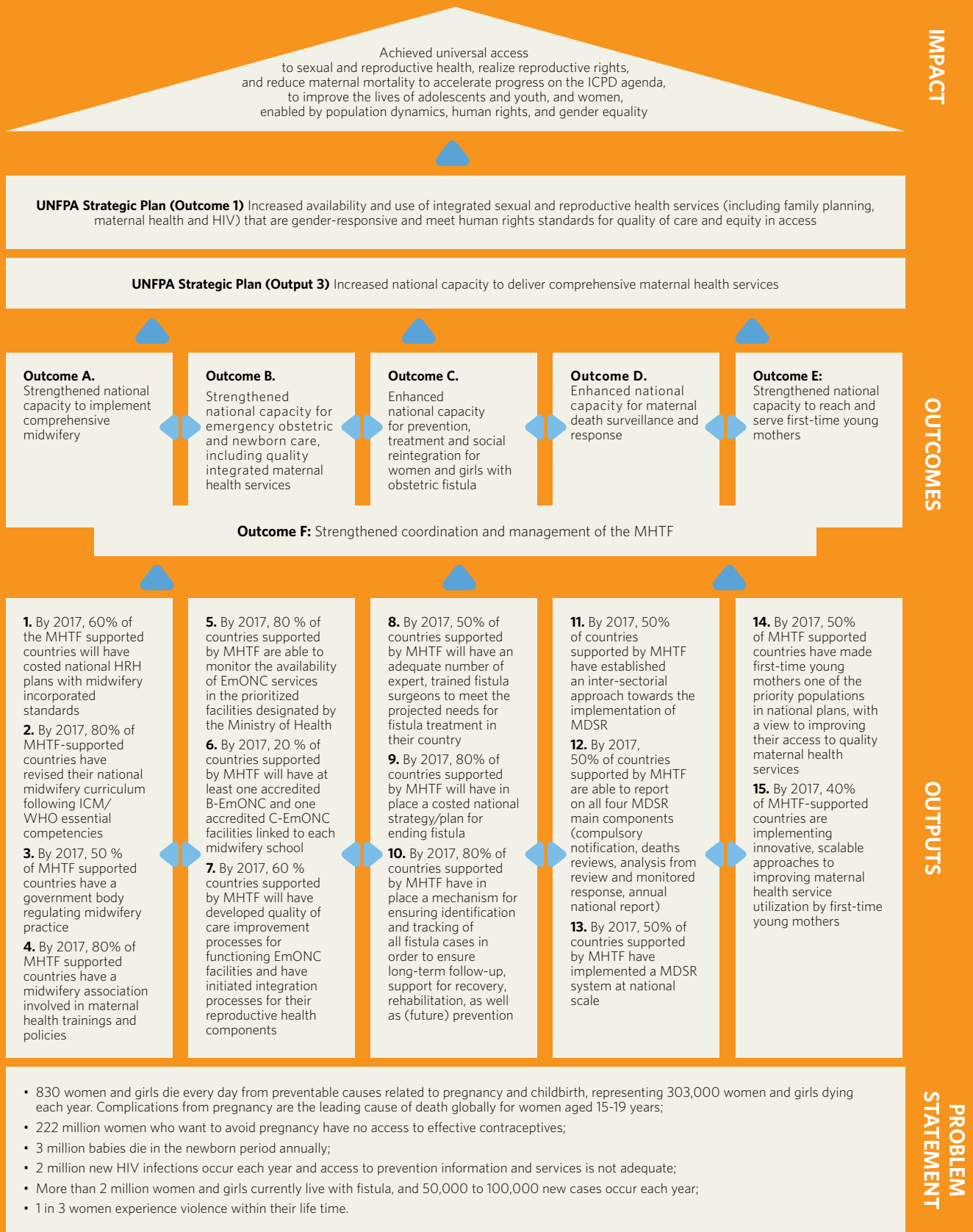


Figure 3: MHTF theory of change



2.2.2 Contributing to health systems building blocks: reflections

The following section highlights tangible examples of the MHTF's contribution to health system strengthening, although this provides only a brief glimpse at the level and extent of the MHTF's engagement.[14]

- ***Leadership/governance***

Health systems are fast changing and extremely context specific, requiring effective and resilient leadership and strong governance to advance and realize measurable health outcomes, including MNH. The MHTF continues to promote, at all levels, the need to accelerate increased coverage of priority maternal health interventions and the positioning of maternal health in policy, plans and budgets. Supporting and strengthening policy engagement capacity at the regional, national and subnational levels has been a vital entry point. With the support of the MHTF, Sudan's new five-year strategy on RMNCAH is closely aligned to the global commitment of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).

- ***Health financing***

The MHTF helps ensure that high-impact maternal health interventions and broader SRHR are prioritized in national and subnational plans, strategies and budgets, and delivered in an efficient and equitable manner, while recognizing that substantial additional resources (domestic, international, public and private) are necessary to fully achieve the maternal health and broader SRHR agenda.[15] Innovative approaches include Uganda using performance-based financing to facilitate Village Health Teams in 2016 to increase the identification and referral of fistula cases. In Ghana, 139 fistula survivors were registered under the National Health Insurance Scheme, with 70 survivors undergoing surgical repairs. This was achieved through partnership with the Ministry of Health; Ghana Health Services; the Ministry of Gender, Children and Social Protection; the Ministry of Local Government and Rural Development, and regional and district councils. At the country, regional and global levels, the MHTF continues to advocate the prioritization of and investment in maternal health, which remains substantially underfinanced, absorbing only a small share of total development assistance for health.[16]

- ***Health workforce***

Desirable sexual and reproductive health outcomes, including in maternal health, require the mobilization of health workers across the continuum of care to deliver quality reproductive health services where and when required. Maternal health depends on having the right skills available on demand, 24 hours a day, seven days a week, at different levels of the health system. Targeting specific cadres of the health workforce has been a key priority for MHTF-supported countries as a contribution to strengthening broader human resources for health. Approximately 90 per cent of these countries have aligned their national midwifery curricula to ICM global standards, competencies and tools, and broader sexual and reproductive health issues. In addition, MHTF-targeted interventions have helped address the severe shortage of highly skilled, trained, and competent fistula surgeons and care teams, contributing to equal access to high-quality care. The MHTF globally has engaged in a number of processes and initiatives backing human resources for health more generally, including the State of the World's Midwifery Report[17] and the United Nations Secretary-General's High-Level Commission on Health Employment and Economic Growth.[18]

- ***Medical products***

A well-functioning health system requires strong supply chains with on-demand availability of essential drugs, commodities (including for reproductive health) and supplies. The MHTF is addressing the strengthening of supply chains in specific areas, such as the procurement of two types of obstetric fistula repair kits that have all the necessary items for surgical repairs. The MHTF ensures that these kits can be procured and distributed whenever needed. During 2014-2016, 35 UNFPA country offices ordered 1,236 fistula Kit 1s and 1,477 fistula Kit 2s on behalf of fistula treatment centres. The MHTF collaborates closely with UNFPA Supplies, while also maximizing entry points such as strengthening the health workforce; enhancing policies, planning and regulation; supporting robust information systems; and focusing on people who are furthest behind to ensure equitable access to quality commodities and supplies.

14 Chapter 3 provides detailed results linked to equality in access, quality of care and accountability.

15 K. Stenberg et al., 2014, "Advancing social and economic development by investing in women's and children's health," The Lancet. Volume 383, No. 9925, p1333-1354, 12 April 2014.

16 J. J. Dielman, et al., 2016, "Development assistance for health: past trends, associations, and the future of international flows for health," The Lancet. Volume 387, Issue 10037, 18–24 June 2016, p2536-2544.

17 See: www.unfpa.org/sowmy.

18 See: http://www.who.int/hrh/com-heeg/en/.

Mother and Child at Pediatric Unit in Schiphra Hospital, Ouagadougou. Burkina Faso.
© Evan Schneider, UN photo, 2016.

- ***Information and research***

Strengthening the evidence base and using data to inform, unlock, and drive policy and programming on maternal health has been a central premise for MHTF-supported interventions. In addition, the MHTF in its second phase has assisted countries to document best practices and learning to inform future programming, scale up successful interventions and broaden policy directions. It has supported UNFPA's East and Southern Africa Regional Office to collaborate with the WHO, the Centers for Disease Control and Prevention, the Department for International Development, professional societies and universities to advance the institutionalization of MDSR. With MHTF support, Zambia has developed the first ever national MDSR report; data which will inform the 2017 national, provincial and district plans.

- ***Service delivery***

The MHTF supports countries to deliver comprehensive quality maternal health services, as part of a broader package of SRHR services applying a rights-based approach. At the same time, the MHTF continues to strengthen the knowledge base, promote the latest available evidence and address emerging issues. The Thematic Fund recognizes different country contexts, and responds to specific national needs to contribute to

MHTF: The Young Midwifery Leaders' Programme in the Caribbean: Supporting the leaders of the future

With the support of the MHTF, 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. It sought to help establish a culture of leadership within ICM member associations and regionally so that competent midwives and midwifery services are available to address the sexual and reproductive health needs of all women and girls in the region. An orientation workshop was successful, and the 18-month programme is expected to be completed by February 2018. Participants are committed to design and implement a leadership project that will enhance the development and strengthening of professional midwifery locally or regionally.

the greatest improvements in maternal health. Its role in supporting countries to strengthen the availability, accessibility, acceptability and quality of health service delivery has been significant during 2014 to 2016, under the five key intervention areas as elaborated in detail in Chapter 4.

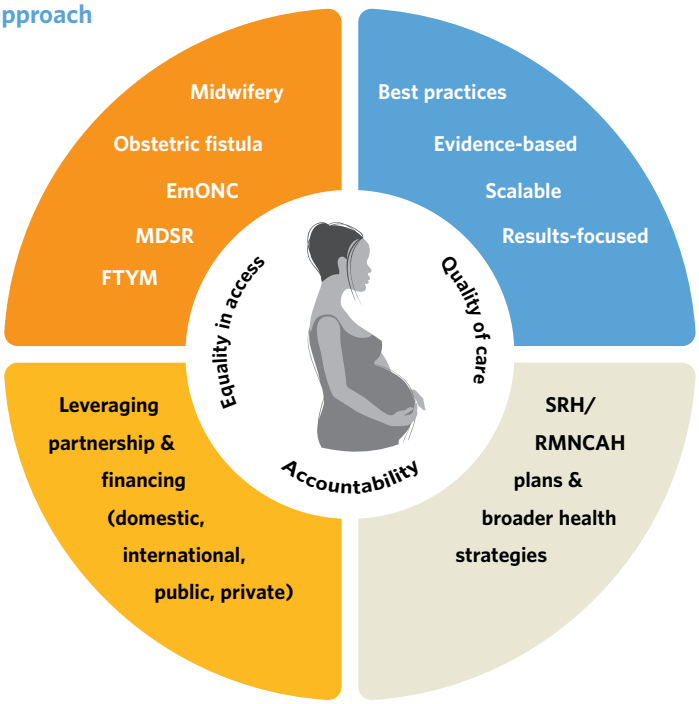
2.3 Catalytic aim and sustainability

The MHTF was established as a catalytic fund to complement UNFPA's core resources in enhancing the evidence base; promoting best practices and integration across the continuum of care; addressing scalability while leveraging additional resources to ensure the financing and sustainability of the MNH agenda; and advancing broader SRHR investment spanning domestic and international, as well as public and private resources (Figure 5). The MHTF was established at a time of limited focus on and resources for maternal health and broader SRHR.

In its second phase, the MHTF has more systematically documented results, best practices, lessons learned and emerging issues, and promoted South-South learning. As a result, alongside the spotlighting of critical interventions in areas such as midwifery, additional funding has been mobilized nationally by several MHTF-supported countries, such as Bangladesh, Ethiopia, Sierra Leone, South Sudan, Uganda and Zambia. This has comprised both domestic and international funds, with the latter coming, for instance, from the Swedish International Development Agency, the United Kingdom's Department for International Development, and Canada's Department of Foreign Affairs, Trade and Development.

In addition, UNFPA has effectively capitalized on results and lessons learned from MHTF-supported countries to promote, shape and position the maternal health agenda at the regional and global level. This includes in the context of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), where, for example, 45 countries pledged additional support to midwifery, drawing on extensive advocacy done through the MHTF. At the same time, the MHTF has been opportunistic, harnessing financing instruments such as the World Bank Group's Global Financing Facility (International Development Association, the International Bank for Reconstruction and Development, and trust funds), where MHTF-supported countries have technically positioned critical areas of the maternal health agenda in country RMNCAH investment cases. The MHTF has also been able to leverage the H6 partnership in support of MHTF maternal health interventions at all levels.

Figure 5: The MHTF's catalytic approach



2.4 Innovations

Innovation is a core component of the MHTF approach; it has received increased focus during the second phase of the MHTF, with an emphasis on transformational initiatives and encouragement at all levels, but particularly the country level, to push forward ideas and initiatives.

Harnessing Information and Communication Technology for improved midwifery education, monitoring and support

In 2016, a highly successful pilot project on a **portable mobile learning system** was launched in Ethiopia and the United Republic of Tanzania, with MHTF support complemented by assistance from the UNFPA Innovation Fund.* The project sought to train midwives and health workers in remote rural areas with poor infrastructure (erratic electricity, poor Internet connectivity, and poor health and training facilities) on key lifesaving skills.

The environmentally friendly system comprises a technology kit with a WiFi battery-operated, palm-sized projector with a built-in Android tablet, portable speakers and a solar charger kit. The projector comes preloaded with multimedia training e-modules on life-saving skills (e.g., on managing hypertension, post-partum haemorrhage, danger signs in pregnancy, sepsis, etc.).

The kit brings world class training to rural areas with a huge shortage of trainers and resources. The projectors allow any blank wall to become a classroom, and seamless training can be provided with the solar charger even if electricity outages occur. In the 2016 pilot phase, the mobile learning system was successfully implemented in 22 low resource sites (health centres and midwifery schools) in Ethiopia and the United Republic of Tanzania. A total of 116 training sessions were conducted on key obstetric emergencies, reaching 2,525 health workers (nurses, midwives, midwifery students and community health workers) and around 500 non-health-care workers between April and December 2016.

* UNFPA's innovation fund is bringing together the most innovative initiative to scale dynamic, new solutions to our delivery and operations. www.unfpa.org/innovation

Although momentum is there, coupled with significant enthusiasm, this is an area that will require greater focus. For the next phase, this might involve enhancing learning across countries and potentially targeted resources (e.g., exploratory or challenge funding).

Leveraging funds through MHTF results in South Sudan

In 2012, the Strengthening Midwifery Project was launched for four years (2012 to 2016) with Canadian support. UNFPA has helped the National Health Science Institute train 334 nurses and midwives. Over 85 per cent of graduates were placed in facilities across South Sudan; 10 state-level nursing and midwifery associations were established; six tutors were trained in Arusha, United Republic of Tanzania; and several clinical officers and doctors were trained through South-South collaboration in EmONC, general surgery, anesthesiology and obstetrics. Based on the progress of this initiative, in 2013, the four-year **Deploying Midwives Project** was launched, bringing an additional investment of $10.6 million. To keep up the momentum in 2016, Canada and Sweden came forward to fund Phase II of the **Strengthening Midwifery Project (2016-2020)**, impressed by success primarily driven by the catalytic approach of the MHTF.

Support for South Sudan, a country with one of the highest maternal mortality ratios (MMR) in the world, began in 2009 with the placement of two international midwife advisors at the UNFPA country office and at the Ministry of Health. At that time, there were fewer than eight midwives in the entire country. By 2016, the numbers had increased to over 325. Within a short span of three years, with MHTF support, a detailed midwifery gap analysis and needs assessment were conducted. The midwifery curriculum was reviewed, revised and implemented in training programmes, and the national association of midwives was launched. With impressive progress but still monumental needs on the ground, UNFPA was able to garner additional financial support from Australia, Canada and Sweden.

Transforming lives: Treatment and social reintegration of women suffering "incurable" fistula in northern Nigeria

In Nigeria, obstetric fistula prevalence is estimated at 150,000 cases, with about 12,000 new cases each year. UNFPA supports approximately 1,000 fistula repair surgeries annually. While a majority of women and girls who receive treatment will be continent after the surgery, there are, unfortunately, women whose fistula is so severe that it is not fully repaired after surgery. In some cases, because the physical damage is so extensive, women cannot undergo surgery. These cases are deemed incurable or inoperable, and require specialized support. They are often forgotten in national and international fistula programmes.

In 2016, UNFPA, in partnership with Fistula Foundation Nigeria, received a grant from the UNFCU Foundation to continue rehabilitation and reintegration of fistula survivors as well as pilot an innovative treatment initiative for a group of seven women and girls with fistula deemed incurable or inoperable. The catalytic nature of the MHTF, which has been supporting fistula work in Nigeria for several years, helped to attract and secure the UNFCU Foundation funding; the initiative also complemented work supported by the MHTF.

A series of advanced surgical treatment options were offered, including diversion, grafting and augmentation. A team of international surgeons was brought together to re-evaluate the women and girls, and conduct staggered advanced reconstructive surgeries. All seven reconstructive surgeries were successful. Following this positive outcome, UNFPA has been overwhelmed with requests in Nigeria to scale up surgeries for other women and girls with fistula deemed incurable or inoperable.

Sources: Prevalence figures are from the National Population Commission and ICF International, 2009, *Nigeria Demographic and Health Survey 2008*, Abuja. The survey estimates fistula prevalence at 0.4 per cent, which was applied to an estimated number of women of reproductive age in Nigeria (approximately 38 million) to arrive at an estimated 150,000 women and girls with fistula. Figures on annual cases come from EngenderHealth, 2010, "Strengthening Fistula Prevention and Treatment Services in Nigeria: An Environmental Scan."

A woman after the successful repair of a fistula deemed inoperable.
© International Society of Media in Public Health (ISMPH), Nigeria, 2016

3 | KEY RESULTS – 2014 TO 2016

The MHTF Results and Indicators Framework for Phase II has been developed in alignment with UNFPA's Strategic Plan for 2014-2017. It is based on a menu of strategic interventions that countries can select to best fit their context and integrate in annual work plans. The MHTF team, based at UNFPA headquarters, monitors planning and reporting twice a year with support from regional office colleagues. In early 2017, a survey was launched to collect more information

Figure 6: Scorecard on the cumulative achievement of MHTF outputs from 2014 to 2016

Outcome A: Midwifery		
1	By 2017, 60% of the MHTF-supported countries will have costed national HRH plans with midwifery incorporated	
2	By 2017, 80% of MHTF-supported countries have revised their national midwifery curriculum following ICM/WHO essential competencies	
3	By 2017, 50 % of MHTF-supported countries have a government body regulating midwifery practice	
4	By 2017, 80% of MHTF-supported countries have a midwifery association involved in maternal health trainings and policies	
Outcome B: EmONC		
5	By 2017, 80 % of countries supported by MHTF are able to monitor the availability of EmONC services in the prioritized facilities designated by the Ministry of Health	Baseline and Target not applicable
6	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	Baseline and Target not applicable
7	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	
Outcome C: Obstetric fistula		
8	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	Baseline and Target not applicable
9	By 2017, 80% of countries supported by MHTF will have in place a costed national strategy/plan for ending fistula	
10	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	
Outcome D: MDSR		
11	By 2017, 50 % of countries supported by MHTF have established an inter sectorial approach towards the implementation of MDSR	
12	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)	
13	By 2017, 50% of countries supported by MHTF have implemented a MDSR system at national scale	
Outcome E: 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	
15	By 2017, 40% of MHTF-supported countries are implementing innovative, scalable approaches to improving maternal health service utilization by first-time young mothers	

2017 target achieved in 2016 | on-track to be achieved in 2017 | off-track to be achieved in 2017

on strategic interventions undertaken in 2016, beyond what was reported by countries in the Results and Indicators Framework (Annex II of MHTF annual country reporting). Survey results have been used for data quality checks through comparison with achievements identified by country offices in annual reporting.

As illustrated in Figure 6, for six outputs, the 2017 targets were achieved in 2016 (as defined in 2014). Three output targets could not be used as they were defined based on incorrect baseline information, and were therefore highly over- or underestimated. The last year of Phase II implementation will therefore particularly focus on ensuring that six outputs reach their targets. As described in the section below, four of these (output 4 on strengthening the involvement of midwifery associations in policies and capacity building, output 7 on strengthening quality of care and integration processes in EmONC facilities, output 11 on establishing an intersectoral approach towards implementation of MDSR, and output 14 on making first-time young mothers one of the priority populations in national plans) are expected to reach their 2017 targets, meaning 10 out of 15 outputs will achieve their targets by the end of 2017.

The adoption of the **midwifery** competency-based standard (output 2) by most countries is the main achievement of the MHTF in midwifery during Phase II. Thirty-seven of the 39 MHTF-supported countries used many of the proposed strategic interventions to strengthen their national competency-based curriculum for midwives (Figure 7).

During Phase II, the number of midwifery schools supported by the MHTF increased from 180 to over 300 (Figure 8).

The accreditation process and the assessment of midwifery schools, and the in-service training of midwives on "respectful care" are remaining challenges. While the MHTF has assisted national midwifery and nursing councils in developing regulatory standards, accreditation mechanisms, midwifery scope of practice guidelines and codes of ethics, the number of countries having a governing body that regulates midwifery practice (output 3) only slightly increased (Figure 7). Further support is needed in this area.

Despite significant efforts to help countries to strengthen the role of midwifery associations in maternal health training and policies, output 4 has not yet reached its target. Since 2013, the MHTF has supported the strengthening of the managerial, leadership and advocacy capacities of associations in 14 countries; 16 more countries have declared that midwifery associations are involved in training and policies. Additional efforts are needed, however, as the influence of the associations and the status of midwives is still too weak in most countries. More support to define the role of associations in supporting the capacity-building of midwives should be considered. Based on 2017 annual work plans, nine additional countries are expected to have midwifery associations involved in maternal health training and policies, reaching the target for 2017.

For **EmONC** development, two out of three outputs have reached their 2017 targets (Figure 9).

Figure 7: Outcome A: midwifery output achievements (2016) versus targets (2017)

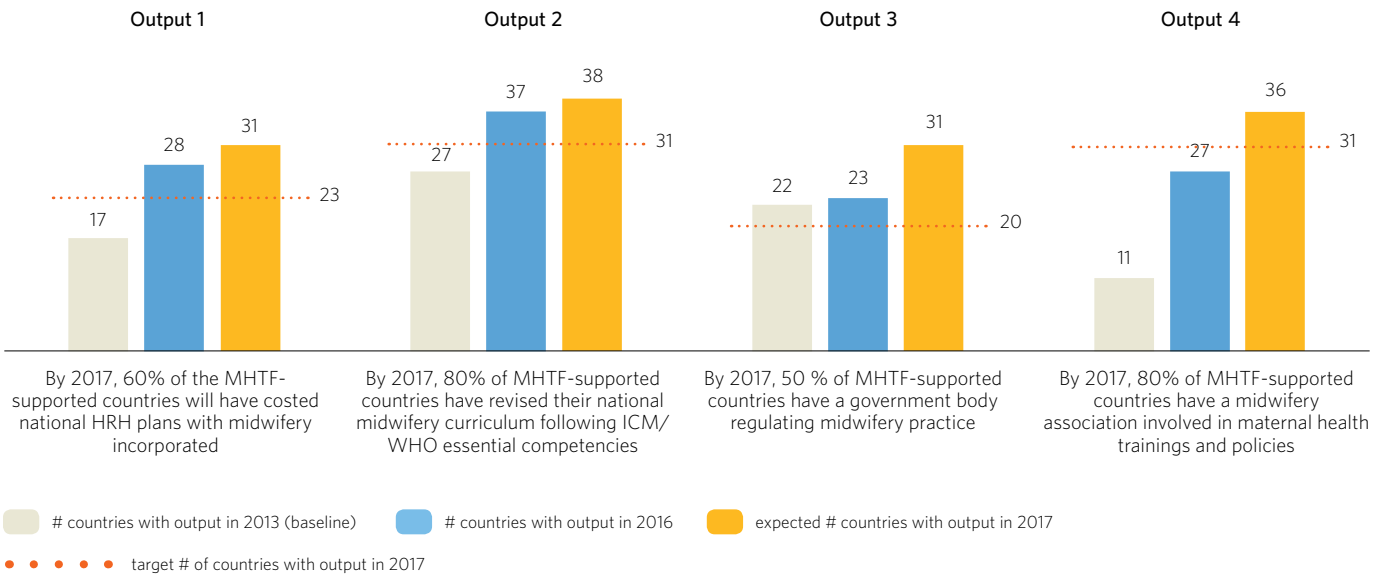
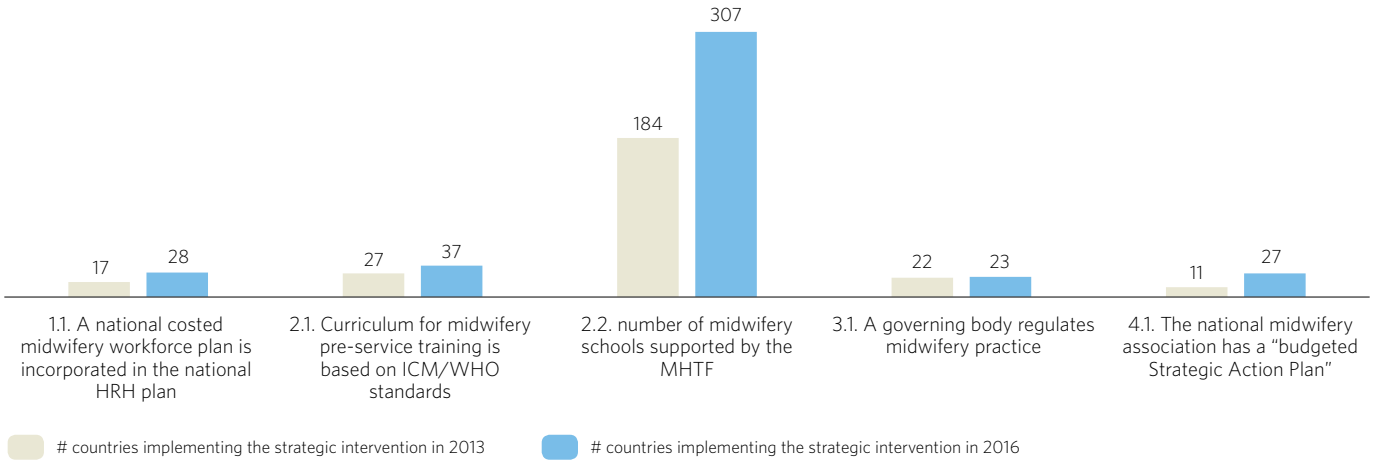


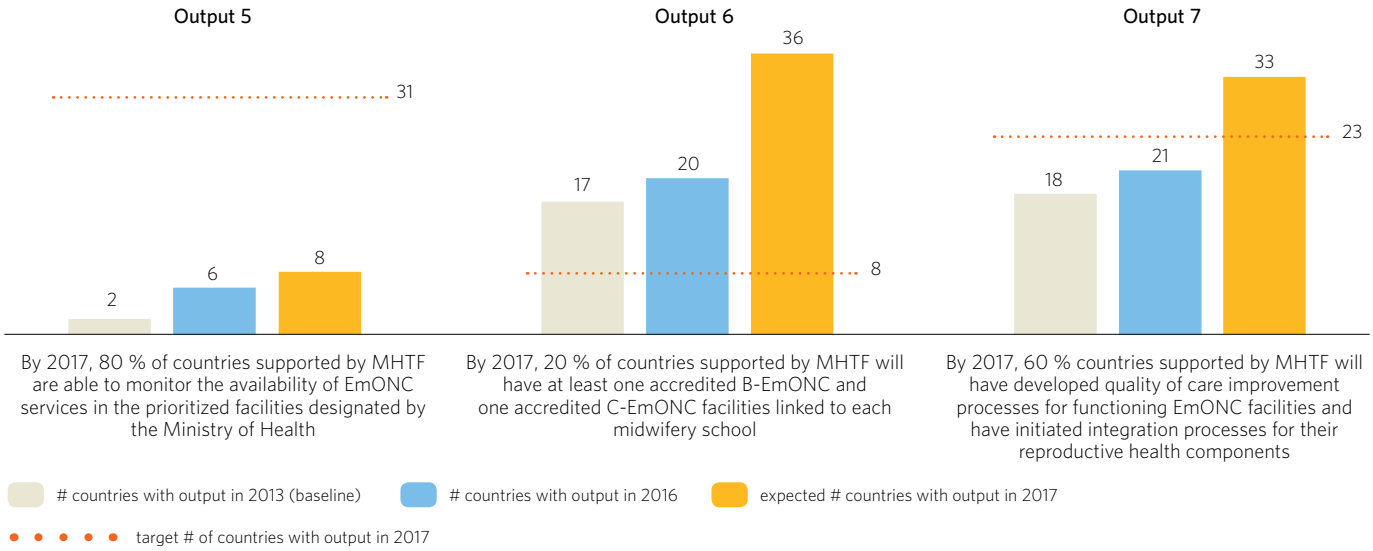
Figure 8: Outcome A: midwifery strategic intervention indicators, progress from 2013 to 2016



Output 5 on the monitoring of the availability of EmONC services in facilities designated as EmONC health facilities by ministries of health has not yet reached its target. This output is one of the most challenging as it aims to strengthen service availability and quality by supporting countries to identify their network of EmONC facilities, and set up a monitoring and response mechanism at all levels of the health system to address identified gaps. This requires a paradigm shift in the role of EmONC facilities in the health system, in the number of EmONC facilities and in the resources required to make an EmONC network function effectively 24/7. The 2017 target for output 5 was defined based on information available in 2013. Different misunderstandings concerning the definition of the "availability of EmONC"[19] indicator among experts resulted in an overestimation of the 2017 target. Instead of the former baseline of 21 countries, only two countries were able to effectively monitor the "availability of EmONC" indicator. This number increased to six countries in 2016 and is expected to be eight countries in 2017. Given the strategic decisions that are required from a Ministry of Health to implement the EmONC facility development process recommended by the MHTF, this can be considered a promising result.

19 The availability of EmONC is measured based on the number of facilities that perform the complete set of signal functions 24/7, in relation to the size of the population.

Figure 9: Outcome B: EmONC output achievements (2016) versus targets (2017)



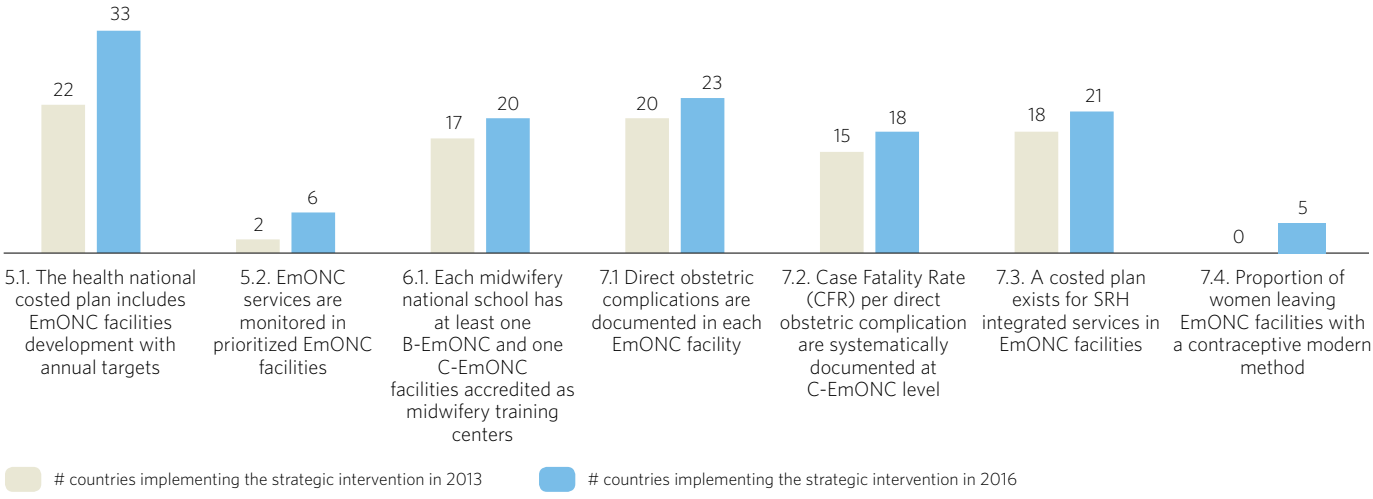
Output 6 on supporting countries to link each midwifery school with at least one accredited B-EmONC facility and one C-EmONC facility has reached its 2017 target, although not well defined given the lack of information available on this in 2013 (Figure 9). In 20 countries, each ICM midwifery school is linked to at least one accredited B-EmONC and C-EmONC facility (Figure 10). This should be considered a minimum. More efforts are required to ensure that more EmONC facilities will serve as pre-service training centres for midwives. Above all, quality of care and international educational standards need to be carefully monitored in all pre-service training centres.

The last output on EmONC development (output 7) also reached its 2017 target, with a slight increase compared to the baseline (Figure 9). Interventions for this output were among the most popular ones, but also the most challenging, as quality improvement and integration processes are intensive to set up and implement. While an additional 11 countries have included annual targets for the availability of EmONC in their national costed plan, fewer countries can document quality related indicators, such as direct obstetric complications and the case fatality rate for direct obstetric complications, even in C-EmONC facilities. One remaining challenge is the coverage of immediate post-partum family planning, as only five countries can document this, highlighting a critical need for more attention and additional interventions to address integrated care in EmONC facilities (Figure 10).

In conclusion, during Phase II, the MHTF is supporting countries to better plan and monitor networks of EmONC facilities and link EmONC, midwifery, MDSR and care for


© UNFPA, Guinea, 2016

Figure 10: Outcome B: EmONC strategic intervention indicators, progress from 2013 to 2016



obstetric fistula. It has also helped countries address gaps in the availability and quality of services through responses at all levels of the health system (from health facilities to district and regional levels to the national level), and to integrate EmONC services with other sexual and reproductive health services. This new strategic approach to EmONC will be further implemented in 2017 and beyond.

For **obstetric fistula**, none of the three outputs have yet reached their 2017 target (Figure 11). An overestimation of the targets for most of the outputs resulted from limited data on obstetric fistula incidence and prevalence in most countries.

Even if the targets have not been reached, the attention raised has moved the entire obstetric fistula programme forward in countries by pushing for national reflections on obstetric fistula incidence and prevalence. In most countries, the lack of obstetric fistula prevalence data makes it impossible for the Ministry of Health to estimate and plan for an adequate number of surgeons to meet needs for obstetric fistula treatment (Output 8).

This also jeopardized output 9, with the lack of data hampering the willingness of many countries to shift from a campaign mode for fistula treatment to a national programme with a budgeted strategic plan for ending obstetric fistula (Figure 11).

Figure 11: Outcome C: obstetric fistula output achievements (2016) versus targets (2017)

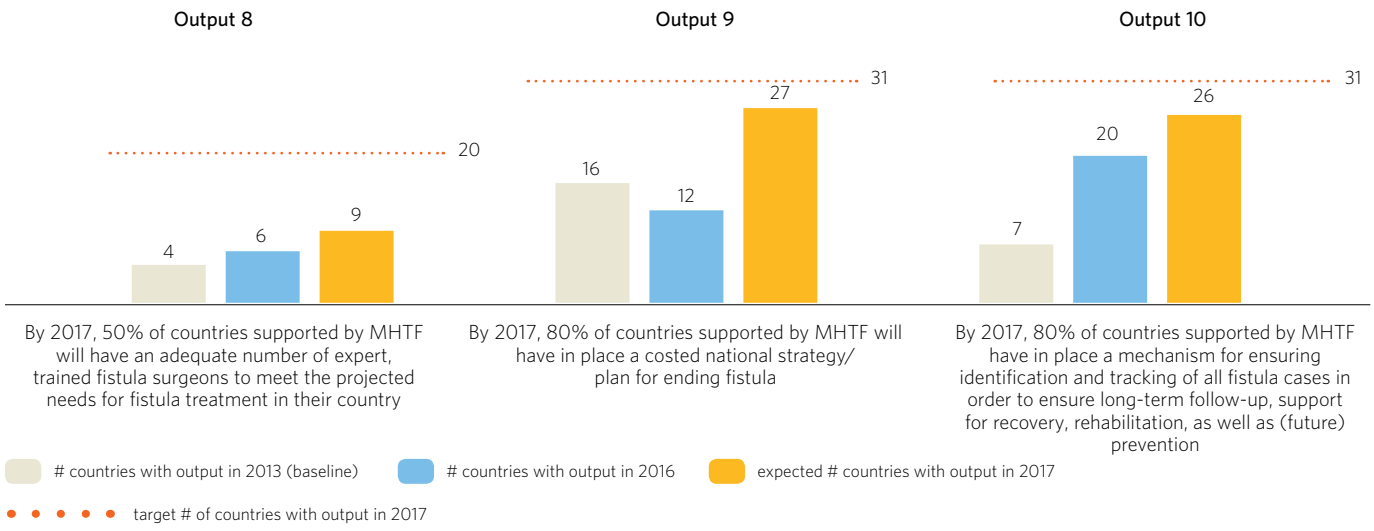
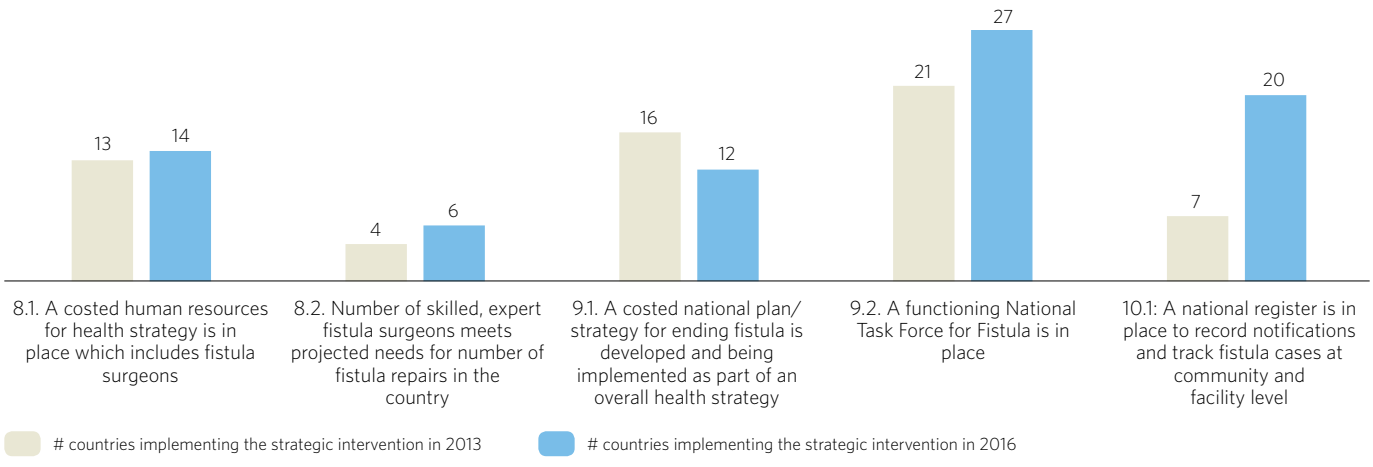


Figure 12: Outcome C: obstetric fistula strategic intervention indicators, progress from 2013 to 2016



Countries have made significant progress, however, in identifying and tracking fistula cases, despite the fact that the target for output 10 was not reached. These data are essential for providing appropriate treatment, support for recovery and socioeconomic rehabilitation, as well as prevention of obstetric fistula in future pregnancies. Since 2013, 13 more countries have set up a mechanism for identifying and tracking fistula cases. Significant progress has also been made in establishing national task forces for ending fistula, which contributes to monitoring obstetric fistula campaigns and national programmes (Figure 12).

For **MDSR**, two of three outputs have reached their 2017 targets (Figure 13). With 12 more countries having a functioning intersectoral MDSR committee, output 11 has achieved 90 per cent of the 2017 target. This is a major achievement, as these committees are more challenging to establish and keep functioning than the health sector MDSR committees that exist in most countries. An intersectoral committee is important to address the various causes and determinants of maternal and newborn deaths related to the health system and beyond.

Important progress has also been made by countries in building an MDSR programme framework (output 12). This includes four components defined by the MHTF: a functioning national MDSR committee, the development of an MDSR national costed plan (in 2013, this component only considered existing MDSR action plans; the "costed" element was added in 2015), mandatory maternal deaths notification, and national standards and tools adopted from WHO recommendations (Figure 13).

Figure 13: Outcome D: MDSR output achievements (2016) versus targets (2017)

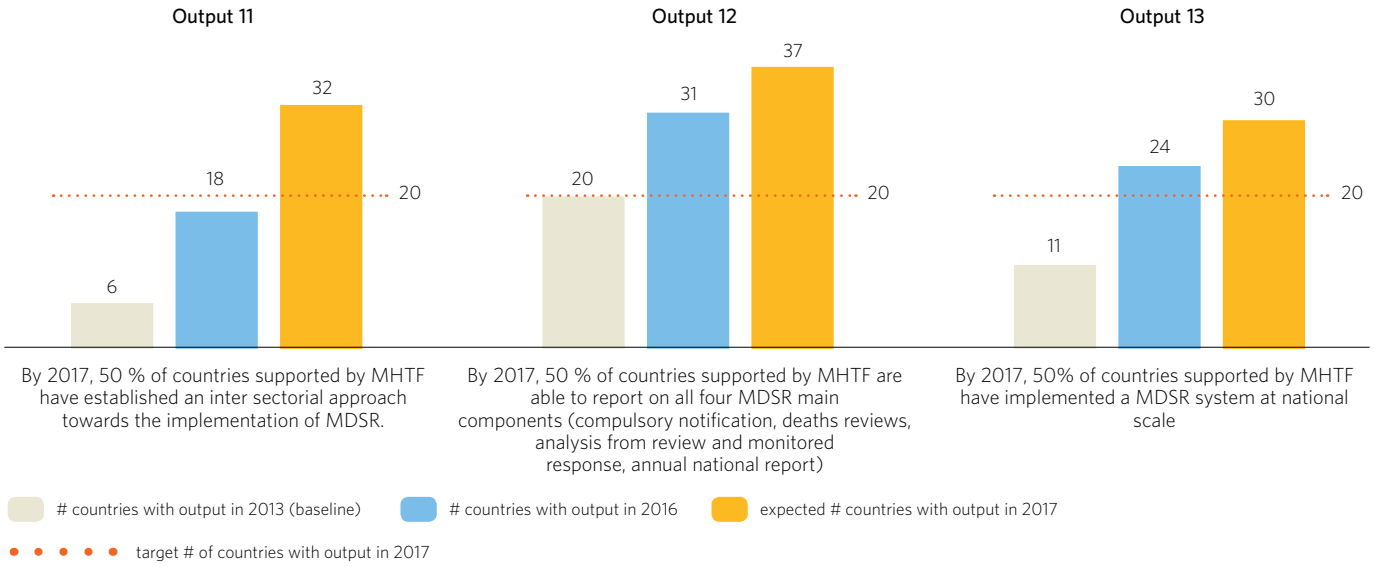
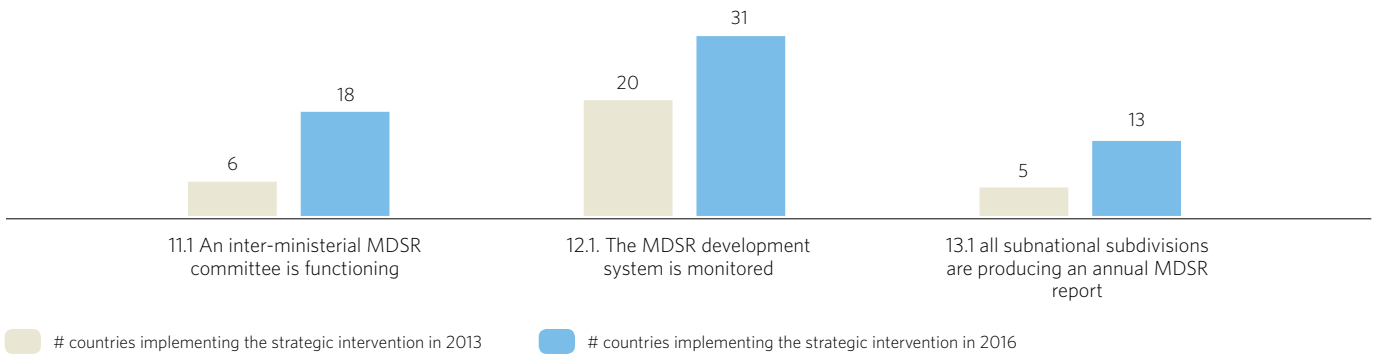


Figure 14: Outcome D: MDSR strategic intervention indicators, progress from 2013 to 2016

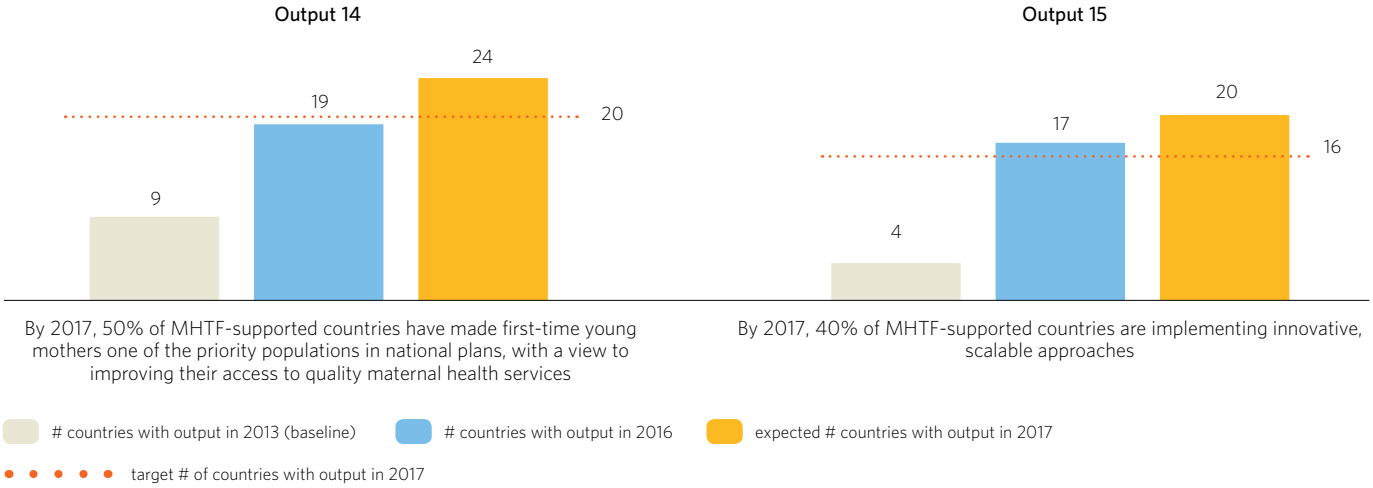


Output 13, the last output on MDSR, has also dramatically improved, reflecting broader coverage of MDSR from the subnational level to national scale in more countries (Figure 13). In 2016, the MDSR program was implemented at national scale in 24 countries compared to 11 in 2013, an increase of 118 per cent (Figure 14). Reporting on MDSR has also significantly improved in these countries; more produce an annual MDSR report at subnational level. Challenges remain in terms of performance and the quality of MDSR implementation, however, especially regarding the coverage of maternal deaths notification and review, the quality of the reviews and the use of review findings. These are the major issues to be addressed in the immediate future.

In 2014, after support for **FTYM** was introduced as a fifth focus area, the MHTF began working with countries to increase the number of FTYMs 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 (Figure 15). In 2016, 10 more countries decided to prioritize FTYM in national RMNCAH plans (output 14), almost reaching the target of 20 countries by the end of 2017. With 13 additional countries implementing at least one innovative, scalable approach to improving maternal health service use by FTYM (output 15), significant efforts have been made by countries over the last two years, and the 2017 target of 40 per cent of MHTF-targeted countries implementing innovative and scalable approaches to improving maternal health services used by FTYM has already been reached. Some of these innovative approaches are described in the various sections of this report.

Schipra Hospital, Burkina Faso. ©Evan Schneider, UN photo, 2016.

Figure 15: Outcome E: FTYM output achievements (2016) versus targets (2017)



Internally dispaced mother and child from Mungole Internally Displaced Persons Camp, in Kitchanga, North Kivu, eastern Democratic Republic of the Congo.
© Eskinder Debebe, UN photo, 2016.

4 MAXIMIZING EQUALITY, QUALITY AND ACCOUNTABILITY

The MHTF contributes to improving equality in access, quality of care, and to strengthening accountability mechanisms at all levels of health systems. The following chapter highlights how its strategic interventions contribute to these three cross-cutting principles.

4.1 Equality in access

All five components of the MHTF contribute to and are aligned with UNFPA's goal of reaching the "furthest behind first." Working on 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 status, geographic location or cultural background, or her willingness and capacity to ask for these services.

In order to improve equality in access, the MHTF pays special attention to vulnerable populations such as adolescent mothers, indigenous peoples, newborns and fistula survivors, who are among the poorest and most marginalized. Support includes measures for achieving equal access to sensitive services like post-abortion care and post-partum family planning, where significant efforts are still required.

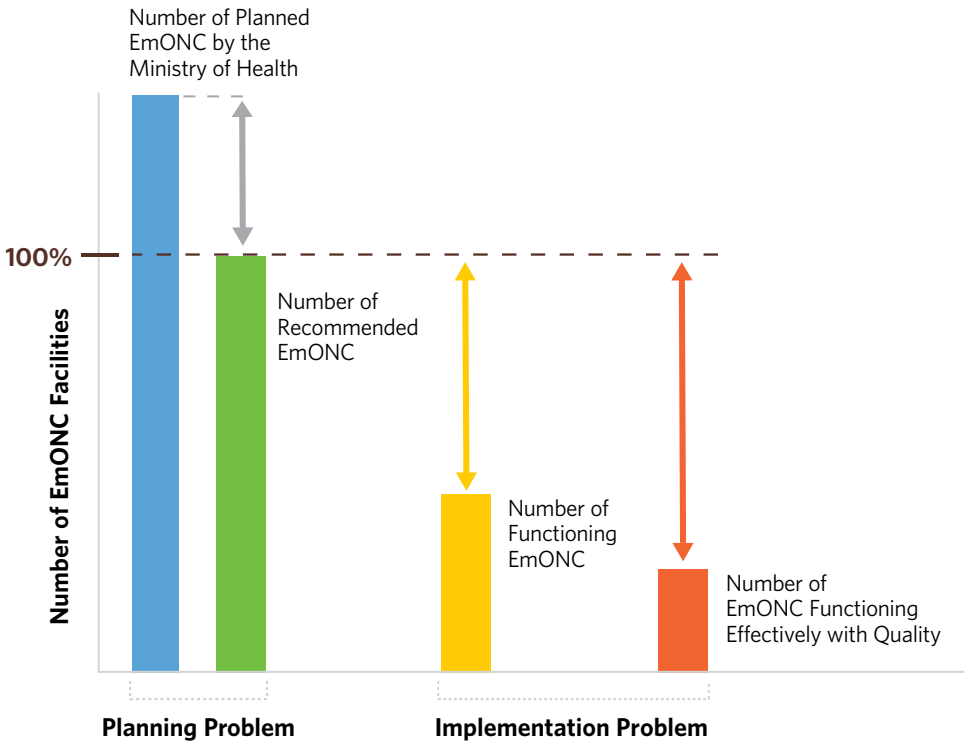
The availability of MNH services largely depends on the availability of and ability to deploy skilled birth attendants, particularly midwives, in health facilities. However, despite progress on institutional deliveries in many countries, access to maternal health care by a skilled birth attendant remains low. To address this gap, the MHTF has supported countries to monitor the deployment of midwives in the health system, especially in EmONC facilities, as midwives are educated to manage basic obstetric and newborn care complications. For example, in Burkina Faso, 568 midwives have graduated from MHTF-supported schools and 357 (62 per cent) were deployed in the health system. In Mauritania, all 25 graduated midwives were deployed.[20] The MHTF has also helped countries to elaborate national standards for EmONC facilities (especially for B-EmONC facilities) in which the needs for staff are defined and quantified. To date, Guinea, Haiti, Timor-Leste and Togo have defined such standards and calculated gaps in the number of midwives in EmONC facilities.

During this second phase, the MHTF has aided countries to strengthen the availability of EmONC services 24/7, and to monitor them with two United Nations recommended indicators: the "availability of EmONC"[21] and the "geographic distribution of EmONC facilities." Both are critical for improving equality in access to maternal and neonatal care.

By promoting the use of the "EmONC availability" indicator, the MHTF helped countries with a high burden of maternal mortality to identify planning and implementation problems in developing their network of EmONC facilities. These countries typically have a number of designated EmONC facilities that is two to four times higher than the minimum EmONC international standard (as illustrated by the grey arrow in Figure 16).

20 Source: UNFPA annual MHTF-supported country survey, 2017 (2016 results from 39 surveyed countries, complementing the RIF).
21 Number of functioning EmONC facilities.

Figure 16: EmONC networks in countries with a high burden of maternal mortality



Source: Adapted from 2016 unpublished graph by Lynn Freedman, Averting Maternal Death and Disability, Columbia University, New York (based on EmONC needs assessments of 15 countries).

This gap reflects a planning problem that hampers the capacity to have functioning EmONC facilities, as scarce resources are spread across too many facilities. While slightly improving since 2014, in most high-burden countries, the coverage of functioning EmONC facilities corresponds to about 30 per cent of the recommended international standard. This gap (illustrated by the yellow arrow in Figure 16) reflects the implementation problem.

As highlighted in Figure 17, in 2016, 21 MHTF-supported countries reported the "availability of EmONC" compared to 13 counties in 2013. No country had EmONC availability above 65 per cent of the international standard in 2013, while in 2016, four countries had reached this percentage (Congo, Nepal, Rwanda and Timor-Leste). Rwanda is the only country supported by the MHTF that claims to have reached the EmONC international standard. This is an important achievement, in line with the fact that the country also achieved its MDG 5a target.[22]

Twenty-five countries are now reporting "geographical access to EmONC," representing a 150 per cent increase from 10 countries in 2013. This indicator reveals important disparities in access to MNH services among provinces and regions.

Data collected on these two indicators show that the number of C-EmONC for some MHTF-supported countries is not far from the international standard. The deficit in B-EmONC facilities remains a concern in most countries, however. As a consequence, the proportion of births occurring in the EmONC facility network and the proportion of direct obstetric complications managed in functioning EmONC facilities have increased at a slow pace. Benin and Togo are positive exceptions where progress is more significant (as shown in Figure 18).

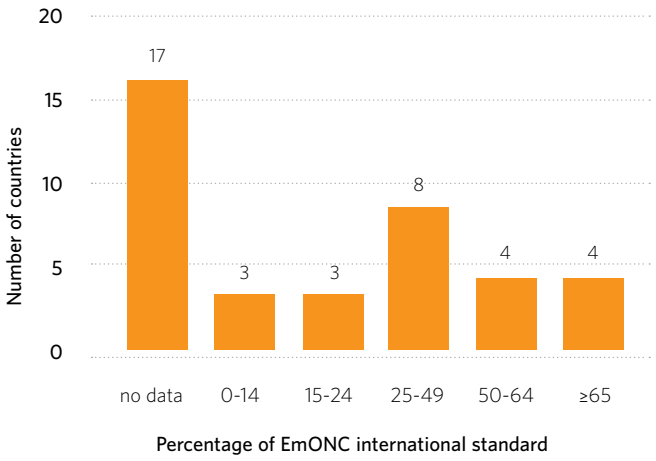
In addition to the two EmONC process indicators mentioned above, the MHTF also supports countries in monitoring EmONC met needs,[23] a result indicator for EmONC. Despite difficulties in collecting data on direct

22 Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

23 The percentage of all women with major direct obstetric complications who are treated in a health facility providing EmONC in a given reference period.

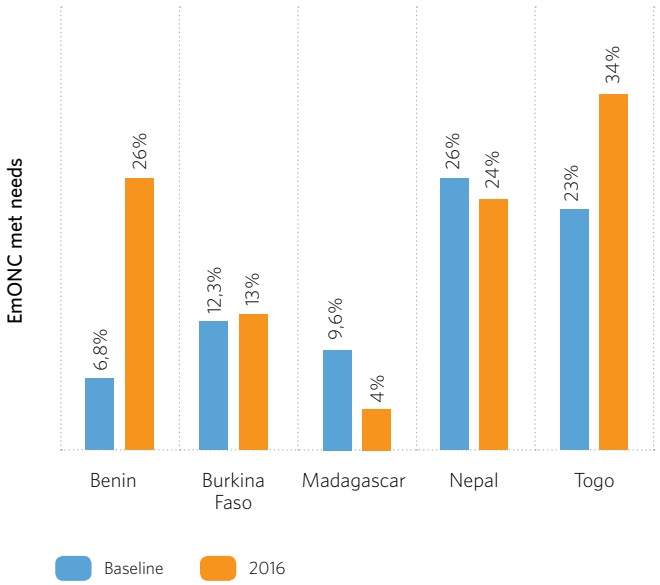
obstetric complications, five countries (Benin, Burkina Faso, Madagascar, Nepal and Togo) are monitoring this indicator during Phase II of the MHTF to strengthen programme performance and advocacy for access to EmONC. The blue columns in Figure 18 represent the baseline, which is the year that the last EmONC needs assessment was conducted: Benin (2012), Burkina Faso (2011), Madagascar (2010), Nepal (2005) and Togo (2013). The political crisis in Madagascar in 2009 to 2012 contributed to the weakening of the health system and slowed progress in access to EmONC.

Figure 17: Number of MHTF-supported countries with EmONC availability as a percentage of the EmONC international standard



Source: 2017 MHTF-supported country survey on 2016 data. Analysis of the availability of EmONC facilities in 2016 against the EmONC international standard of five EmONC facilities (including at least one C-EmONC) for every 500,000 population.

Figure 18: EmONC met needs in 2016 and baseline year



Uganda Karamoja Initiative for midwifery

An assessment conducted in 2016 on the delivery of integrated quality sexual and reproductive health and HIV services in Uganda's Karamoja region has shown significant improvement in maternal health indicators. This has been largely attributed to the increased presence of midwives in health facilities in the region. From 2009 to 2016, the regional referral hospital midwifery gap decreased from 68 per cent to 37 per cent; the health centre II gap decreased from 91 per cent to 16 per cent, and the health centre III gap of 70 per cent was completely eliminated.

The improvement built on a midwifery needs assessment study done in Uganda by UNFPA in 2009. It identified an estimated deficit of 1,961 (36 per cent) in the number of midwives in public health facilities nationwide. Rural areas had a higher proportion of unfilled midwifery positions (43 per cent) compared to urban areas (23 per cent). The study found that the Karamoja region had the highest gap at 68 per cent at the regional referral hospital level, 91 per cent at the health centre II level and up to 70 per cent at the health centre III level, resulting in the region having the worst maternal health indicators.

To address this, UNFPA in partnership with the Ministry of Health and the Ministry of Education and Sports established a bursary fund for midwifery training for underserved districts, and promoted the midwifery profession in 14 schools. This resulted in an overwhelming response and applications from 1,653 students. Since 2010, 130 students from the Karamoja region have been supported, and 97 per cent have been recruited by respective districts, filling 75 per cent of midwifery positions.

Ensuring the right to maternal health for women and girls: a case study of the Republic of Congo

Despite its overall favourable economic situation as a middle-income country, the socioeconomic and health indicators of the Republic of Congo remain highly concerning, with a high MMR (442 [300-638] per 100,000 live births) and a rising number of adolescent pregnancies. Access to maternal health is very inequitable, with adolescent girls and indigenous women among the groups most left behind.

The Ministry of Health, jointly with its international counterparts, including UNFPA, is working hard to push for systemic improvements through the strengthening of health districts, the monitoring of an EmONC action plan, MDSR, improved supply chain management for reproductive health supplies, etc.

Besides these interventions, UNFPA, alongside the national association of midwives and influential female leaders, decided to push a complementary agenda to bring renewed attention and prospective solutions to recurring challenges to the rights of women and girls to deliver safely, with respectful care, regardless of where they live, their age or ethnic origin.

Using a participatory, human rights-based and culturally sensitive approach, UNFPA and the Ministry of Health organized wide consultations and focus groups with health professionals, leaders, FTYM, women living with HIV, indigenous women and fathers to understand and incorporate their perspectives on the issues. This long process resulted in two charters of eight rights mirroring each other: the rights of pregnant girls and women, and the rights of midwives.

Pygmée Aka from the Lakouala department, Republic of Congo
© Nicolas Gayot,UNFPA, 2010.

The MHTF is implementing a systematic initiative in the Sangha Department, with a high density of indigenous populations, and where over 10 per cent of all reported mortality cases are linked to pregnancy. The programme, conducted with Médecins d'Afrique, a national NGO, in partnership with the Ministry of Health, is providing culturally sensitive services to indigenous women in 13 delivery rooms, working with community health workers and indigenous leaders to strengthen linkages. In addition, the collection of health statistics and maternal deaths surveillance are being reinforced. Special attention to teenage mothers enables the provision of comprehensive care, including encouragement to attend or remain in school. Lessons and good practices from this initiative will be used as key recommendations for the upcoming national health plan (2018-2021).

Source: UNFPA Country Office, Congo (2016)

Anita Tharu (20) with two-year-old son near her home in Kapilvastu district of Nepal, patient of a nearby UNFPA supported health center.
© Santosh Chhetri, UNFPA. Photo submitted for the 2017 MHTF photo contest.

In order to improve "EmONC availability," the MHTF has developed a six-step approach (illustrated in Figure 19) to help address planning and implementation problems in developing an EmONC facility network. This approach is intended to follow and complement an EmONC needs assessment (or a lighter version developed by UNFPA's West and Central Africa Regional Office), which is often expensive and usually done every three to five years (or every one to two years for the lighter version). The approach facilitates proactive management of EmONC facilities by ensuring strategic planning and selection of facilities, the regular analysis of key indicators, and the empowerment of local staff to resolve gaps and make facilities function.

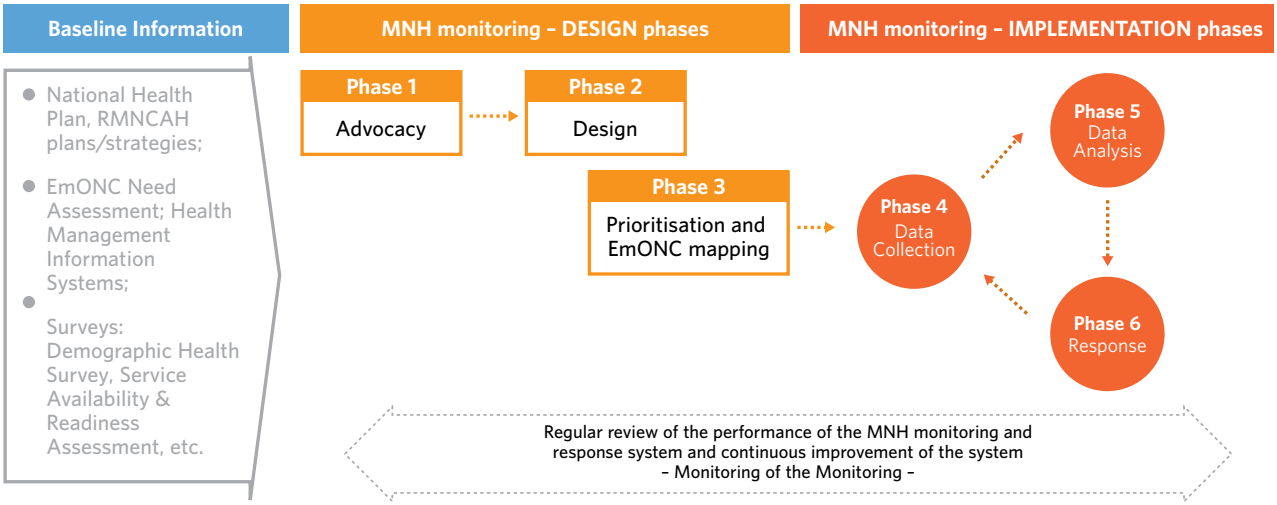
The approach is based on lessons learned from countries in assessing and developing their EmONC facility networks, particularly from Haiti and Togo. Togo is the most advanced in implementation of this approach with a prioritized network of EmONC facilities, routine collection and analysis of MNH data, and the initiation of response processes at regional, district and facility levels since 2016. The MHTF currently is supporting development of an implementation guide describing the approach in detail that is expected to be available at the end of 2017. Technical assistance is supporting Burundi, Guinea, Madagascar and Senegal with implementing this approach for EmONC development.

This six-step approach is not a standalone one. It is intended to support integration of EmONC services within the broader provision of sexual and reproductive health services, through the analysis of indicators, such as the number of women receiving counselling for family planning within 48 hours after delivery (post-partum family planning). It is also designed to be integrated within the health information system, for example, in Togo, where MNH indicators are collected and analysed using DHIS2[24].

To be properly implemented at the country level, the approach requires clarification on the definition of EmONC signal functions, what a "functioning EmONC facility" entails and what is required in terms of referral systems. Other necessary areas for capacity-building and strengthening are:

24 DHIS2 is generally used as a national health information system for data management and analysis purposes, health programme management and evaluation.

Figure 19: A six-step approach to EmONC development



Source: UNFPA Technical Division, 2016

- **Use of Geographic Information Systems (GIS)** that can combine population and topographic data with MNH data to identify the location of EmONC facilities that would maximize access to care. This process includes building scenarios to identify the most cost-efficient options to cover a larger part of the population. The MHTF has introduced this GIS approach in Togo in 2016; it will be extended to Burundi and Guinea in 2017.

- **Elaboration of national standards for EmONC facilities** to define their role in the health system, and required human resources (with a specific focus on midwives), materials, supplies and infrastructure for C-EmONC and B-EmONC facilities.

- **Strengthening of referral links between communities, maternal health facilities and EmONC facilities** as well as between B-EmONC and C-EmONC facilities. Financial costs are a major obstacle for effective referrals, and the MHTF is advocating for increasing domestic funding to improve them. In Guinea and Togo, with MHTF support, all B-EmONC/C-EmONC referral links have been assessed by the Ministry of Health and categorized as "green," "orange" and "red". In 2016 in Togo, around one-third of the B-EmONC/C-EmONC links were classified as orange, meaning that the referral process was usually weakened by financial obstacles or lack of means of transportation. Voucher systems for referral to C-EmONC facilities in emergency situations could be considered. Many countries are facing a similar situation, requiring support to referral systems, including for referrals from communities to B-EmONC facilities.

The MHTF contributed to the development and adoption of strategies and plans for improving the availability of reproductive, maternal and newborn care in facilities. The number of countries with a budgeted plan to increase functioning EmONC facilities rose from 22 in 2013 to 33 in 2016. Twenty-one countries updated reproductive health protocols to foster integration between maternal and reproductive health programmes. Only five countries, however, were able to document the use of immediate post-partum family planning by women who delivered in EmONC facilities (Figure 20), and the uptake rates were low. This reflects continuing challenges in integrating and documenting basic components of reproductive and maternal health programmes.

The lack of access to emergency obstetric care, particularly for women and girls suffering from prolonged obstructed labour, can in many cases lead to **obstetric fistula**. Obstetric fistula is found almost exclusively among the poorest, most vulnerable and marginalized women and girls. The Campaign to End Fistula, supported by the MHTF, has through its network of over 100 partners been key to generating awareness on obstetric fistula in remote places and to improving the identification of women and girls living with obstetric fistula.

Countries where obstetric fistula persists are supported to ensure access to fistula repair surgeries for women and girls. Moreover, a gradual "programmatic shift" has been encouraged from a campaign approach towards the establishment of fistula services anchored in the national health strategies, plan and budgets, and fully integrated into the health system through strategically selected hospitals (e.g., in Ethiopia, Madagascar and Uganda) that provide continuous and holistic fistula care. This shift shows in the fact that as of 2016, 24 of 37 MHTF-supported countries reported having routine and continuous availability of fistula treatment services in strategically selected hospitals. Despite this progress, however, only 11 countries reported that fistula treatment services cover all regions of the country. Ten of the countries reporting full coverage also reported 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)[25] reported an insufficient number of treatment centres conducting surgical repairs on a regular basis. To address these challenges and ensure equitable access to fistula treatment, the MHTF supports countries to undertake the following:

- **Planning** an adequate number of fistula treatment centres depending on the caseload and identification of fistula cases.
- **Strengthening referrals of women and girls** suffering from obstetric fistula for treatment by mobilizing communities and community outreach workers, and using mobile phones. In some countries, the MHTF supports the cost of fistula repair services, transport to and from health care facilities, and other related critical needs that may serve as barriers to care for women and girls. An innovative and cost-effective example of improved access is in Ethiopia, where the identification of fistula case was linked to the door-to-door identification of polio cases during the 2016 polio campaign. As a result, 1,089 women reported incontinence and were referred for medical screening, and those confirmed to suffer from fistula were then connected to fistula treatment services.
- **Building national capacities** in fistula prevention, management, treatment and care. In 2016, the MHTF supported the training of 2,368 nurses and anaesthetists, and 486 surgeons in fistula prevention, management, treatment and care. In addition, strengthening national capacities in midwifery and EmONC contributes to reducing the incidence of obstetric fistula.

25 Source: UNFPA annual MHTF-supported country survey, 2017 (2016 results from 39 surveyed countries, complementing the RIF)

Figure 20: Proportion of women leaving the maternity ward (in an EmONC facility) with a contraceptive method

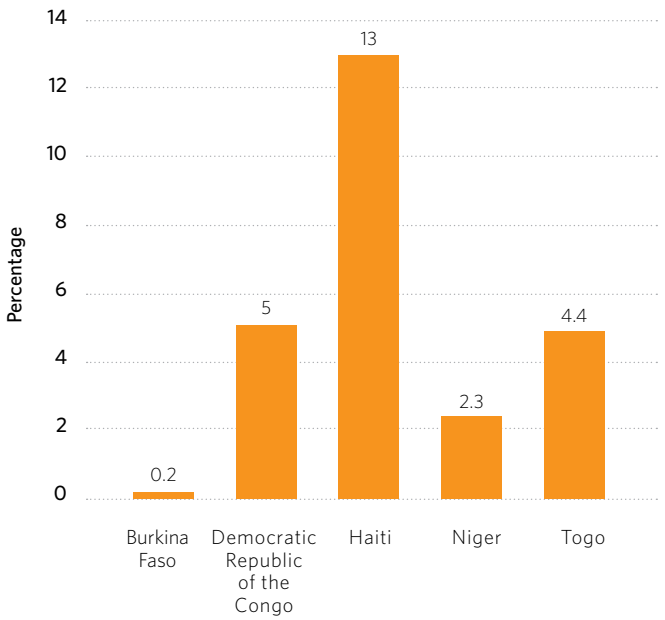
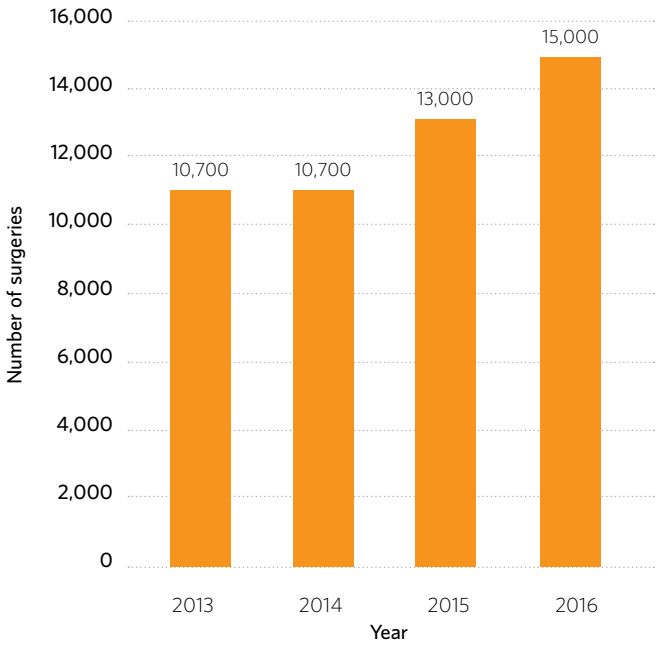


Figure 21: Increase in number of UNFPA-supported fistual repair surgeries during Phase II of the MHTF



- **Complementing** the scale-up of treatment services with direct support to fistula surgeries (without compromising quality, and in accordance with global standards as established by campaign partners such as ISOFS, Engender Health/Fistula Care Plus, FIGO, the Royal College of Obstetricians and Gynaecologists, etc.). As shown in Figure 21, in 2016, over 15,000 fistula surgeries were supported by the MHTF, about 3,000 more than in 2013.

Finally, the MHTF supported 19 countries in ensuring that the needs of the youngest pregnant women were explicitly addressed in health facilities, and in national policies and strategies that impact their access to SRHR. Seventeen countries supported the development and operationalization of outreach strategies targeted to FTYM.

Mozambique conducted community sensitization and outreach in four provinces (Cabo Delgado, Nampula, Sofala and Zambezia) to prevent child, early and forced marriage and support FTYMs. Madagascar is promoting free maternal health and family planning services for FTYMs who are 15 to 19 years of age through home visits, friendly health centres and sensitized health workers.

Liberia started an action research project in 2014 in the suburbs of Monrovia that aimed to provide adolescent and young women with access to antenatal care, delivery and postnatal care as well as family planning services. The project targeted 770 pregnant FTYMs through "big belly clubs" (the term big belly is a local term for a pregnant woman). Community health workers (also known as "big sisters") were recruited and trained to provide individual or group counselling to the girls registered in each big belly club. A total of 10 big sisters and a number of health-care providers, including midwives, conduct monthly club meetings at health facility and community levels to educate FTYMs on safe motherhood practices. The main material used during sessions is a locally designed booklet and flip chart with illustrations and easy to read text concerning what to expect during each month of pregnancy and after birth, and hygiene during and after pregnancy. From 2015 to 2016, almost all pregnant FTYMs attended at least one antenatal care visit, and of the 492 who enrolled during their first and second trimester, 295 (60 per cent) attended at least four visits before their delivery date.[26]

26 Source: Liberia UNFPA country office, 2016.

Student midwives responding to questions in class at the School of Midwifery, Makeni, Sierra Leone. © Suliaman Stevens, UNFPA, 2016. Photo submitted by Margaret Mannah-Macarthy for the 2017 MHTF photo contest.

4.2 Quality of care

"Every woman, every newborn, everywhere has the right to a good quality of care and this care must be appropriate, evidence based, timely and respectful." This is the guiding message of the 2016 Lancet Maternal Health Series.[27]

Quality of care requires appropriate use of effective clinical and non-clinical interventions, strengthened health infrastructure, and optimum skills and attitudes among health providers. Quality of care is considered a key component of the right to health, and the route to equity and dignity for women and children.[28]

During Phase II, the MHTF focused on improving the quality of health services delivery in its five thematic areas. Since the competence and qualifications of the health workforce are major factors in this objective, a major MHTF achievement has been its support for improving the quality of pre-service education for **midwives**. This has included:

- The **alignment of the national curricula** of midwives to international ICM/WHO standards. By 2016, 95 per cent of MHTF-supported countries (37 out of 39) had their national curricula aligned with the standards, covering about 75 per cent (752) of the 997 public schools in the 39 countries.[29] UNFPA, through the MHTF, has gone a step further in strengthening pre-service education for midwives by supporting the development of higher education programmes for them (i.e., bachelors and masters programmes) in seven countries: Afghanistan, Ghana, Lao People's Democratic Republic, Liberia, Pakistan, Somalia and Uganda.

- **The creation of links** between midwifery schools and B-EmONC facilities that serve as practicum sites for students. By 2016, all MHTF-supported countries, except Chad, had their pre-service midwifery education programme linked with B-EmONC facilities, in line with their recent adoption of ICM standards to improve the quality of initial trainings for midwives. This entailed training 710 tutors in pre-service training centres in 16 countries and the set-up of an accreditation mechanism for pre-service training centres in another 11 countries (from 13 in 2013 to 24 in 2016).[30]

- **The strengthening of over 300**[31] **midwifery schools** for improving competency-based skills training through the provision of essential equipment, teaching and learning materials, and the improvement of clinical and teaching skills of teachers and tutors. In 2016, the MHTF provided training material to 10 schools in Chad, 11 in Nigeria, 10 in Cameroon, 23 in Ghana, 8 in Rwanda, 2 in Zambia and to the Kabul Medical University in Afghanistan.

27 The Lancet Maternal Health Series, September 2016.

28 "Conducting a Sexual, Reproductive, Maternal, Newborn and Adolescent Health Workforce Assessment – A Handbook". WHO and UNFPA, 2015.

29 Source: Annex 4, Results Indicators Framework (RIF).

30 UNFPA annual MHTF-supported country survey, 2017 (2016 results from 39 surveyed countries, complementing the RIF).

31 Source: Annex 4, Results Indicators Framework (RIF).

The WHO defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people-centered."

Christine, a midwife trained with UNFPA support, providing antenatal services at the University Teaching Hospital in Lusaka, Zambia. © Jenipher Mijere, UNFPA. Photo submitted by Precious Zandonda for the 2017 MHTF photo contest.

The MHTF also supported countries to improve the skills of midwives already deployed in health facilities (in-service training), using various approaches and tools. Such trainings involved both ministries of health and national midwifery associations, and covered both clinical skills and respectful maternity care. In order to ensure the effectiveness of in-service training in improving the quality of services for women and newborns, the MHTF has backed onsite training of teams of midwives through mentorship programmes. These were developed in collaboration with other stakeholders in seven countries: Burkina Faso, Ethiopia, Kenya, Madagascar, Malawi, South Sudan and Zambia. Figure 22 highlights key elements in three of these countries.

Other examples of capacity-building were in Kenya and Zambia. In Kenya, the MHTF has enhanced the mentorship capacity of 87 midwifery tutors in collaboration with AMREF Health Africa. In Zambia, learning from Kenya, the midwifery mentorship programme was initiated in 2016 by conducting five national training of trainers' workshops. A national midwifery mentorship training package was developed for both facilitators and participants.

Figure 22 : Mentorship programmes in three countries, conducted in collaboration with other stakeholders

	Burkina Faso	Ethiopia	Madagascar
Year in which programme started	2013	2013	2013
Number of supported facilities	33	70	24
Number of supported midwives	72	40	NA
Number of mentors	29	40	19
Programme assessment	Yes	Not yet	Planned in 2017

Voices from a mentorship programme in Burkina Faso

Mrs. Claude Béatrice Sawadogo has been a midwife with a state degree for 14 years. She worked in an international NGO before joining the public service, practicing in Ouahigouya and then in Ouagadougou. After being trained to serve as a mentor, Ms. Sawadogo describes her first experience with mentoring.

"My first trip was to sector 4 in Reo, where I spent 72 hours.... So it was about going to stay with a male midwife, watch everything he does, with your experience, try to reframe some things, allow him to ask questions about certain things. When you say staying, it is really to stay, to be there, because the very idea of mentoring is to be accommodated by your mentee. That is to say that from his reception of the patient to the caring and even his integration in his environment, you as a mentor there, you must be able to act on what you think is not going well...."

She provides help to solve clinical problems and improve clinical practices. She also helped her mentee with the management of abortion cases.

"Well, he could not handle the situation even if he had been trained for manual vacuum aspiration. But he says, for example, that since training he has not practiced. Well, he was afraid to practice. ...he was ready to evacuate the woman there to the hospital in Reo so that the midwives could take them. I say no, it is not a matter of operating facility, over there it is a male or female midwife who is going to take care of the woman. I say you have the equipment? He says yes. I say show me. He shows the equipment. I say we'll do the manual vacuum aspiration (MVA) together. And indeed it was the first time he had done MVA since his training...at least for the 72 hours, he was able to do three MVAs while I was there."

Source: Extract from S. Kouanda, 2016, "Evaluation du système de mentorat dans deux directions régionales de la santé au Burkina Faso. Rapport provisoire."

Other interventions supported by the MHTF for improving the clinical and non-clinical skills of midwives included:

- **Support for supportive supervision of midwives**. Since 2013, 10 more countries have set up such interventions, which need to be complemented by a mentorship programme. In 2016, supportive supervision of midwives was strengthened in Benin, Burkina Faso and Côte d'Ivoire.

- **Support the development of a national in-service clinical refresher training package/manua**l. In 2016, support was provided to Pakistan for developing a national standardized in-service clinical refresher training package/manual to enhance the knowledge and hands-on skills of deployed community midwives through 20 qualified master trainers across the country.

- **Support to distance learning for midwives** (through videos, e-learning), especially for basic clinical skills and non-clinical skills. In Ethiopia and the United Republic of Tanzania, innovative training methodologies like a portable mobile learning system (further described in Section 2.4, p. 11) were piloted to enhance the quality of pre-service programmes (ICM-FIGO-WHO competency-based standard, accredited EmONC centres). In Zambia, in collaboration with the national association and the Swedish Embassy, the Midwives4All campaign was implemented in the north-western province. The campaign aimed to strengthen the role of midwives in adolescent sexual and reproductive health services. The knowledge and skills of 68 midwives from 10 districts were strengthened to improve adolescent sexual and reproductive health and youth-friendly health services. The knowledge and skills of 200 teachers and other health-care providers in comprehensive sexuality education were also improved by engaging the midwifery association.

In all MHTF-assisted countries, EmONC needs assessments and midwifery workforce assessments have been critical in helping the Ministry of Health identify critical MNH knowledge and capacity gaps in staff, including for the management of emergencies. In most countries, they have highlighted that staff knowledge in EmONC is not satisfactory. As an example, Figure 23 provides a knowledge assessment of midwives in three key areas of maternal health in four countries.

In addition to strengthening the education of midwives, the quality of care improved by bolstering the regulatory aspects of midwifery practice through support to midwifery councils and other regulatory bodies in all MHTF-assisted countries. Midwifery councils or boards are accrediting midwifery schools, establishing codes of conduct and ethics, setting the scope of practice of midwifery, addressing complaints, and licensing and relicensing midwives.

Figure 23: Percentage of midwives with knowledge on three key maternal health-care concerns.

	Guinea	Malawi	Senegal	Timor-Leste
EmONC needs assessment year	2013	2014	2014	2016
Knowledge of which pregnant women are at risk	NA	35%	43%	37%
Knowledge on active management of the third stage of labour	1%	65%	68%	88%
Knowledge on heavy bleeding management	2.7%	71%	59%	73%

Source: EmONC needs assessments to define requirements for mentorship and in-service training

Figure 24: EmONC indicators on quality of care in countries in 2016

	Benin	Burkina Faso	Cameroon	Madagascar	Nepal	Timor-Leste	Togo
Case fatality rate per direct obstetric complications (%)	4.8	1.2	1.2	1.21	Less than 1%	0.8	1.2
Intra-partum and very early neonatal death rate (%)	21	34	21	25.4	NA	12	68

Source: 2016 EmONC national survey of these selected countries.

Having a sufficient number of **EmONC** facilities[32] functioning 24/7 is vital for the provision of quality maternal and newborn care. Some EmONC indicators promoted by the MHTF to monitor quality are:

- **Case fatality rate per direct obstetric complication**, which gives the proportion of obstetric complications that led to maternal deaths (according to WHO standards, it must be below 1 per cent); and
- **Stillbirth rate and neonatal death rate**, which reflect the capacity of staff to manage neonatal emergencies.

Figure 24 and Figure 25 display these indicators at national level for seven countries, and the related number of complications for Madagascar and Togo. Data are also available at facility level, making possible analysis and evidence-based decision-making to address and improve the health services.

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 on a regular basis, and to address gaps in the availability and quality of MNH services, including EmONC, at the national, subnational and facility levels (see the previous section on equality in access for a detailed description of the approach). Since its implementation in Madagascar, this monitoring has been combined with the recording of maternal and newborn deaths in EmONC facilities.

In addition, the MHTF in Phase II is supporting:

- Twenty countries to update their obstetric and neonatal care protocols in facilities;
- The development (in collaboration with partners) of EmONC standardized protocols that serve as a reference in treating obstetric complications; and
- Countries to develop national standards for B-EmONC as an extremely important basis for quality audits. To date, only Burkina Faso, Guinea, Haiti, Togo and Timor-Leste have defined these standards. They are among the most advanced in EmONC development and have improved the quality of care.

Another important MHTF contribution to the improved quality of EmONC services came through support to national **MDSR** systems, particularly to improve the quality of

32 Basic signal functions: 1) antibiotics to prevent puerperal infection, 2) anticonvulsants for treatment of eclampsia and preeclampsia, 3) uterotonic drugs (e.g., oxytocics) administered for post-partum haemorrhage, 4) manual removal of the placenta, 5) assisted or instrumental vaginal delivery, 6) removal of retained products of conception and 7) neonatal resuscitation.

Figure 25: Overview of data collected on a quarterly basis in all EmONC facilities of Madagascar and Togo in 2016

	Madagascar		Togo	
Obstetric activity in 2016	In the national network of EmONC facilities	In the EmONC facilities of the national network supported by UNFPA	In the national network of EmONC facilities	In the EmONC facilities of the national network supported by UNFPA
Normal deliveries	42,318	6,015	59,137	21,221
Assisted vaginal deliveries	3,403	251	1,080	505
C-section	1,232	814	16,850	3,316
Haemorrhage	1,137	237	2,348	1,329
Prolonged or obstructed labour	1,389	1,585	8,547	NA
Ruptured uterus	179	30	NA	NA
Post-partum sepsis	321	77	298	144
Pre-eclampsia or eclampsia	438	93	2,439	942
Complications of abortion	809	168	388	NA

Source: Data collected on a quarterly basis in Togo and Madagascar for the 2016 EmONC national survey in these 2 countries.

maternal deaths reviews, and ultimately to drive actions to reduce maternal deaths. MDSR contributes to higher quality of care by strengthening accountability at all level of the health system. It is further described in the next section on accountability.

Quality of care is also an important aspect of MHTF's work on **obstetric fistula**. Capacity building of obstetric fistula surgeons and surgical care teams has been a cornerstone of the UNFPA-led Campaign to End Fistula's work, which has included:

- Supporting some of the world's leading surgeons from the International Society of Obstetric Fistula Surgeons (ISOFS) to conduct skills-building workshops at key global meetings (e.g., FIGO, the International Urogynecological Association) and convening key stakeholders to share the latest knowledge and strategies through the biennial International Obstetric Fistula Working Group (IOFWG) meeting.

- Enabling training and mentoring of local fistula surgeons in countries that face a severe capacity deficit.

- Brokering "South-South" collaboration to extend access to the highest quality fistula treatment and care, and to global excellence in teaching competency-based fistula surgery.

- Improving the working conditions of surgeons and health providers with the procurement of two types of fistula repair kits with all necessary items for surgical repairs. The kits were designed in collaboration with expert fistula surgeons from ISOFS. The MHTF ensures that these kits can be procured and distributed whenever needed.

- Fostering knowledge exchange on quality care for fistula treatment by producing quarterly e-bulletins, which highlight the latest research publications, relevant tools and resources in the field, along with news and updates from the United Nations and other partners.

Since **FTYM** was introduced only in 2014 as a fifth focus area of the MHTF, countries that have developed interventions in this area are still at initial stages of implementation. Most have focused on improving access to services that address the specific needs of FTYM. Bangladesh and Kenya have decided to address both access and quality issues in their support.

In 2016, Bangladesh, in collaboration with Jhpiego, conducted a baseline study on respectful maternity care, with a specific focus on FTYM. A major finding was that midwives are not aware of the developmental needs of young mothers, and often treat them like children in their communications. This led to the organization of a two-day training of 22 selected midwives from three rural hospitals, followed by on-site mentoring of midwives to improve the quality of care for FTYM. This approach will be scaled up to 38 rural hospitals in 2017.

In Kenya, a country with high teenage pregnancy at 103 per 1,000 girls aged 15 to 19, the government has decided, with MHTF support, to increase access to skilled care in the continuum from pregnancy through delivery and the post-partum period. This is being done in Kilifi County, which has the 12th highest teenage pregnancy rate. Two health facilities (Kilifi County Referral Hospital and Mtwapa Health Centre) were selected to improve the quality of care, with a specific focus on care for FTYM. In 2016, 520 FTYM benefited from the programme, which included two major interventions:

- Enhancing the skills of health care workers on quality, youth-friendly services; and

- Training community health volunteers and peer educators to identify and provide support to FTYM, including support for referrals.

Leveraging the experience in Kilifi County, the Ministry of Health, with support from UNFPA, is revising the national training manual for community health workers to include support to FTYM.

4.3 Accountability

As mothers and their newborns are at highest risk of death and morbidity during labour, childbirth and the first week after birth, investing in improved access to and quality of care, especially through developing and strengthening the midwifery workforce and EmONC, are essential. Despite being priorities for the global health community since the Safe Motherhood Conference of Nairobi in 1987, however, the deficit in midwifery workforce availability is still high and the coverage of EmONC services is still low in most MHTF-supported countries. Only a few are able to regularly analyse key MNH indicators, and address gaps in the availability and quality of services. Among the consequences of poor midwifery care and the limited availability of EmONC services are the risks for millions of women and girls of

Two teen girls participating in UNFPA's First-Time-Young-Mother programme waiting for medical treatment in the "Star of the Sea Hospital" in Monrovia, Liberia. © Lothar Mikulla, UNFPA, 2016. Photo submitted for the 2017 MHTF photo contest.

dying or being affected by sometimes lifelong ill-health and disabilities such as obstetric fistula.

To support countries in addressing these gaps, and to ensure accountability and ownership at all levels of the health system for improving access to quality care, the MHTF contributes to strengthening governance and coordination mechanisms; to generating, sharing and enabling the use of data; to empowering health system stakeholders and beneficiaries; and to raising awareness on these issues through global, regional and country advocacy.

4.3.1 Governance and coordination

Midwives are at the forefront in guaranteeing the rights of women and newborns to receive quality and respectful care. The MHTF supports countries to secure an enabling professional environment for them towards ensuring their own professional accountability to their patients. In fact, many midwives in the 39 MHTF-supported countries still work in difficult, unsafe, isolated and poorly equipped settings, experience gender-based violence, struggle with poor salaries and working conditions, and lack access to continuing professional development. All of these factors impede quality of care. 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."*[33]

To improve the professional environment for midwives and strengthen accountability for ensuring the access of women and newborns to quality care, the MHTF has supported countries to reinforce the regulation of midwifery practice, including through registration and licensing, and the accreditation of education programmes as well as continuing professional development frameworks. Regulation is critical to ensure that midwives have an identified scope of practice and follow a proper code of ethics, that schools are accredited and follow a curriculum per international standards, that a register of qualified midwives is maintained to support needs-based deployment, and that mechanisms are in place to maintain quality of care standards and to address gaps.

One of the major areas of MHTF support has been in ensuring that countries have an autonomous midwifery council or board that is either standalone, or part of the nursing council or another government body. During the second phase of the MHTF, six more countries have established a regulatory body or midwifery council, bringing the total to 29 (74 per cent of the 39 countries supported by the MHTF). Fourteen of these countries have a defined scope of practice for midwives. Since 2013, the MHTF has also supported 26 countries (66 per cent) to establish accreditation mechanisms for midwifery schools, with 17 having accredited more than three-quarters of their midwifery schools by 2016.

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

The strengthening of midwifery associations is another important component in creating accountability, as they have a critical leadership role to play in quality assurance of the midwifery programmes, in advocating and contributing to the establishment of standards of education and regulation, and in defining the scope of practice for the profession, including opportunities for career development as well as promotion and incentives for retention. The MHTF has specifically contributed to reinforcing the capacity of national and subnational midwifery associations in all supported countries. It has played a major role in the creation of the national midwifery association in 26 countries (66 per cent), for example, in 2016 in Kenya, and has supported the set-up and functioning of 176 subnational associations in 17 countries. Furthermore, with MHTF support, 27 countries (69 per cent) have assessed the capacity of the national midwifery association using the ICM assessment tool (MACAT) for the last five years. These assessments have informed strategies and actions to address areas of weakness, including where national midwifery associations have developed strategic costed plans to guide their actions for the next four to five years.

As part of its commitment to support countries to improve the quality of care and to strengthen accountability at all levels of the health system, the MHTF has helped 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. The MHTF has particularly supported countries to develop the four components of an MDSR programme framework (detailed in Chapter 3 on key results). Compared to 2013, 11 additional countries have a complete or partial MDSR framework, for a total of 31 countries in 2016.

Finally, the MHTF has helped countries set up a national taskforce for supporting the development, implementation and monitoring of a national strategy and action plan to end obstetric fistula. Since 2013, six additional countries have done this, for a total of 27 (70 per cent).

4.3.2 Implementation monitoring – strengthening data collection, analysis and response systems

The MHTF is supporting countries to monitor maternal health programmes by strengthening data collection, analysis and response systems. These are used to address gaps in access and quality of care.

MHTF contributions include the development and dissemination of the data-rich second *State of the World's Midwifery* report (2014). It features 73 midwifery country profiles where more than 92 per cent of all maternal and newborn deaths and stillbirths occur. In addition to supporting policy dialogues on midwifery workforce availability and met need, education, regulation and association, the report also contributes to future strategic planning by providing estimates and projections of the midwifery workforce by 2030 and changes in met need. Thirty-four countries (87 per cent) have used evidence generated by the report to promote national policy advocacy for addressing barriers and challenges to the availability, accessibility, acceptability and quality of midwifery services, in particular, the midwifery workforce. With MHTF support, UNFPA's 15 country offices in the Arab States region developed a regional midwifery report in 2015; UNFPA offices in Eastern and Southern Africa are preparing a similar report in 2017.

Since 2013, the MHTF has supported midwifery workforce assessments in five countries (Afghanistan, Bangladesh, Mozambique, Ethiopia and the United Republic of Tanzania) and gap analyses in 28 countries, with specific collaboration with the ICM in 21 francophone countries. Overall, about 33 countries (85 per cent) have done a midwifery workforce assessment or a gap analysis in the last five years. Midwifery workforce assessments allow countries to review the implementation of midwifery programmes and to model projections of midwifery service needs, workforce demand and supply to inform costed scenarios and policy options for improving equitable access to quality midwifery services. Gap analyses are lighter assessments to support countries in identifying key gaps in midwifery education, association and regulation according to ICM standards, and to systematically address them. As described, p. 36 in "The Accelerated Midwifery Training Programme in Ethiopia", the MHTF also supports performance assessments of midwifery programmes to ensure evidence for scale-up.

The MHTF helps ministries of health to regularly collect and analyse data on the midwifery workforce, an area of work that will require further focus in the future. Since 2013, four countries have established a midwifery data registry and regularly update it (at least once a year). Four countries generate regular data (at least once a year) on midwifery workforce availability and deployment. A total of 10 countries have regular data on midwifery workforce availability and deployment and 17 countries (43 per cent) have an updated midwifery data registry.

Since 2013, the MHTF has also supported 11 countries to conduct national EmONC needs assessments, and 13 countries have developed and implemented a costed national plan for increasing the number of functioning EmONC facilities. Beyond supporting the implementation of the assessments, the MHTF is contributing to the revision of EmONC needs assessment collection and analysis tools, with a major revision in 2015 to further focus on newborn health.

During Phase II, the MHTF has supported the development of the MDSR programme framework, including the set-up of national MDSR committees. Seventeen more countries have established the committees, increasing in number from 6 countries in 2013 to 23 in 2016. The MHTF also backed the implementation of MDSR in facilities and districts. As shown in Figure 26, the number of countries with national level implementation significantly increased from 11 in 2014 to 27 in 2016.

As a complement to monitoring the midwifery workforce and the availability and quality of EmONC services, the MHTF has supported health system capacities to report and analyse maternal deaths, and to monitor the coverage and performance of MDSR by promoting the use of the maternal death notification rate (number of maternal deaths notified/expected maternal deaths) and the maternal death review rate (number of maternal deaths reviewed/expected maternal deaths). Eleven more countries, from 20 in 2013 to 31 in 2016, are monitoring the performance of the MDSR system by regularly collecting the number of maternal deaths notifications and maternal deaths reviews, including 28 countries that include these data in their health information system.

Such monitoring of MDSR implementation is particularly important because, as highlighted in the quality of care section, despite progress in the availability of MDSR frameworks, countries are still facing implementation challenges that are reflected in low notification and review rates. Implementation of the MDSR programme is still in its early stages, with an average for the MHTF-supported countries of 21 per cent of expected maternal deaths notified (ranging from 1 per cent to 59 per cent), and 12 per cent of expected maternal deaths reviewed (ranging from 1 per cent to 43 per cent). Only seven countries were reviewing more than 20 per cent of estimated maternal deaths in 2016 (see Figure 27).

To increase awareness of these implementation challenges, the MHTF has developed MDSR country profiles to highlight

The Accelerated Midwifery Training Programme in Ethiopia

In Ethiopia, a performance assessment of the Accelerated Midwifery Training Programme was carried out with MHTF support in 2016. This programme aims to improve access to quality sexual and reproductive health services in remote areas by supporting midwifery schools and training nurses to become professional midwives. The programme has been supported since 2009 by the MHTF and specific funding from the Swedish International Development Agency. Between 2011 and 2015, the MHTF helped train 4,471 midwives in 15 health sciences colleges in six regions, which aided Ethiopia in achieving its target of training 8,635 midwives under the United Nations Secretary-General's Global Strategy for Women's and Children's Health (2010-2015). The MHTF also supported 33 midwifery training institutions with lab equipment, books and vital teaching materials, and helped establish a new midwifery school in the Gode region bordering Somalia.

A performance assessment found that the programme has boosted the number of midwives in the country and their equitable distribution. According to data from 91 district health offices, almost all (99 per cent) of programme graduates were assigned to health centres. A vast majority of health centres now have two midwives (or three in the bigger centres); the total numbers of antenatal visits and deliveries at the centres have seen a significant increase with a 48 per cent rise in normal deliveries. In family planning, a large increase in the use of long-acting contraceptive methods has been noted.

In 2016, over 88 per cent of graduates reported having a supervisory visit in the past 12 months, and rated the supervision as being good or satisfactory.

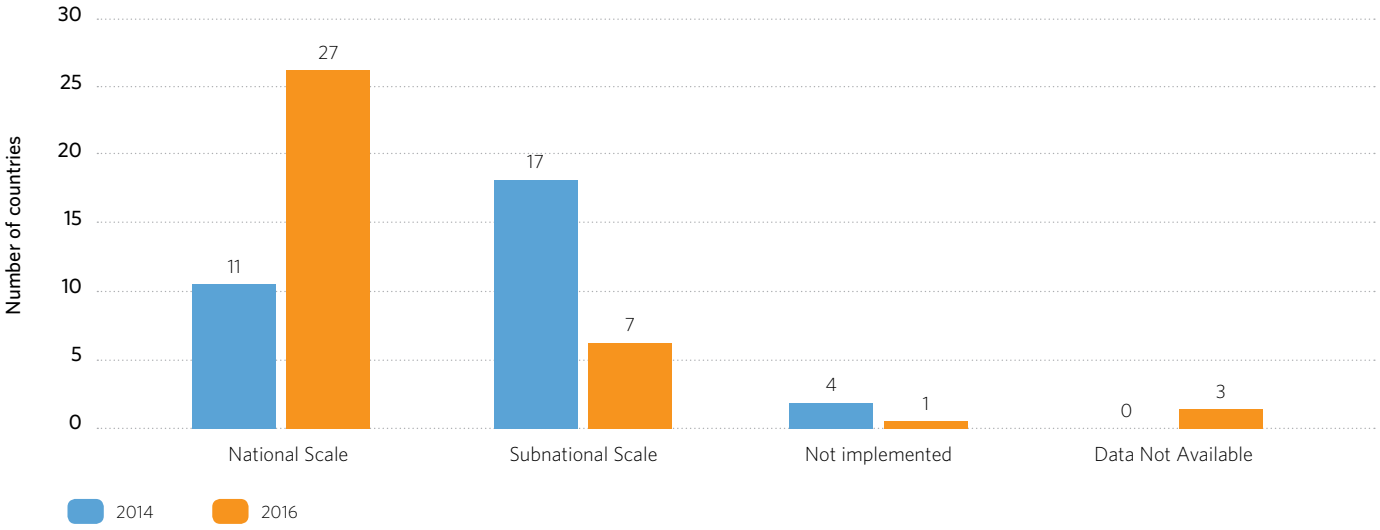
changes since 2014 in MDSR frameworks, reporting and performance in terms of notifications and reviews (See examples: Figures 28 and 29).

The MHTF also supports countries to strengthen the analysis and quality of MDSR reporting through the development of an MDSR annual report. With only 15 countries developing a national MDSR annual report, however, additional efforts are required. In most countries, the rate of maternal deaths review is still low and only based on facility data, and excludes community-based data that is more difficult to collect. These biases make maternal deaths trends analysis not yet possible at subregional and subnational levels. The quality of the reviews also remains very challenging due to funding constraints and the limited number of staff trained to perform them.

An estimated 2 million women and girls live with obstetric fistula, and 50,000 to 100,000 new cases occur each year.[34]

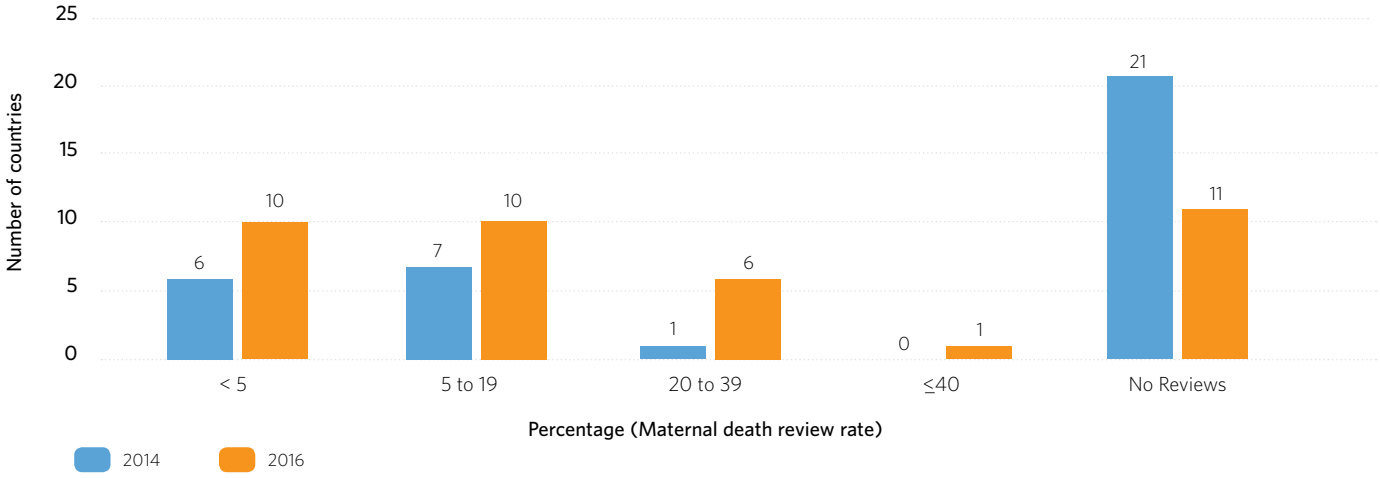
34 Source: WHO "10 facts on obstetric fistula", updated May 2014: http://www.who.int/features/factfiles/obstetric_fistula/en/ accessed on 17/08/2017.

Figure 26: The scale of MDSR programme implementation in countries in 2014 and 2016



Note: For 2016, data were not available for Somalia, South Sudan or Yemen.
Source: UNFPA annual MHTF-supported country survey, 2017 (2016 results from 39 surveyed countries, complementing the RIF)

Figure 27: Maternal death review rate in countries in 2014 and 2016



Source: UNFPA annual MHTF-supported country survey, 2017 (2016 results from 39 surveyed countries, complementing the RIF)

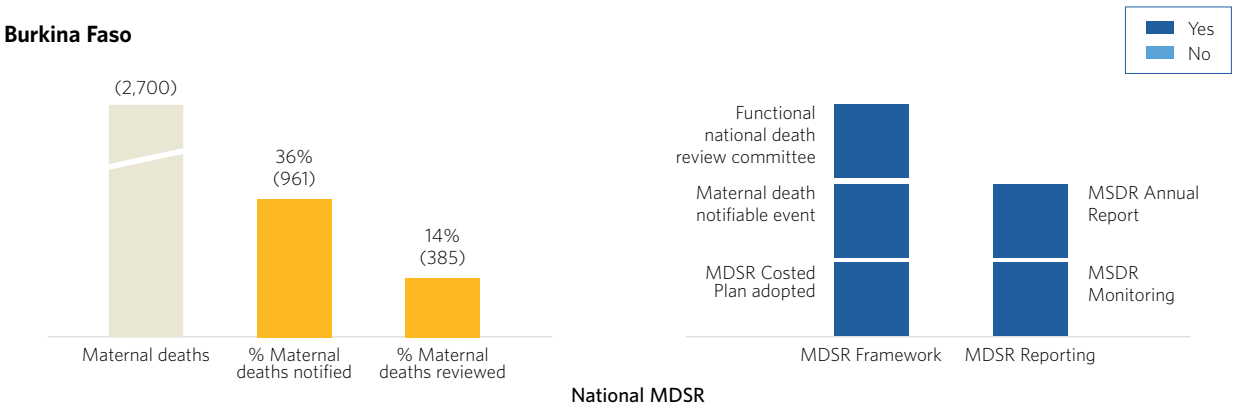
As obstetric fistula largely affects poor and marginalized women and girls, it is challenging to identify them, and for countries to regularly collect data to estimate the prevalence and incidence of obstetric fistula. Nonetheless, the MHTF has supported countries to strengthen this data. By 2016, 20 countries had reinforced their systems to identify and register new obstetric fistula cases; 30 countries were monitoring an obstetric fistula programme, including improving the tracking of the success rate of fistula repairs. At the global level, the MHTF has also assisted, through the Campaign to End Fistula and in collaboration with the WHO, a strategic initiative to make fistula a nationally notifiable condition. It is collaborating with Jhpiego to make the first global estimates of obstetric fistula prevalence and incidence available in 2018.

4.3.3 Empowerment and advocacy

MHTF support for the leadership and empowerment of midwives occurs 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 and treatment.

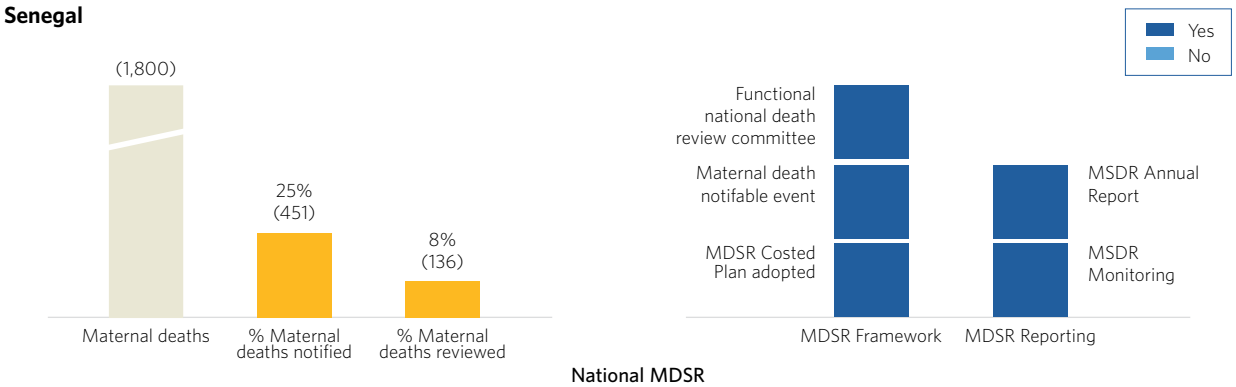
In collaboration with its partners, the MHTF in 2016 launched a global initiative to engage and strengthen the advocacy capacities of the next generation of **young midwifery leaders**, who can foster innovations, engage in health systems strengthening, and help build national commitments and midwifery capacities. This has served as a platform for empowering young midwives and the profession as a whole.

Figure 28: A profile of the maternal death surveillance and response system in Burkina Faso



Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division Geneva: World Health Organization, 2015 and UNFPA annual MHTF-supported country survey, 2017.

Figure 29: A profile of the maternal death surveillance and response system in Senegal



Source: Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division Geneva: World Health Organization, 2015 and UNFPA annual MHTF-supported country survey, 2017.

Since 2008, the MHTF has been supporting the institutionalization of the International Day of the Midwife on 5 May as a major advocacy opportunity to build awareness among stakeholders, policymakers and the public on the central role that midwives play in access to quality sexual and reproductive health care, and preventing maternal and newborn mortality and morbidity. The day is also a chance to stress the need to invest in and motivate midwives. In the 39 MHTF-supported countries, events to mark the day take place in collaboration with national and subnational midwifery associations, ministries of health, civil society and other partners, and include public marches of midwives, multimedia broadcasts, public debates, free family planning, testing for HIV and sexually transmitted infections, and breast and cervical cancer screening camps.

Assisting interventions for the social reintegration and rehabilitation of women treated for obstetric fistula is another way that the MHTF advances empowerment. One example is Ethiopia, where women who receive surgical treatment to repair their fistulas (approximately 400 women in 2016 with MHTF support) are referred to an institution called Healing Hands of Joy, where they get training in income-generating activities as well as on becoming safe motherhood ambassadors who can educate their communities on obstetric fistula and the importance of delivering with a skilled birth attendant. They also identify and refer possible fistula cases for treatment.

To accelerate progress towards ending obstetric fistula, a number of key advocacy initiatives were undertaken with MHTF support at the global, regional and country levels. These initiatives were conducted as part of the Campaign to End Fistula, where more than 90 global partners operate in over 50 countries across Africa, Asia and the Pacific, the Arab States and Latin America and the Caribbean. At the global level, advocacy efforts reached a new height when, on 23 May 2016, the International Day to End Obstetric Fistula, United Nations Secretary-General Ban Ki-moon called upon the world "to end fistula within a generation." This message was reinforced by the late UNFPA's Executive Director, Dr. Babatunde Osotimehin, and was announced to the international community by the UNFPA-led Campaign to End Fistula at the fourth Women Deliver conference

Global Midwifery Symposium: "Young Midwives in the Lead"

In 2016, with MHTF support, UNFPA launched a global initiative to engage and build the capacities of the next generation of young midwifery leaders, towards the attainment of the SDG on health. The purpose was to identify and support a cohort of young champions and leaders who could engage in national policy dialogue and advocacy to help improve the quality of midwifery care, and promote a conducive environment for midwives to practice their profession.

At the 2016 Women Deliver Conference in Copenhagen, Denmark, UNFPA organized the **Third Global Midwifery Symposium**, entitled "**Young Midwives in the Lead**," in collaboration with the ICM, the WHO, Jhpiego, the USAID Maternal and Child Survival Program, Johnson & Johnson, AMREF Health Africa, the Danish Midwives Association and a host of other partners. Thirty-two young midwifery leaders from 31 countries were selected to attend from a pool of over 700 applicants. At the symposium, they took part in leadership and communications skills training, engaged with global SRMNH leaders and practitioners on using evidence-based arguments, and built their understanding of the role of midwifery in the 2030 Agenda.

The outcome of the symposium was a **Declaration of Commitment** by the young midwifery leaders and the launch of a **Facebook networking platform**. By the end of 2016, the platform boasted over 1,000 members who were actively exchanging stories, resources and concerns through live South-South exchanges. Most of the symposium participants, after returning to their countries, have been exercising leadership roles in promoting their profession through the national association, training institutes and regulatory bodies. They have been promoting respectful maternity care, improving breastfeeding practices, advocating for more mother- and baby-friendly health facilities, and applying research and scientific evidence in engaging with policymakers in making midwifery an autonomous and well-supported profession.

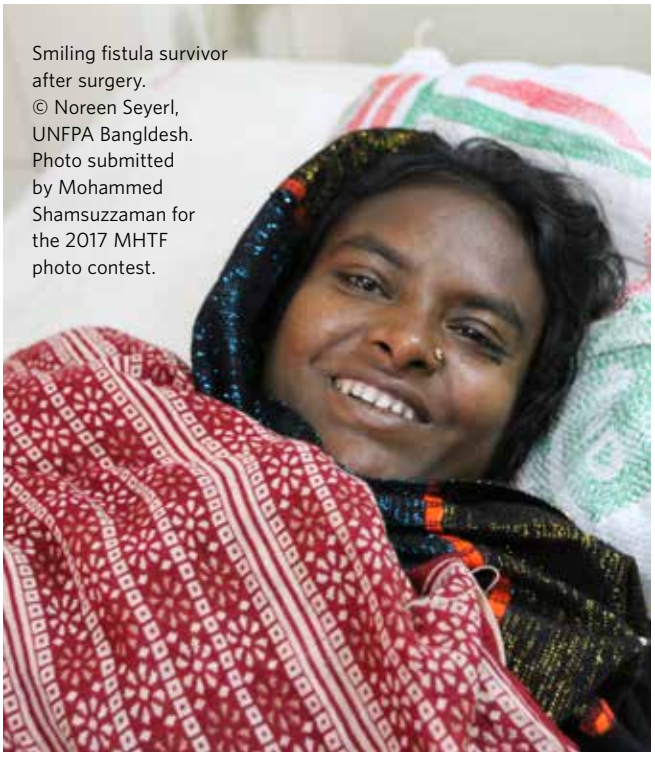
As (former) United Nations Secretary-General Ban Ki-moon noted in his 2016 report on intensifying efforts to end obstetric fistula, fistula is a stark reminder of health systems' failures to meet the needs of women and girls, and fistula survivors are the living testimony to the severe consequences of lack of timely and high quality, life-saving care.

in Copenhagen, Denmark. This vision and goal were also enshrined in a report from the Secretary-General and an accompanying resolution[35] on ending fistula passed in the United Nations General Assembly in late 2016 (co-sponsored by more than 130 countries).

MHTF support helps countries celebrate the International Day to End Obstetric Fistula, which aims to increase government leadership, ownership and buy-in; to sensitize the public on fistula conditions; and to ultimately prevent, identify and treat cases of fistula. Thirty-four countries supported by the MHTF reported that from 2013 to 2016, awareness on fistula prevention, treatment and social reintegration rose. Twenty countries reported that the national capacity for resource mobilization for fistula had increased.

A number of governments strongly stepped up their leadership and ownership on the issue. For example, in 2016, Uganda hosted its first national conference focused on ending obstetric fistula. Recommendations from the conference included increased access to surgical treatment of fistula, and increased involvement of community health extension workers in the identification and referral of fistula cases. Stakeholders also advocated for greater attention to fistula by members of Parliament and for obstetric fistula to be included in the next national census.

MHTF support for the development and use of data and for advocacy campaigns has contributed to enhancing national commitments to strengthen midwifery, EmONC, MDSR and obstetric fistula work. Over 25 countries have made political commitments to these areas as part of their support to the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).



Smiling fistula survivor after surgery. © Noreen Seyerl, UNFPA Bangldesh. Photo submitted by Mohammed Shamsuzzaman for the 2017 MHTF photo contest.

A key high-level global and regional advocacy event was UNFPA's support, through MHTF funding, to a screening of the movie "Dry" to mark the 2016 International Day to End Obstetric Fistula. The screening took place in Gambia at the Banjul+10 Conference in commemoration of the African Youth Charter. *Dry* is a Nigerian film by actress/filmmaker Stephanie Okereke Linus that tells the story of a Nigerian girl forced to marry at a young age who later develops fistula during childbirth. Over 500 individuals attended the event, which not only raised awareness of fistula, but also encouraged proactive measures to combat the condition. During the event, the Gambian Vice-President called on relevant government agencies to develop a plan to end obstetric fistula in the country. This very important, strategic step forward in government leadership and ownership on ending fistula is essential towards ensuring equality in access to care for all, even those most "invisible" and "furthest behind" women and girls living with fistula.

35 A/71/306 dated 5 August 2016.

5 | RESOURCES AND MANAGEMENT

5.1 Background

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

In line with most multilateral organizations, more and more of UNFPA's resources are being earmarked for a specific purpose or region by donors. While it is positive that non-core resources continue to increase, it creates challenges for the organization to ensure that the many pockets of non-core funds are not deployed in isolation but work together towards the realization of UNFPA's Strategic Plan (2014-2017).

To that end, the Non-Core Funds Management Unit was established in the Office of the Executive Director with five specific goals: 1) increased harmonization with other funds, 2) closer integration with existing strategies and programmes, 3) increased transparency in decision-making, 4) a higher level of accountability in the management of non-core funds, and 5) enhanced standardization of practices and processes.

To meet these goals, the Non-Core Funds Management Unit established four priorities: a new non-core funds management policy, a frequent and standardized monitoring system, a needs-based resource allocation system as well a new work planning process with greater involvement of UNFPA's regional offices, and an earlier start to the planning process.

The changes related to work planning and resource allocation took effect in 2016, with the aim of transferring funds to country offices earlier in the year, and allocating resources in accordance with pre-defined, transparent criteria based on country needs (this drew on the previous allocation system). For the MHTF, the criteria and weighting in Figure 30 were

In 2016, the Thematic Trust Fund for Maternal Health had an operating budget of $16.8 million. It:

- Achieved an implementation rate of 92 per cent (against the approved allocation of $14.8 million), and 81 per cent against the total available operating budget.
- Allocated 78 per cent of its approved allocations ($11.5 million) for regional and country programmes in 39 countries. In addition, $800,000 was disbursed through global implementing partners for countries.

In 2016, the Thematic Fund for Obstetric Fistula had an operating budget of $447,982. It:

- Achieved an implementation rate of 75 per cent against the total available operating budget;
- Allocated 100 per cent of its expenditures for regional and country programmes, primarily in sub-Saharan Africa.

In terms of MHTF expenditures in countries, the EmONC programme intervention areas accounted for the largest share, at 39 per cent. Midwifery came second with 29 per cent followed by obstetric fistula at 27 per cent.

used to calculate the needs of programme countries and allocate resources accordingly.

In each category, each of the 39 MHTF-supported countries receive a score. Cumulatively, these form the basis for the annual resource envelope from the MHTF. To mitigate the impact of sudden changes in allocations, a cap limits budget reductions to 10 per cent from year to year.

In 2016, the MHTF continued to work in high maternal mortality countries in accordance with its programme agreement. Funds were allocated to activities in 39 countries and 2 regional offices, with one more country office than in 2015, due to the revitalization of the programme in Yemen. It paused in 2015 due to the situation in the country. The MHTF Team constantly reviews and assesses where and through which activities its resources can make the most significant contributions to the health and well-being of women and girls.

The MHTF's two funds have been programmatically integrated under the MHTF 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 2.5 per cent of overall funds for the MHTF and fistula programming was provided via the Thematic Fund for Obstetric Fistula.

Figure 30: MHTF resource allocation criteria and weighting

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

5.2 Thematic Trust Fund for Maternal Health

Contributions

As shown in Figure 31, $13.4 million was received by the Thematic Trust Fund for Maternal Health in 2016, a 7 per cent decrease from 2015, when it received $14.4 million.

Operating budget

The operating budget for the Thematic Trust Fund for Maternal Health in 2016 encompassed the end-of-year balance for 2015 plus income received during the first three quarters of 2016. 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.

As Figure 32 shows; the Thematic Trust Fund for Maternal Health received $13 million in the fourth quarter of 2015 to be used in 2016. An additional $2.9 million was carried over from the regular programme budget from 2015 to 2016. Further, $900,000 was received in donor contributions during the first three quarters of 2016. This brings the total operating budget for the Thematic Trust Fund for Maternal Health to $16.7 million in 2016, and the operating budget to $18.4 million (Figure 33).

Figure 31: Total donor contributions to the Thematic Trust Fund for Maternal Health in 2016

Donors	Recognized revenue* (US$)	Collected revenue (US$)*
Austria**	46,304	46,304
Friends of UNFPA		71,027
GE Health**	25,000	25,000
Germany***		832,408
Luxembourg**	1,521,739	1,521,739
Sweden**		10,868,384
TOTAL 2016	**1,593,043**	**13,364,863**

*Recognized revenue signifies new pledges in 2016, whereas collected revenue comprises the actual amounts transferred to UNFPA in 2016. 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.
**Received in the fourth quarter of 2016 and intended for programming in 2017.
*** Germany's additional contribution of Euro 900,000 will be recognized in 2017.

Expenses

In 2016, expenditures for maternal health through the Thematic Trust Fund for Maternal Health totaled $13,634,042, compared to $13.4 million in 2015 and $16.8 million in 2014.

During 2016, spending by country and regional programmes accounted for 77 per cent of expenditures, whereas global activities accounted for 23 per cent. Included in the global activities are disbursements of $800,000 to international implementing partners. When accounting for the fact that international implementing partners use resources for country and regional level operations, the distribution was 82 per cent for countries and regions, and 18 per cent for global activities.

Out of total expenditures, 15 per cent or $2 million was disbursed via NGOs; 30 per cent or $4.1 million was disbursed via a governmental partner; and 55 per cent, corresponding to $7.5 million was disbursed via UNFPA directly.

West and Central Africa accounted for most of the funds allocated to maternal health, with 32 per cent ($4.3 million) of the total. East and Southern Africa came second at 26 per cent ($3.5 million). Global allocations constituted 18 per cent ($2.4 million) with an additional 6 per cent ($800,000) channeled to NGOs and other institutions for their interventions, particularly at country level. Asia and the Pacific accounted for 10 per cent ($1.4 million), the Arab States for 5 per cent ($709,000), and Latin America and the Caribbean for 4 per cent ($581,000). See Figure 34.

Figure 32: Budget for the Thematic Trust Fund for Maternal Health in 2016

Donors	Contributions (US$)
Carry-over from 2015	2,908,525
Contributions received in the fourth quarter of 2015 for programming in 2016	12,960,580
Contributions received during first three quarters of 2016	903,435
TOTAL operating budget in 2016	**16,772,540**
Contributions received in the fourth quarter of 2016 (for the 2017 programme and therefore not included in the 2016 budget)	12,461,427

In 2016, expenditures on maternal health of $13.6 million represented a financial implementation rate of 75 per cent against the total operational budget of $16.8 million. The amount transferred to 39 country offices, 2 regional offices and headquarters units was $14.8 million. As in previous years, part of the budget was kept to manage unexpected issues faced by countries and regions, and variations in exchange rates. Against approved allocations, the implementation rate was 92 per cent in 2016. This compares to 87 per cent in 2015, where total approved allocations were $15.5 million and expenses were $13.4 million for 38 countries, 2 regional offices and headquarter units.

Figure 33: Operating budget for maternal health in 2014, 2015 and 2016

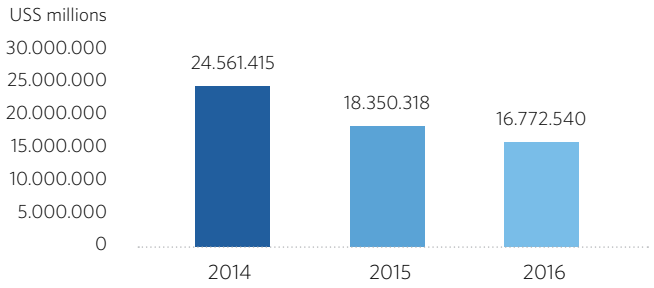
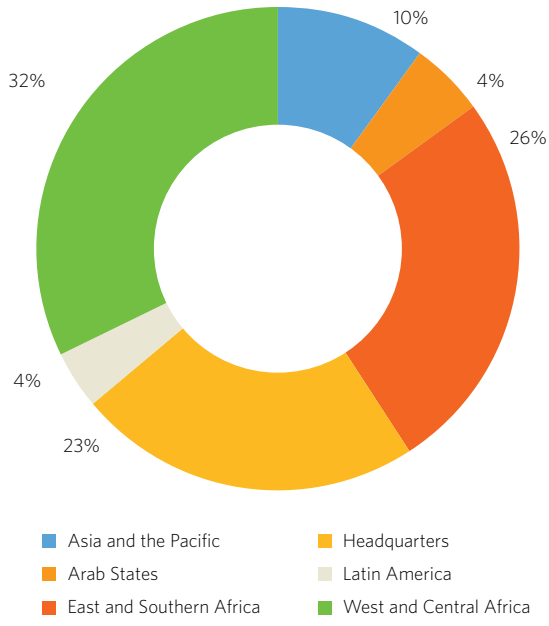


Figure 34: Shares of expenditures for maternal health by region, headquarters, NGOs and other institutions* in 2016



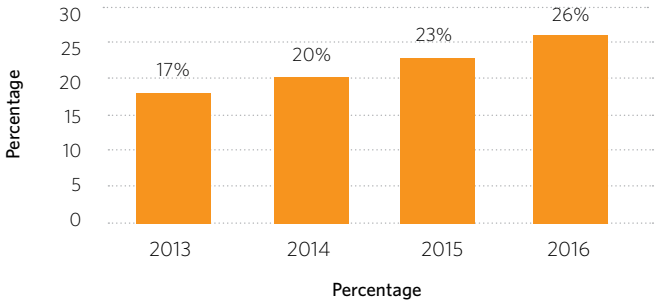
*Includes activities at headquarters and from partners (Implementing partners such as research institutions, NGOs, etc.) the majority of which are in support of the country level.

Categories of expenditure

As highlighted in Annex 1, the total allocation to country, regional and global programmes in 2016 was $14.8 million, and the corresponding expenses were $13.6 million. The corresponding figures for 2015 were $15.5 million and $13.4 million, respectively. In 2014, $17.6 was allocated to country, regional and global programmes of which $16.8 was spent.

Figure 35 shows that there has been a slight increase from 2015 to 2016 as a result of the recruitment of much needed technical experts and advisers in a number of priority countries[36]. The increase was by 3 percentage points over 2015 (Figure 35).

Figure 35: MHTF staff costs as a percentage of total expenditure



5.3 Thematic Trust Fund for Obstetric Fistula

Contributions

Figure 36 shows that donor contributions (collected revenues) in 2016 reached $366,824, almost the same as in 2015, where the collected revenue amounted to $370,269.

36 Staff at regional and global level are providing technical assistance and backstopping to country offices.

Operating budget

Figure 37 shows that the operating budget for the Thematic Fund for Obstetric Fistula for 2016 was significantly larger than contributions received in 2016 because it included carry-over funds from 2015. Contributions received in the fourth quarter are not included in the operating budget since they are intended for programming in 2017.

Figure shows how the 2016 operating budget for the Thematic Fund for Obstetric Fistula compared to 2015 and 2014. The downward trend is not an indication of failing support to fistula, but reflects the tendency for more funds to be channeled through the Thematic Trust Fund for Maternal Health.

Expenses

The Thematic Fund for Obstetric Fistula's 2016 expenses totaled $334,119 compared to $264,148 in 2015 and $491,968 in 2014 (Figure 38).

Figure 37: Operating budget for the Thematic Fund for Obstetric Fistula for 2016

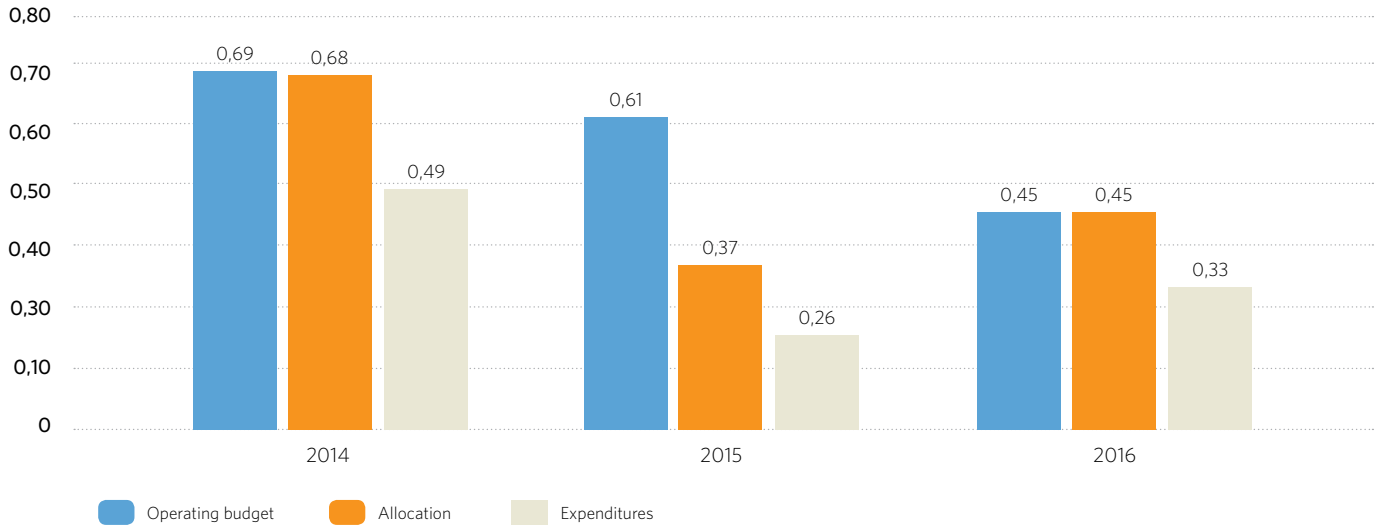
Donors	Contributions (US$)
Carry-over from 2015	318,929
Contributions received in the fourth quarter of 2015 for programming in 2016	29,053
Contributions received during the first three quarters of 2016	100,000
TOTAL operating budget in 2016	**447,982**
Contributions received during the fourth quarter of 2016	266,824

Figure 36: Total recognized and collected revenue for the Thematic Fund for Obstetric Fistula 2016

Donors	Recognized revenue (US$)*	Collected revenue (US$)*	Deposit received
Iceland	100,000	100,000	8-Sep-16
Poland	27,693	27,693	30-Nov-16
Luxembourg	239,130	239,130	21-Dec-16
Total for 2016	366,824	366,824	

* Recognized revenue signifies new pledges in 2016. Collected revenue is the actual amount transferred to UNFPA.

Figure 38: Operating budget, allocations and expenditures for obstetric fistula 2014-2016



Women of the Ziway Dugda woreda, Oromia Region in Ethiopia
©Eskinder Debebe, UN Photo, 2016

6 | CONCLUSION AND LOOKING FORWARD

As the MHTF approaches the end of Phase II (2014-2017), the findings and results reflected throughout this report continue to demonstrate its value and unique role in global health. It has continued to support countries to strengthen their policy frameworks and capacities, but also increasingly has assisted them to accelerate implementation and use disaggregated data to improve interventions, inform policy direction and, fundamentally, to reach those furthest behind first. The MHTF has also demonstrated that it can respond and adapt to different contexts, including in fast-moving and at times challenging situations arising from natural disasters and conflict.

On the core issues of the MHTF, no other current mechanism or fund (Figure 40) provides a similar combination of strategic, proven interventions underpinned by human rights and gender equality principles, and where women and girls, particularly the most disadvantaged, are at the heart of actions to improve maternal health. The MHTF is backed by a wealth of technical expertise providing state-of-the-art knowledge and skills, complemented by an innovative vision to support country leadership to advance maternal health and the broader SRHR agenda. Its reach spans the global, regional and country levels, and diverse partners – governments, civil society organizations, academia, the private sector, UN organizations and donors. All are dedicated to making a difference by changing the status quo to achieve better health and well-being for all women and girls.

Figure 39: Summary of key results from 2014 to 2016

Midwifery

- Almost all countries implement ICM education standards (44 per cent more countries than in 2013).
- Over 32,000 midwives* supported (in both pre-service education and in-service training).
- National associations with a costed plan in place in 70 per cent of countries.

EmONC

- Availability of EmONC measured in 21 countries, reaching on average of 30 per cent of the EmONC international standard.
- Four countries reached 65 per cent of this standard in 2016.
- Six countries have the capacity to monitor the availability and quality of EmONC services.

MDSR

- All 39 countries have initiated an MDSR programme.
- A national MDSR system has been implemented to notify and review all maternal deaths in 70 per cent of countries.

Fistula

- Over 39,000 obstetric fistulas were repaired between 2014 and 2016.
- 15 countries have national strategies for eliminating obstetric fistula.
- UNFPA is co-leading, with Johns Hopkins University, the estimation of the first global number of fistula cases, and the provision of estimates to countries to strengthen their planning for eliminating obstetric fistula.

FTYM

19 countries have prioritized FTYM in their national health plans.

* Based on UNFPA country reported data from 2014 to 2016

UNFPA estimates that 66,400 maternal deaths have been averted since 2010[37] in the 39 MHTF-supported countries. Notwithstanding this success, it represents only 16 per cent of the 411,350 women who could have been saved between 2010 and 2015 in these countries if the MDG 5 targets for maternal health had been reached in all these countries. Only three countries supported by the MHTF achieved the MDG 5 target of a 75 per cent reduction in the MMR.

In order to address this unfinished agenda, the MHTF remains on the frontlines in contributing to the SDGs, particularly to SDG 3 (target 3.1). It is supporting countries to reduce their national MMR by two-thirds, and contribute to the global target of less than 70 maternal deaths per 100,000 live births by 2030. Reaching target 3.1 will require substantial efforts from countries and the need to mobilize additional funds, both domestic and international, to tackle the unacceptable failures leading to 303,000 maternal deaths per year. These funds should specifically focus on high-impact interventions addressing maternal mortality and morbidity – such as those advanced by the MHTF in its second phase.

In looking forward, the next phase of the MHTF (2018-2021) will contribute to UNFPA's new Strategic Plan (2018-2021) to advance the ICPD and the 2030 Agenda. The MHTF will complement both core and non-core resources, working in tandem with UNFPA Supplies to have an even greater impact on SRHR.

37 See Annex 2: Maternal deaths averted methodology.

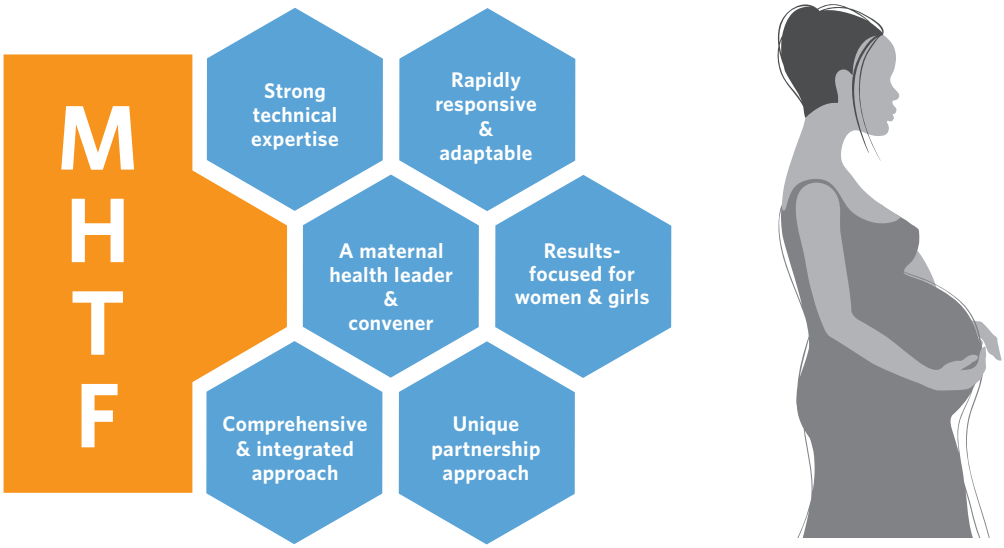
Phase III will have a specific focus on those left furthest behind (e.g., FTYM, adolescent girls and indigenous women), and support countries to scale up efforts to ensure that policies and programmes are tailored to deliver for those who are most disadvantaged.

The Third Phase III of the MHTF will consolidate results of the first two phases by focusing on:

- Equity in access to care;
- Quality of care; and
- Accountability mechanisms for both the availability and quality of care.

The MHTF will also continue to support countries more generally to make the best-informed policy choices, based on the latest evidence, so that they can prioritize, plan, budget, implement, monitor and evaluate maternal health services that deliver results for women and girls, particularly those left furthest behind. Phase III will also strengthen integration and enhance the complementarity between MHTF areas of work and other sexual and reproductive health components to have an even greater impact. A detailed business plan will be elaborated to support implementation, with all efforts directed towards sustainable change in countries with high maternal morbidity and mortality so that they can deliver improved health and well-being for women and girls.

Figure 40: The MHTF's unique approach



ANNEX 1: RESOURCES AND MANAGEMENT – APPROVED ALLOCATIONS, EXPENDITURES AND FINANCIAL IMPLEMENTATION RATES FOR THE MHTF, 2014-2016

	2014			2015			2016		
Regional office/country office/ Global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**
Sub-Saharan Africa									
East and Central Africa Regional Office/ Johannesburg	262,500	155,094	59	79,180	38,101	48	171,200	124,704	73
Western and Central Africa Regional Office/Dakar	210,000	28,903	14	-	(7)	0		-	0
Benin	420,000	395,190	94	300,762	324,875	108	277,938	234,239	84
Burkina Faso	500,000	399,268	80	308,000	401,408	130	326,431	313,244	96
Burundi	385,000	397,055	103	296,450	279,224	94	398,856	373,150	94
Cameroon	35,000	30,554	87	39,590	38,047	96	123,050	103,014	84
Central African Republic	128,079	63,121	49	159,497	111,771	70	131,622	130,222	99
Chad	960,000	820,773	85	739,038	670,403	91	788,870	794,258	101
Congo	120,000	115,064	96	120,000	104,205	87	212,100	202,815	96
Côte D'Ivoire	443,539	380,951	86	385,000	285,344	74	399,745	369,340	92
Democratic Republic of the Congo	1,001,630	962,921	96	804,538	561,754	70	775,750	812,166	105
Ethiopia	750,000	1,485,731	198	1,700,074	1,090,253	64	1,125,658	413,681	37
Ghana	270,000	272,987	101	207,912	189,765	91	311,868	292,688	94
Guinea-Conakry	180,000	94,017	52	148,302	162,074	109	171,400	170,168	99
Guinea-Bissau	140,000	100,187	72	3,282	68	2	81,793	35,827	44
Kenya	215,000	191,250	89	165,604	125,627	76	236,414	236,189	100
Liberia	210,000	185,725	88	177,098	132,332	75	121,017	124,418	103
Madagascar	595,000	554,535	93	431,200	431,261	100	456,890	450,221	99
Malawi	315,000	279,041	89	126,000	108,295	86	94,500	95,577	101
Mali	120,000	56,164	47	92,400	56,293	61	106,259	66,153	62
Mauritania	60,000	55,862	93	96,162	62,002	64	144,243	143,648	100
Mozambique	140,000	134,497	96	107,800	100,961	94	112,950	105,609	94
Niger	280,000	272,196	97	215,600	229,385	106	323,399	301,428	93
Nigeria	300,000	281,886	94	372,497	261,850	70	323,973	394,128	122
Rwanda	150,000	149,964	100	182,940	163,584	89	249,982	227,826	91
Senegal		-12,764		154,000	141,546	92	199,144	190,308	96
Sierra Leone	515,000	525,018	102	437,225	437,749	100	265,902	262,414	99
South Sudan	612,500	610,441	100	494,340	460,164	93	107,000	109,249	102
Togo	100,000	99,729	100	77,000	71,336	93	136,900	134,835	98
Uganda	350,000	428,843	123	302,437	293,893	97	241,758	229,090	95
Zambia	300,000	292,708	98	231,000	214,981	93	376,684	334,284	89
Sub-Saharan Africa total	**10,180,748**	**9,957,213**	**98**	**8,954,928**	**7,548,542**	**84**	**8,793,296**	**7,774,892**	**88**

Annex 1: Resources and Management – Approved Allocations, Expenditures and Financial Implementation Rates for the MHTF, 2014-2016 (continued)

	2014			2015			2016		
Regional office/country office/ Global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**	**Approved allocation (US$)**	**Expenses (US$)**	**Impl. rate (%)**
Arab States									
Djibouti				-	(65)	0	-	-	0
Somalia	300,000	306,372	102	275,390	271,508	99	274,925	258,875	94
Sudan	425,000	369,950	87	327,250	301,240	92	338,214	353,339	104
Republic of Yemen	100,000	75,026	75	-	-		104,076	96,966	93
Arab States total	825,000	751,349	91	602,640	572,683	95	717,215	709,180	99
Asia and the Pacific									
Afghanistan	438,800	398,911	91	335,000	330,956	99	404,620	404,300	100
Bangladesh	120,000	119,985	100	119,840	116,905	98	138,416	137,905	100
Cambodia	80,000	79,935	100				-	-	0
Lao People's Democratic Republic	282,587	267,492	95	282,801	280,947	99	339,361	337,561	99
Nepal	100,000	95,480	95	100,045	94,213	94	150,068	135,745	90
Pakistan	250,000	229,981	92	191,304	181,082	95	286,874	269,507	94
Timor-Leste	156,000	136,472	87	77,000	86,592	112	115,494	113,505	98
Asia and the Pacific total	1,427,387	1,328,256	93	1,105,990	1,090,695	99	1,434,833	1,398,523	97
Latin America and the Caribbean									
Latin America and the Caribbean Regional Office	87,500	74,691	85	87,500	87,499	100	87,740	86,951	99
Subregional Office, Kingston	0	3,534			1,010	0	-	-	0
Haiti	950,599	935,246	98	654,500	632,156	97	499,977	493,705	99
Latin America and the Caribbean total	1,038,099	1,013,470	98	742,000	720,665	97	587,717	580,656	99
Global technical support									
Global technical support, including implementing partners**	3,606,627	3,210,603	89	3,574,627	3,012,178	84	2,984,475	2,711,646	91
Information and External Relations Division	282,800	278,290	98	116,058	72,024	62	-	-	0
Media and Communications Branch	250,000	249,431	100	194,242	194,962	100	272,049	272,333	100
Non-Core Funds Management Unit	0	0	0	200,071	198,354	99	-	186,813	0
Global technical support total	4,139,427	3,738,323	90	4,084,998	3,477,519	85	3,256,524	3,170,792	97
GRAND TOTAL	17,610,660	16,788,611	95	15,490,556	13,410,103	87	14,789,585	13,634,042	92
Non-allocated*				3,000,000			1,982,955		
Total incl. non-allocated				8,490,556	13,410,103	73	16,772,540	3,634,042	81

*Includes contributions received during the year.

**Support to international implementing partners (which primarily operate at country and regional levels) constituted $800,000 in 2016. In 2015, support for international implementing partners was $1.1 million.

ANNEX 2: MATERNAL DEATH 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 WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division)[38].

Estimates for intervening years and for 2016 were interpolated assuming a linear trend.
For each country, estimates of the number of live births in each year from 1990 to 2016 were taken from the United Nations Population Division's World Population Prospects website[39] using the medium variant estimates.

For each country, the number of maternal deaths in each year from 1990 to 2016 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 2016 had the country's maternal mortality ratio remained at its 2009 level was calculated for each year from 2010 to 2016 as follows:

- MMR2009 * 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 2016 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 the elasticity relating population coverage and obstetric fistula was less than 1.

As a result of this calculation, the MHTF has contributed to avert about 19,200 maternal deaths during the 2014-2016 period. The estimated number of averted maternal deaths in to which MHTF has been contributing since 2010 is 66,400.

38 Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division Geneva: World Health Organization, 2015.
39 esa.un.org/unpd/wpp/

ANNEX 3: CAMPAIGN TO END FISTULA PARTNERS

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 (CDC), 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 (AMDD), Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), 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, 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), Human Rights Watch

Institut de Formation et de Recherche en Urologie et Santé de la Famille (IFRU-SF) (Senegal), International Confederation of Midwives (ICM), International Continence Society, International Federation of Gynecology and Obstetrics (FIGO), International Forum of Research Donors (IFORD), International Nepal Fellowship (INF), International Planned Parenthood Federation (IPPF), International Society of Obstetric Fistula Surgeons (ISOFS), International Urogynecological Association (IUGA), 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 (LIRASEF, Cameroon), London School of Hygiene and Tropical Medicine

Maputo Central Hospital (Mozambique), Médecins du Monde, Médecins Sans Frontières (MSF), 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 (PAUSA), Population Media Center, Psychology Beyond Borders

Regional Prevention of Maternal Mortality Network (RPMM, Ghana), Royal College of Obstetricians and Gynaecologists (RCOG)

Sana'a Hospital (Yemen), Selian Fistula Project (United Republic of Tanzania), Société Africaine des Gynécologues-Obstétriciens (SAGO), Société Internationale d'Urologiel, Solidarité Femmes Africaines (SOLFA)

The Association for the Rehabilitation and Re-orientation of Women for Development (TERREWODE, Uganda)

Uganda Childbirth Injury Fund, United Nations Population Fund (UNFPA), United States Agency for International Development (USAID), University of Aberdeen, University Teaching Hospital of Yaoundé (Cameroon)

Virgin Unite, White Ribbon Alliance, Women and Health Alliance International (WAHA), Women's Health Organization International (WHOI), Women's Hope International (WHI), Women's Missionary Society of the African Methodist Episcopal Church, World Health Organization (WHO), World Vision, Worldwide Fistula Fund, Zonta International

ANNEX 4: RESULTS INDICATORS FRAMEWORK (2013-2016)

Outcome A : Strengthened national capacity to implement comprehensive midwifery programs										
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**				
	2013 (baseline)	**2014**	**2015**	**2016**	**2017 (target)**	**2013 (baseline)**	**2014**	**2015**	**2016**	**2017 (target)**
Afganistan						N	N	N	Y	Y
Bangladesh	31,7%	31,7%	45,0%		50,0%	N	N	Y	Y	Y
Benin	60%	84%	100%		100%	Y	Y	Y	Y	Y
Burkina Faso	50,5%	50,5%	67,5%		85,0%	Y	Y	Y	Y	Y
Burundi	51%	73%			60,0%	N	N	Y	Y	N
Cameroon	19,1%	19,1%							Y	Y
Central African Republic	33,1%	33,1%			40%	Y	Y	Y	Y	Y
Chad						Y	Y	Y	Y	Y
Congo						N	N	N	N	N
Côte d'Ivoire	35%	35%				Y	Y	Y	Y	Y
Democratic Republic of the Congo						N	N	N	Y	
Ethiopia	2%	16%				N	N	N	Y	Y
Ghana	38,6%	38,6%		46,9%		N	N	N	N	Y
Guinea	45%	45%	45%	49%		Y	Y	Y	Y	Y
Guinea Bissau						Y	Y	Y	N	N
Haiti	9,6%	9,6%			20%	N	N	Y	N	Y
Kenya	44%	44%	62%	62%	65%	N		N	Y	Y
Lao People's Democratic Republic						Y	Y	Y	Y	Y
Liberia	61%	61%			80,0%	N	N	Y		Y
Madagascar	27%	27%				N	N	N	N	Y
Malawi	71%	71%	71%			Y	Y	Y	Y	
Mali						Y	Y	Y	Y	Y
Mauritania						Y		Y		Y
Mozambique						Y	Y	Y	Y	Y
Nepal				55,6%		N	N	N	N	N
Niger						Y	Y	Y	Y	Y
Nigeria	6%	6%				N	N	N	Y	Y
Pakistan						Y	Y	Y	Y	Y
Rwanda						N	N	N	N	Y
Senegal						N	N	N	Y	Y
Sierra Leone						N	N	N	Y	Y
Somalia						Y	Y	Y	Y	Y
South Sudan						N	N	N	Y	Y
Sudan						N	N	N	Y	Y
Timor-Leste						N	N	N	N	N
Togo	27%					N	N	Y	Y	Y
Uganda					70%	Y	Y	Y	Y	Y
Yemen	17%	17%				N	N		N	N
Zambia						Y	Y	Y	Y	Y

Y = Yes

N = No

	Curriculum for midwifery pre-service training is based on ICM/WHO standards					Number of midwifery school supported by the MHTF					A governing body regulates midwifery practice					The national midwifery association has a "budgeted Strategic Action Plan"				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
	Y	Y	Y	Y	Y	0	0	2	2	2	N	N	N	N	Y	N	Y	Y	Y	Y
	Y	Y	Y	Y	Y	16	16	31	38	3	N	N	Y	Y	Y	N	N	Y	N	
	Y	Y	Y	Y	Y	1	1	1	1	2	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y	8	8	8	10	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	1	1	1	1	1	N	N	Y	Y		N	N	N	N	Y
	Y	Y	Y	Y	Y	0	0	10	10	10	N	N	N			Y	Y	Y		
	Y	Y	Y	Y	Y	0	0	0	10	10	Y	Y	Y		Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y	1	1	3	7	7	N	N	Y	N	Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y	2	2	2	2	2	Y	Y	Y	Y	Y	N	N	N	Y	Y
	Y	Y	Y	Y	Y	5	5	5	5	5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	6	6	0	12	12	N	N	N	N		Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	31	31	0	35	35	N	N	Y	Y	N	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	20	20	25	36	36	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	0	0	0	0	2	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	0	0	0	1	1			N	N	N			Y	Y	Y
	Y	Y	Y	Y	Y	1	1	1	1	1	N	N	N	N	Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y	0	0	1	4	6	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	N	N	Y	Y	Y	9	9	9	9	9	Y	Y	Y	Y	Y	N	N	Y	N	Y
	Y	Y	Y	Y	Y	4	4	5	0	5	Y	Y	Y		Y	Y	Y	Y		Y
	N	N	Y	Y	Y	6	6	6	6	6	Y	Y	Y	Y	Y	N	N	N	Y	Y
	Y	Y	Y	Y	Y	1	1	1	0	0	Y	Y	Y	Y		Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	5	5	5	5	5	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	Y	N	Y	5	2	5	3	5	Y	N	Y	N	Y	N	N	N	N	Y
	Y	Y	Y	Y	Y	0	0	0	0	0	N	N	N	N	Y	N	N	N	Y	Y
	N	N	N	N	Y	0	0	0	1	4	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	Y	Y	Y	2	2	2	2	2	N	N	N	N	Y	N	N	Y	N	Y
	N	N	N	Y	Y	0	0	24	25	25	Y	Y	Y	Y	Y	N	N		Y	Y
	N	N	N	Y	Y	1	16	1	1	2	Y	Y	Y	Y	Y	N		N	Y	Y
	N	N	N	Y	Y	0	0	8	8	8	Y	Y	Y	Y	Y	N	N	Y	N	Y
	Y	Y	Y	Y	Y	0	0	1	7	7	N	N	Y	Y	Y	N	N	N	Y	Y
	N	N	N	Y	Y	0	0	2	0	3	Y	Y	Y	Y	Y	N	N	N	N	N
	Y	Y	Y	Y	Y	6	6	11	15	16	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y	1	1	1	5	7	N	N	N	N	Y	N	N	N	Y	Y
	N	N	N	N	N	18		23	23	23	N	N	N	Y	Y	N		N	N	Y
	Y	Y	Y	Y	Y	0	1	1	1	1	N	N	N	N	N	N	N	N	N	Y
	Y	Y	Y	Y	Y	1	2	2	0	1	N	N	N	N	N	N	N	Y	Y	Y
	N	N	Y	Y	Y	18	18	18	18	40	Y	Y	Y	Y	Y	N	N	N	Y	Y
	Y	Y		Y	Y	0	0	0	0	0	N	N		N	Y	N	N		N	Y
	N	N	Y	Y	Y	15	3	4	3	6	Y	Y	Y	Y	Y	N	N	Y	Y	Y

Annex 4: Results Indicators Framework (continued)

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

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				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
Afganistan						Y	Y	Y	Y	Y
Bangladesh						N	N	Y	Y	Y
Benin	23%	23%			75%	Y	Y	Y	N	Y
Burkina Faso	18%	18%	25%	32%	80%	Y	Y	Y	Y	Y
Burundi	18%				20%	Y	Y	Y	Y	Y
Cameroon						Y	Y			
Central African Republic	29%	29%			40%	N	N	N	N	Y
Chad						Y	Y	Y	Y	Y
Congo						Y	Y	Y	Y	Y
Côte d'Ivoire	39%	39%				N	N	N	Y	Y
Democratic Republic of the Congo						Y	Y		Y	Y
Ethiopia									Y	Y
Ghana						Y	Y	Y	Y	Y
Guinea						Y	Y	Y	Y	Y
Guinea Bissau						Y	Y	Y	Y	Y
Haiti	20%	20%	16%		10%	N	N	Y	Y	Y
Kenya	3,70%	3,70%	3,95%			Y	Y		Y	Y
Lao People's Democratic Republic						N	N	Y	Y	Y
Liberia						Y	Y	Y		Y
Madagascar						Y	Y	Y	Y	Y
Malawi						Y	Y	Y	Y	
Mali						Y	Y	Y	Y	Y
Mauritania						N	N	N	Y	Y
Mozambique						N	Y		N	N
Nepal						N	N		N	N
Niger						Y	Y	Y	Y	Y
Nigeria						Y	Y	Y	Y	Y
Pakistan						N			Y	Y
Rwanda						N	N	Y	Y	Y
Senegal						N	N	N	Y	Y
Sierra Leone						Y	Y	Y	Y	Y
Somalia						N	N	Y	Y	Y
South Sudan						N	N	Y	Y	Y
Sudan						Y		Y	Y	Y
Timor-Leste						N	N	N	Y	Y
Togo			24%		80%	Y	Y	Y	Y	Y
Uganda						N	N	Y	Y	Y
Yemen	40%	40%				Y	Y		Y	Y
Zambia						N	N	N	Y	Y

Y = Yes

N = No

	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)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
	Y	Y	Y	Y	Y	N	Y	N	Y	Y
	Y	Y	Y	Y	Y	N	N	N	N	Y
	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	Y	Y	N		
	N	N	N			N	N	N		Y
	N	N	N		Y	Y	Y	Y	N	Y
	N	N	Y	Y	Y	N	N	N	N	Y
	N	N	Y	N	Y	N	N	N	Y	Y
	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	N	Y		N		N	N		Y	Y
				N		N	Y		N	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	Y	Y	N	Y	N	Y	Y	Y	Y
	Y	Y	Y	Y		Y	Y	Y	Y	
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y		N	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	N	N	N	N	Y
	Y	Y	N		Y	Y	Y	Y		Y
	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y		Y				N	N	
	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	Y	N	N	N	N	Y
	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	Y	Y	Y	Y	Y				N	Y
	Y	Y	Y	Y	Y	N	N	Y	N	Y
	N	N	N	Y	Y	Y	Y	Y	Y	Y
						N			N	Y
		N	Y	Y	Y				Y	Y
	Y	Y	N	Y	Y	N	N	Y	Y	Y
	N	Y	Y	N	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
	N	N	N	Y	Y	N	N	N	N	Y
	N		Y	Y	Y	N	-	N	N	Y
	N	N	N	Y	Y	N	N	N	Y	Y
	N	Y	Y	Y	Y	N	N	N	N	Y
	N	N	N	Y	Y	Y	Y	Y	Y	Y
	N	N		N	Y	Y	Y		Y	Y
	Y	Y	N	Y	Y	Y	Y		N	Y

Annex 4: Results Indicators Framework (continued)

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

Indicators	Direct obstetric complications are documented in each EmONC facility					Case Fatality Rate (CFR) per direct obstetric complication are systematically documented at C EmONC level				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
Afganistan	Y	Y	Y	Y	Y	N	N	N	Y	Y
Bangladesh	Y	Y	Y	Y	Y			Y	Y	Y
Benin	Y	Y		N	Y	N	N		N	Y
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	Y	Y	Y	Y	Y		Y			Y
Cameroon	N	N	N			N	N	N		
Central African Republic	N	N	Y	N	Y	N	N	Y	N	Y
Chad	N	N	Y	Y	Y	N	N	Y	N	Y
Congo	N	N	Y	N	Y	N	N	Y	N	Y
Côte d'Ivoire	N	N	N			N	N	N	N	Y
Democratic Republic of the Congo	Y	Y		Y	Y	N	Y		N	Y
Ethiopia				Y	Y			Y	Y	Y
Ghana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Guinea		Y	Y	N	Y	Y	Y	Y	N	Y
Guinea Bissau			Y	Y	Y			Y	N	Y
Haiti	N	N	N	Y	Y	N	N	N	Y	Y
Kenya	Y	Y	Y	Y	Y	Y	Y		Y	Y
Lao People's Democratic Republic	N	N	N	N	Y	N	N	Y	N	Y
Liberia	Y	Y	N		Y	Y	Y	Y		Y
Madagascar	N	N	N	Y	Y	N	N	N	Y	Y
Malawi	Y	Y	Y	N		Y	Y	Y	N	
Mali	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mauritania	N	N	N	N	Y	N	N	N		Y
Mozambique	Y	Y	Y	Y						
Nepal	Y	Y	Y	Y	Y	Y	Y		Y	
Niger		Y		Y	Y		Y		Y	Y
Nigeria	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pakistan	Y			Y	Y	Y			Y	Y
Rwanda				Y	Y			N	Y	Y
Senegal	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sierra Leone	Y	Y	Y	N	Y	Y		Y	Y	
Somalia	Y	Y	Y	N	Y	Y	Y	Y	N	Y
South Sudan	N	N	N	N	Y	N	N	N	N	Y
Sudan	N		Y	N	Y	N		Y	N	Y
Timor-Leste	N	N	N	N	Y	N		N	N	Y
Togo	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Uganda	Y	Y	N	Y	Y	Y	N	N	Y	Y
Yemen		Y				N	N		N	Y
Zambia	N	N	N	Y	Y	N	N		N	Y

Y = Yes

N = No

	A costed plan exists for RH integrated services in EmONC facilities					Proportion of women leaving EmONC facilities with a contraceptive modern method				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
	Y	Y	Y	Y	Y					
	N	N	N	N	Y	55%				65%
	Y	Y	Y	Y	Y					
	Y	Y	Y	Y	Y			26%		
	N	N	Y	Y	Y			20%		
			N							
	N	N	Y	Y	Y					
	Y	Y	N	N	Y					
	N	N	Y	Y	Y					80%
	N	N	N	Y	Y					
	N	N		N						
	Y	Y		Y	Y					
	N	N	N	N		97%				
	Y	Y	Y	N	Y	68%				
			Y	N	Y					
	N	N	Y	Y	Y				12,85%	25%
	N	N	Y	N	Y					
	N	N	Y	N	Y					
	Y	Y	Y		Y			29%		
	Y	Y	Y	Y	Y					
	Y	Y	Y	N						
	Y	Y	Y	Y	Y					
	N	Y	N	Y	Y					
	Y	Y	Y	Y	Y					
	N	N								
	Y	Y	Y	Y	Y				2,3%	25%
	Y	Y	Y	Y	Y					
	N			N	Y					
	N			N	Y					
	N	Y	N	Y	Y					
	Y	Y	Y	Y	Y					
	Y	Y	Y	N	Y		39%			5%
	N	N	N	N	Y					
	in some states		in some states	N	in some states					
	Y	Y	Y	N	Y					5%
	N	N	Y	Y	Y			5%		10%
	-	-	Y	Y	Y			< 10%	< 20%	5%
	Y	Y	-	Y	Y					2%
	Y	Y	Y	Y	Y					

Annex 4: Results Indicators Framework (continued)

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

Indicators	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)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
Afganistan	N	N	Y	Y	Y					
Bangladesh	N	N	N	N	N			24	106	
Benin	Y	Y	Y	N	Y					
Burkina Faso	Y	Y	Y	Y					70	
Burundi	N	N	N	N	Y					
Cameroon	N	N								
Central African Republic	Y	Y	Y							
Chad	N	N	N	Y	Y	6/450		8/450	10/450	
Congo	N	N	N		Y					
Côte d'Ivoire	Y	Y	Y	Y	Y				167	182
Democratic Republic of the Congo	N	N		N						
Ethiopia	Y	Y		Y	Y					
Ghana	N	N	N	N						
Guinea	Y	Y	Y	Y	Y	15		20		
Guinea Bissau			Y	N	Y					
Haiti				N					2	
Kenya	N	N	N	N	Y					
Lao People's Democratic Republic										
Liberia	Y	Y	Y		Y					
Madagascar	N	Y	N	N	Y			3	12	25
Malawi	Y		Y							
Mali	Y	Y	Y	Y	Y			20		
Mauritania	N	N	N	N	Y	2		6		6
Mozambique	N	N	N		Y					
Nepal	N	N		N	N					
Niger	Y	Y	Y	Y	Y			13		
Nigeria	N	N	N	N	N			11		
Pakistan	N			N	N					
Rwanda	N	N	N	N	N					
Senegal	Y	Y	N	Y	Y	110/64		76/150	100/176	
Sierra Leone	Y	N	N	Y	Y					
Somalia	N	N	N	N	Y					
South Sudan	N	N		Y	Y					
Sudan	N		N	N	N					
Timor-Leste	N			N	N					
Togo	N	N	Y	Y	Y					
Uganda	Y	Y	Y	Y	Y					
Yemen	N	N		Y	Y	4			6	10
Zambia	Y	N		N	Y			4		

Y = Yes

N = No

	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				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
	N	N	N	N	Y	N	N	Y	Y	Y	N	N	Y	N	N
	N	N	Y	N	Y	N	N	Y	Y	Y	N	N	Y	Y	
	Y	Y	Y	N		N	N	N	N	Y	N	N	Y	Y	Y
	Y	Y	Y	N		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N	Y
	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	N			Y
	N	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N		Y
	N	Y	N	N	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Y	Y	N	N	Y	N	N	Y	Y	Y	N	N	N	Y	Y
	N	N	N	N	Y	N	Y	Y	N	Y	N	N		N	
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N		N	Y
	N	N	N	N	Y	N	N	Y	Y	Y	N	Y	N	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y
	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
			N	N				N	N					N	
	N	N	N	N	N	Y	Y	Y	Y	Y	N	N	N	N	Y
			N												
	Y	Y	N		Y	Y	Y	Y		Y	Y	Y	Y		Y
	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N	Y
	N	N	N	N		Y	Y	Y	Y		N	N	N	N	
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y	
	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y
	N	N	N	N	N	Y	N	Y	N	Y	N	N	N	N	N
	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N		
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y
	N		N	N	N	N			N	N	Y			Y	Y
	N	N	N	N		N	N	N	N	Y	N	N	N	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	N	N	N		N	N	Y	Y	Y	Y	Y
	N	N	N	N	Y	N	N	Y	Y	Y	N	N	N	Y	N
	N	N	N	N	Y	N	N	N	N	Y	N	N	N	Y	Y
	N		N	N	N	N		N	Y	Y	N		N	N	N
	N		N	N	N	N			N	N	N			N	N
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y
	N	N	N	N	Y	N	N	N	Y	Y	N	N		Y	Y
	N	N	N	N	Y	N	N	Y	Y	Y	N	N	Y	Y	Y

Annex 4: Results Indicators Framework (continued)

Outcome D : Enhanced national capacity for maternal death surveillance and response.

Indicators	An inter-ministerial MDSR committee is functioning					The MDSR development system is monitored				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
Afganistan	N	N	Y	Y	Y	N	N	Y	Y	Y
Bangladesh	N	N	N	Y	Y	N	N	Y	N	Y
Benin	N	N	-	N	Y	N	N	Y	N	Y
Burkina Faso	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Burundi	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Cameroon					Y			N	Y	Y
Central African Republic	Y	Y	Y	N		Y	Y	Y	Y	Y
Chad	N	N	N	N	Y	Y	Y	Y	Y	Y
Congo	N	N	N	N	Y	Y	Y	Y	Y	Y
Côte d'Ivoire	N	N	Y	N	Y	Y	Y	Y	Y	Y
Democratic Republic of the Congo	N	N	N	Y		Y	Y		Y	
Ethiopia			N	N	N			Y	Y	Y
Ghana		N	N	N		N	N	N	Y	Y
Guinea		Y	Y			Y	Y	Y	Y	Y
Guinea Bissau	Y	Y	Y	Y	Y			Y	Y	Y
Haiti	N	N	N	N	Y	N	N	Y	N	Y
Kenya	N	N	N	N	Y	Y	Y	Y	Y	Y
Lao People's Democratic Republic	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Liberia	Y	N	Y		Y	Y	Y	N		Y
Madagascar	N	N	Y	Y	Y	Y	Y	N	Y	Y
Malawi	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Mali	N	N	N	Y	Y	N	N	Y	N	Y
Mauritania	N	N	N	N	Y	N	N	N	Y	Y
Mozambique	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Nepal	N	N	N	N	N			N	Y	Y
Niger	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nigeria	N	N	N	Y	Y	N	N	N	Y	Y
Pakistan	N			N	N	N	N	N	Y	Y
Rwanda	N	N	Y	Y	Y	Y	Y	Y	Y	Y
Senegal	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Sierra Leone	N		Y	Y	Y	Y		Y	Y	Y
Somalia	N	N	N	N	Y	N	N	N	N	Y
South Sudan	N	N	N	N	Y	N	N	N	N	Y
Sudan	Y		Y	Y	Y	Y		Y	Y	Y
Timor-Leste	N	N	N	N	Y	N	N	Y	Y	Y
Togo	Y	Y	N	N	Y	Y	Y	Y	Y	Y
Uganda	N	N	N	Y	Y	Y	Y	Y	Y	Y
Yemen	Y	Y		N	Y	N	N	N	N	Y
Zambia	N	N	N	N	Y	N	N	N	Y	Y

Y = Yes

N = No

	All subnational subdivisions are producing an annual MDSR report				
	2013 (baseline)	2014	2015	2016	2017 (target)
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	Y	Y	Y
	Y	Y	Y	Y	Y
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	N	N	N
	N	N	N	Y	Y
	Y	Y	Y	Y	Y
	N	N	N	N	N
	N	N	N	N	N
	N	N	Y	Y	Y
	N	N	N	N	Y
	Y	Y	Y	Y	Y
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	N	Y	Y
	N	N	N	N	N
	N	N	N	N	Y
	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y
	N	N	N	N	Y
	N	N	Y	Y	Y
	N	N	N	N	N
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	N	N	N
	N	N	Y	N	Y
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	N	N	Y
	N	N	Y	N	Y
	N	N	N	N	N
	N	N	Y	Y	Y
	N	N	Y	Y	Y
	N	N	N	N	Y
	N	N	N	N	Y

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Annex 4: Results Indicators Framework (continued)

Outcome E : Strengthened national capacity to reach and serve 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)					
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)	
Afganistan											
Bangladesh											
Benin	86%	86%			90%	84%	84%				
Burkina Faso	< 20 y. o. : 96,3%	< 20 y. o. : 96,3%	< 20 y. o. : 93%	< 20 y. o. : 93%		< 20 y. o. : 68,5%	< 20 y. o. : 68,5%	< 20 y. o. : 82%	< 20 y. o. : 82%		
Burundi						73%	73%			100%	
Cameroon											
Central African Republic	< 20 y. o. : 69%	< 20 y. o. : 69%	< 20 y.o: 67%	< 20 y.o: 67%	< 20 y. o. : 80%						
Chad											
Congo											
Côte d'Ivoire						58%	58%				
Democratic Republic of the Congo											
Ethiopia	20%	20%				19%	19%				
Ghana											
Guinea											
Guinea Bissau											
Haiti											
Kenya	88.5% 93%	88.5% 93%				46.6% 42.7%	46.6% 42.7%				
Lao People's Democratic Republic											
Liberia	97%	97%			98%						
Madagascar	< 20 y. o. : 80,9%		80,9%	80,9%		< 20 y. o. : 42.4%		42,4%	42,4%		
Malawi											
Mali											
Mauritania											
Mozambique											
Nepal											
Niger											
Nigeria	"61% for at least one visit	6%				N	N	N	Y	Y	
Pakistan	51% for at least four visits"					38%					
Rwanda	75,9%					55%					
Senegal											
Sierra Leone											
Somalia											
South Sudan											
Sudan											
Timor-Leste											
Togo											
Uganda	72%					59%					
Yemen											
Zambia											

Y = Yes

N = No

	14.1. First-time young mothers are a priority population in the national RMNCH plan					15.1. At least one innovative, scalable approach to improving maternal health service utilization by first-time young mothers is implemented				
	2013 (baseline)	2014	2015	2016	2017 (target)	2013 (baseline)	2014	2015	2016	2017 (target)
	N	N	Y	Y	Y	N	N	Y	Y	Y
	N	N	N	N	N	N	N	N	N	N
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y			Y	Y	Y
	N	N	N	N	Y	N	N	N	N	N
	N	N	N	N		N	N	N	N	
	N	N	Y	Y	Y	Y	Y	Y	Y	Y
	N	N	Y	Y	N	N	N	Y	Y	Y
	N	Y	Y	Y	Y	N	N	N	N	Y
	N	N	N	N	Y	N	N	N	N	Y
	N	N			N	N	N			N
			N	N	N			N	N	
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
						N	N	N	N	N
			N	N	Y					
	N	N	Y	Y	Y	N	N	N	N	Y
	N	N	Y	Y		N	N	Y	Y	
	N	N				N	N			
	N	N	N	N	Y	N	N	Y	Y	Y
	Y	N	Y	Y	Y	N	N	Y	Y	Y
	Y	-	Y	Y						
	N	N	N	N	Y	N		N	N	
	N	N	N	N	N	N	N	N	N	N
	N	N				N	N			
			N	N				N	N	
	N	Y	Y	Y	Y	N	N	Y	Y	
	N	N	N	N	Y	N	N	N	N	Y
	N				N	N				N
	N		N	N	Y	N				Y
	Y	Y	Y	Y	Y	N	N	N	N	N
	Y		Y	Y	Y			Y	Y	Y
	N	N	N	N	Y	N	N	N	N	Y
	N	N	N	N	Y	N	N	N	N	Y
			N	N				N	N	
	N				N	N				N
	Y	Y	Y	Y	Y	N	N	Y	Y	Y
	N	N	Y	Y	Y	N	N	N	N	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	N	Y	Y	Y	Y	N	Y	Y	Y	Y

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 cross-cutting 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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